Submission No 55

HEALTH SERVICES AMENDMENT (SPLITTING OF THE HUNTER NEW ENGLAND HEALTH DISTRICT) BILL 2025

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I am semi retired GP who works currently part time in Guyra Hospital (MPS)

I am still a VMO at Armidale Hospital of 40 years standing.

Both of these hospitals are in the HNE Health district.

I have worked during periods when the New England proper i.e. the New England tableland and immediate western slopes were administered from, respectively, Armidale , Tamworth and then Newcastle.

The original model was that Armidale administered hospitals at Armidale, Guyra and Tenterfield and had a teriary referral arrangement with St. Vincents Hospital in Sydney who rotated resident medical officers to Armidale.

The next model was that Tamworth Base hospital became the administration centre for all of what is now the non-Hunter part of the New England Health area, and of course this was followed by the current arrangement where administration is centred in Newcastle.

The advantages of the original model was that medical decisions were taken locally, resulting in a well equipped hospital with very good staff morale and an attraction for GPs and specialists to the area.

As control of decisions and finances moved further away, it became more difficult for the hospital to obtain what was needed. Indeed at one Medical Staff Council meeting when a failed piece of equipment was needing to be replaced, the CEO of Armidale hopital told us that he was only authorised for spending up to $1000 and that submissions through Tamworth would take some months.

The pathology service at the hospital became downgraded with many important tests being moved off site (and needing time delaying transport to Tamworth).

More recently under Newcastle administration (although our radiology manager is in Tamworth), we lost our excellent ultrasonographer because he was doing the work of essentially 2 ultrasonographers, and his and the Medical Staff council's pleas for a second person fell on deaf ears. Of course a second ultrasonographer would have more than doubly paid for their salary in Medicare rebates for outpatient referrals, so our only conclusion was an exercise showing us who was running the place.

Other examples of the problems of distant control have occurred at Guyra Hospital where I often cover the hospital and ED.

The slit lamp for examining eyes and removing foreign bodies became unservicable a few years ago, never to be replaced.

The X-ray machine broke down 2 months ago with no timetable for it's repair or replacement. Both of these are absolutely basic items for a rural hospital ED, but it seems no priority exists outside of Guyra for these.

Another example was the lack of internet service in the Guyra staff accomodation (3 units) in a renovated house near the hospital, where there is no reliable Telstra or Optus service to even use mobile internet or indeed, on occasions, get phone calls. For the first year I worked here I , and the manager, put in a nummber of requests for the NBN to be connected (there is an NBN terminal outside the door) but this had to authorised by IT in Newcastle. After a year

of no action I stopped doing 24 hours on call (at $14/hr plus $150 per night call-out) and left the night ED on call to the teledoctor service ($550 per consultation). This teledoctor fee comes out of the local Guyra budget. So for the sake of an inability to arrange a $50 per month internet service the local hospital pays out tens of thousands yearly.

This didn't only affect my time on call. More recently 2 student nurses arrived at Guyra hospital for a 4 weeks learning attachment, staying in the staff accommodation. they were dumbfounded at the situation, having to go to the hospital at night and make use of one of the 2 terminals at the nurses station to do their university work. Any attempt by the universities to give these students some encouragement toward rural medicine was only discouragement.

The other frustration with the current situation in Hunter New England is the often poor support from the Tamworth Base and the tertiary hospital, John Hunter (JHH), in having patients transferred.

The admitting registrars seem to, as one told me today, "feel they have to defend their patch".

I spent an hour on the phone yesterday and another hour today trying to transfer a patient who is severely debilitated [redacted]. The doctor I am locuming for, arranged transfer to Armidale last week to be under a specialist but he was sent back to Guyra the same day as unsuitable for Armidale. The neurosurgical registars at JHH on successive days say they won't accept admission until the patient has an MRI, and Tamworth Base won't accept him because they don't have MRI on a weekend. The roundabout of spending long conversations with 3 different hospitals up the chain from a town where there is effectively 1 doctor for 3,500 people during the middle of a 10 hour overbooked day is demoralising.

I have a colleague, a very experienced locum doctor with obstetric, surgical and ED training who lives in [redacted] who refuses to do locums in the HNE area because of these problems.

[redacted] is happier spending a day's travel each way to Western Area where [redacted] gives terrific support to the practitioners in the many small health facilities, with specialist support over the phone and ready to go transfer arrangements.

Another problem is the arrangements for the actual transport of patients.

At another NEAH facility it took 3 days for an 80yo fit patient with a fractured neck of femur to be transported via Patient Flow (the last word being a misnomer) for a 1 hour trip to Tamworth Base. (Studies show the rise in mortality after fractured NOF is 20% per day). On the same locum I had to watch a young girl fitting (despite multiple IV medications) for 40 minutes while I sat on the phone waiting for Patient Flow to answer, after being told by the registrar at the Base that the only way to get the patient to the Base ED was via Patient Flow. This was not quite correct, as I was told later, as an emergency ambulance call would have been more appropriate but policy was to use Patient Flow as the ambulance costs have to be paid for by the hospital system.

A real problem is the referral system, with JHH meant to be providing the tertiary clinics for patients in the northern New England area. The transport for patients to Newcastle is in general more difficult than for referrals to Sydney. Nearly all private patients go to Sydney or Brisbane because of this , whereas public (non-insured) patients have extremely long waiting lists to even get to see a specialist at JHH. I cite the example of a patient I referred to JHH with an

accompanying letter from the Armidale orthopaedic surgeon, who was seen 2 years later, (and subsequently operated some months later) and who spent 3 years off work on Centrelink payments.

While health services' waiting times for surgery are monitored and published, I believe health service clinic waiting times are far more of an issue in NEAHS. Trying to refer outside the area to other hospitals is also fraught, with my patients having being told they cannot have appointments to, for example Lismore, which is actually more convenient for them.

Mental Health referrals also became centralised with generally long wait times on the central call line followed by long case discussions for vetting to see whether the patient was suitable for a HNE service, so that this became impractical for GPs to use, with most now sending such patients to an ED.

What I am trying to convey with this submission is, that the further away administration and services are from the patients the poorer the service becomes unless a conscious effort is made to overcome the bias that comes with centralisation.

Your Inquiry would never have come about except for repeated complaints about the poor service being provided to outlying areas of the HNE district.

This is not to say that most patients don't get a good service.

I have no opinion as to whether the area should be split as the issue which needs to be addressed in Newcastle or, presumably Tamworth in a split area, is that the central culture of not having knowledge nor respect for the needs of the outlying and less resourced areas needs to fundamentally change.

On occasions I talk to registrars, CMOs or Vmos who have actually worked in Guyra or Armidale and it is totally refreshing to talk to people with insight into the local situation and our level of expertise, instead of a registrar in JHH who thinks that country GPs don't have a clue.

In about 2006 I did a costing of the amount of health money spent on the regional population of of NSW. Then a regional citizen cost Medicare 80% of what it cost an urban citizen, the obvious cause being lack of services.

The figure for NSW Health was that a regional citizen had 70% of the per capita expediture spent in their region. This did not take into account the the added cost of the services provided to regional citizens when they got to a teriary hospital which may, or more likely not, bring that percentage up toward the average per capita expenditure.

These figures may have somewhat changed with Medicare now subsidising ED and outpatient visits.

Whatever comes out of this inquiry is that there needs to be a conscious bias in any administration and an overhaul of the current systems of support, referral and transport toward bringing equity to the more distant citizens of whichever health area they administer.