Submission No 10

INQUIRY INTO CURRENT AND FUTURE PROVISION OF HEALTH SERVICES IN THE SOUTH-WEST SYDNEY GROWTH REGION

Organisation: Liverpool Hospital Medical Staff Council

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Submission to the Legislative Council enquiry into Health Services in Southwest Sydney by Liverpool Hospital Medical Staff Council

Executive summary

Thank you considering a submission, prepared after extensive consultation, on behalf of the Medical Staff Council at Liverpool Hospital. This submission addresses all aspects of the Terms of Reference of this Inquiry, in particular issues in relation to health services expenditure and health workforce in the South-West Sydney Growth Region in comparison to local population and clinical need. We strongly request that the inequities identified in health care expenditure be rectified urgently, and the mechanisms and funding algorithms that we believe led to the inequities be corrected. We are very proud of the extraordinary efforts of our clinicians, academics and Executive in Southwest Sydney Local Health District. Our clinical practice, teaching and research is outstanding and comparable and in many cases the best of any other facility in the country. This has grown as a result of the commitment and passion of our staff.

For many years, we have been concerned about inadequate funding which is based on incorrect and assumptions and an inequitable funding algorithm . Whilst we acknowledge the funding challenges in the health system across the country, the historical funding deficiencies in the Southwest Sydney Local Health District (LHD) are accelerating to the point that we cannot continue to provide safe access for our community.

We include with this submission some patient stories and clinician experiences that reflect the consequences of inadequate funding. We include a summary of key findings from the independent Westir report (also attached) which was commissioned by Liverpool Hospital Medical Staff Council in November 2018. The report clearly defines the marked relative funding deficiency compared to other health districts. This, combined with a relative deficiency in community health resources and relative greater socio-economic disadvantage, has resulted in a perfect storm of access block and safety risk.

We understand that the health system and the economy are in crisis as a result of COVID-19 and that the timing for this review is not ideal. However, the financial difficulties of the South Western Sydney Local Health District will be even further exacerbated by this crisis and makes this issue even more urgent. Every health consequence current or in the future that results from COVID-19 will be worse for patients in our health district, who rely more than most on a hospital with capacity to meet their needs.

Submission

We, the Liverpool Hospital Medical Staff Council, write to you as representatives of the senior doctors of Liverpool Hospital. We are extremely concerned that resources for South Western Sydney Local Health District are inadequate to meet the needs of our community. Every year it gets worse, as the gap between our lean resources and the relentless growth in health service needs widens. There is no fat in our system, our belt cannot be tightened.

Approximately 15 years ago, Liverpool Hospital developed into a tertiary and quaternary facility providing excellence in teaching with outstanding specialist departments delivering high quality clinical care and research. We are proud to say that patients with more complex disease no longer need to travel significant distances for care, and our large local population can reasonably expect best practice care close to home, A stroke can be reversed with clot retrieval for embolectomy, cancers can be managed by multidisciplinary teams, significantly improving quality of life and extending survival , and quaternary expert diagnostics and assessment services are all available.

Unfortunately the model for calculation of funding for this care has never been appropriate. Multiple funding models have not redressed the historical imbalance between "developed" and "developing" areas within the metropolitan region. This imbalance gets worse year by year rather than better. We are in perpetual 'bed block', with more than 100% bed occupancy, and despite competitive length-of-stay across most specialties, our Emergency Department remains so full that patients often receive care in waiting rooms and corridors.

In 2018 we commissioned an external report prepared by Amy Lawton, Barbara Beard and Dr Olivia Hamilton, Social Research and Information Officers, WESTIR Limited entitled "DECEMBER 2018: Condition Critical . An insight into the pressures that impact Liverpool Hospital staff in servicing the needs of the community " and now referred to as The Westir Report"(attached) which clearly describes what we had long suspected, that Southwest Sydney Local Health District are significantly under-resourced compared to other districts.

The reasons for this are complex and related to a major construct error: when the Activity Based Funding model was initiated, our base funding was accepted as "sufficient". This error has never been corrected and all subsequent enhancements are mathematically calculated to allocate budget increases based only on growth. It appears that there never was an intention or capacity to rectify deficiencies in our base funding.

Because **our base funding was not sufficient**, our "growth" money has necessarily been used to develop services that should have been within our base services but were not, as described, we were only developing into a complete specialist hospital. For example a unit that did not exist In the Southwest Sydney Local Health District before (although existed in every single other Local Health District) such as non-invasive ventilation, had to be funded using our "growth" money.

Consequently there are **no remaining funds to manage actual growth**. This year it is worse than ever as, despite having a robust Clinical Council which debates and prioritises enhancements, no enhancements can be approved! We are in a phase of "consolidation" meaning none of the agreed critical priorities can be funded, none at all.

We provide here a sample of consequences that affect our ability to deliver safe access to quality care:

- Liverpool Hospital Clinical Council considers critical needs but there are **inadequate funds to support actions:** For Example**,** a recent **Root Cause Analysis** investigating a neonatal death recommended Liverpool Hospital must have a Head of Birthing Unit to prevent further events. Even though this became a top priority as decided by Clinical Council, the Chief Executive has been unable to support the recommendation because there are no funds.
- Liverpool Hospital does currently have **insufficient resources for emergency surgery** to be done in a timely fashion. Whilst the National Elective Surgery Targets (NEST) targets for elective surgery may tell a good story, timing of emergency surgery patients is not measured by these targets. Similar access problems exist for emergency endoscopy, emergency interventional radiology for cancer diagnosis and treatment,. The delay in providing these emergency services poses significant safety risks for our community .
- Liverpool Hospital has **significant shortfalls the junior medical staff number**. There is broad agreement that, like other hospitals of our size, we should have enough funds to employ senior resident doctors (SRMOs) who would be employed subsequently into accredited training positions. Our excellent junior staff are frustrated by the lack of such positions and leave to go to other hospitals where there is an appropriate pathway to progress their surgical training. The Chief Executive is unwilling to approve these agreed priority positions in view of the budget position.
- Despite the size of Liverpool Hospital, and its function as a major Trauma and Clot Retrieval for Acute Stroke service centre**, we have inadequate radiology services**. Liverpool Hospital only has sufficient staff to operate one computed tomography (CT) scanner after hours (including the whole weekend) and the radiology department only have staff to provide ultrasound in office hours, not after hours. The impact on safe, quality patient care is significant, particularly in the Feto-Maternal Unit and Emergency Department, where management of suspected ectopic pregnancy and testicular torsions is negatively impacted by the use of alternate clinically inferior imaging. Resultant delays in treatment become routine, with significant implications on quality of care and length of stay. That a hospital of this size has these limitations is one of the most telling consequences of our gross under-resourcing. Comparator hospitals have much increased access to after-hours imaging services for their patients. There are no funds to employ staff to achieve adequate staffing of our after-hours imaging services, and we keep getting busier and busier. Our on-call radiology staff work harder than elsewhere and simply cannot provide more service with such relatively small staff numbers.
- A significant additional deficiency in our radiology services is that we are the *only* comparable size hospital that **does not have a mammography machine.** Patients with a treated breast cancer or those at risk of breast cancer do not have equitable access to post-operative mammography unless they pay for these services in the community. They are least equipped to do so, and have been independently lobbying on this topic.
- The Resource Distribution (Allocation) Formula, introduced in 1991 to more equitably provide funding to Local Health Districts, is a complex formula which takes into account at least three factors, premature mortality (Standardised Mortality Ratio less than 65

years), socioeconomic status or EDOCC (Australian Bureau of Statistics SEIFA Index of Education–Occupation), and a rurality index. **It is not currently adjusted for the high proportion of culturally and linguistically diverse people in our community**, and this factor provides significant additional work for health staff in the South West Sydney Local Health District.

- **Timely access to interpreters** is vital to delivering adequate health care to our population where a significant proportion speak little or no English. Difficulty obtaining timely informed consent for procedures without the timely support of interpreters naturally results in increased length of stay.
- There are **significant barriers to providing adequate facilities for high quality haemodialysis**. Australian standards for quality haemodialysis (centre-based) across Australia consists of three dialysis sessions per week. In South West Sydney Local Health District, not all of our centre based HD patients are offered three sessions per week due to insufficient centre-based dialysis capacity (chair numbers). For the past three years, to be able to accommodate new patients requiring haemodialysis, we have had to cut haemodialysis sessions of selected existing patients. This practice predominantly occurs in jurisdictions without universal healthcare (for example India and the Philippines). For every one patient over total capacity, sessions from two other existing patients are reduced, in order to offer the new patient two days of dialysis. Since 2016, between five and forty-five haemodialysis patients are only able to be offered one or two sessions per week at any given time, due to this overcrowding. In addition, an estimated 20 patients resident in SWSLHD continue to have to travel to other LHDs to have their dialysis treatments. Within SWSLHD, patients are moved between dialysis units depending on capacity and have to travel long distances rather than being treated closer to home. This is a particular problem for Campbelltown/Macarthur residents. Estimates suggest that this will continue to get worse. Whilst critical safety issues have been recently averted by signing a public-private agreement with a local private dialysis facility, allowing decanting of some patients to this unit, capacity is still running at greater than 100% and some patients continue to be offered only one or two sessions per week due to these capacity constraints.
- There is much data on the **Emergency Department access block** which is an acknowledged risk to patients. We can provide stories of situations for individual patients in the Emergency Department that would alarm you. Sometimes these are presented at our Clinical Council as an alarming patient's story. Nevertheless, patient experiences in the Emergency Department reflect the whole hospital. If we cannot manage to discharge patients because of resource limitations, we will have a full hospital and a full Emergency Department. It is a cycle that cannot be fixed without appropriate resources.
- The **lack of mental health beds** in our district (a much greater deficiency than in other districts) means that on many days a significant proportion of our Emergency Department beds are used by patients who need admission to a mental health unit. The stress of a prolonged stay in an Emergency Department exacerbates a patient's mental health crisis and this may precipitate behavioural problems such as verbal or physical aggression because of the confined, noisy, brightly-lit environment not appropriate for the purpose of managing a mental health crisis. The trauma of this experience may even

result in a prolongation of the mental health problem that brought the patient to the Emergency Department. We have insufficient funds to rectify this significant mental health bed problem.

- **Childhood disability and chronic health conditions, both exacerbated by social disadvantage**, are significant issues in this District. South West Sydney Local Health District has the largest child and youth population in the state, encompasses some of the lowest socio-economic populations (see Figure 1), and has the highest rates of refugees settlement in New South Wales. Without additional resources it is extremely difficult to meet the needs of the child developmental/diagnostic services where there is a disproportionate (impaired to other local health districts) waiting list for support. Whilst we know early intervention makes a difference, children in our District are not able to access timely early intervention. This is an opportunity lost forever unless we rectify it. Only increased resources will allow that service to compare with other priorities in the district.
- Whilst **innovative models of care** are considered**,** these require support from a "patient based" business unit, and these are impossible to develop as our financial support staff are so thinly spread. Other health districts have up to five times as many financial support staff in their executives units compared to us, for similar size hospitals. This is acknowledged but there are no funds to change the model of executive support.
- Our **Pathology services are also substantially underfunded**. Southwest Sydney Local Health District receive one of the lowest reimbursement of all Pathology services, 93.5% of the MBS schedule fee for each test, whereas Sydney Local Health District labs receive 112.4% and Sputh Eastern Sydney LHD labs receive 108.2% and Westmead is even higher. This reflects an estimate of the amount that the LHDs can afford to pay, but have arisen as a consequence of funding inequities. This reduced funding, combined with lower health insurance rates, result in inadequate funding for pathology services with consequent demoralisation, poor staff retention, less ability to recruit for teaching, research, reduced support for multidisciplinary tumour meetings and other non-funded activities. It is yet another example of where there is no fat in the system.

In addition to the fact that we are underfunded relative to other districts, the Westir Report identifies extremely **serious confounders that substantially impact the delivery of health care** to patients in this area, such as lower English proficiency(see figure 2) , greater financial challenges, lower levels of education with impacts on health literacy, lower employment, higher rates of disability and need for assistance, higher rates of single-parent family, higher birth rates, higher obesity, smoking and diabetes rates which all increase the rate of acute and chronic disease.

The lack of resources naturally limit our ability to serve **the needs of our Aboriginal and Torres Islander peoples**. Whilst some specialists have expressed an interest and some support limited outreach clinics as occurs in other districts some of these arrangements have been cancelled in view of the relative lack of specialist in our hospital or are limited to monthly which is below the patients need. . This is a missed opportunity and a great shame.

The **community health care resources available in the SWSLHD** are also markedly less compared to other districts such as General Practitioner numbers (see Figure 3), Specialist numbers (See Figure 4), Private Hospital beds, total hospital beds, and Private Health Insurance (see figure 5) rates. These

and other elements increase the complexity of patients in our area (not always manifest in the measured complexity indices) and have a considerable impact on discharge planning and alternate models of care, increasing the reliance on the public hospital. None of this is accounted for in our funding.

In summary, in South Western Sydney Local Health District we are profoundly and unfairly under-resourced (see Figure 6) , with the lowest per population funding which when combined with the lowest rates of alternative health infrastructure in community, lowest private health insurance rates, and highest rates of culturally and linguistically diverse residents, mount to a significant strain on the hospital (see Figure 7) . The comparisons are irrefutable. The government asks for clinician engagement and we ask government to listen when we tell you that the health care challenges in South Western Sydney Local Health District cannot be met equitably unless we receive equitable funding.

Armed with our Westir Report we approached the honourable Minister for Health, Mr Brad Hazzard 12 months ago to consider an urgent enhancement so that we could appropriately fund priorities we identified as critically under-resourced. We were unsuccessful. We only received growth money marginally above the state average which in no way compensated for these relative funding inequities. The mathematics of the funding model does not allow it.

We believe an urgent review of the healthcare budget allocation formula with more equitable resource allocation is required to allow us to continue to provide appropriate and safe access to health care for the community in our local health District. We cannot wait for buildings to be built and slowly filled as funds become available over the years. We need funds urgently, in advance of bricks and mortar. We would like our patients to receive a fair share of the health dollar so that their needs can be met.

We thank you for your consideration. Please do not hesitate to contact any of us at any time. We would be delighted to provide more information.

Sincerely,

Liverpool Hospital Medical Staff Council Executive team:

A/Professor (UNSW) Miriam Levy Chair of Medical Staff Council, MBBS (UNSW Hons 1), FRACP, PhD (USyd), Director of Gastroenterology and Liver, Liverpool Hospital.
Dr Zinta Harrington, MBBS, BA, MSc, FRACP, Head of Department of Respiratory and Sleep Medicine
Dr Eugene Moylan, Director of Oncology Liverpool Hospital
Dr Guruprasad Nagaraj, Emergency Medicine Staff Specialist with special interest in Geriatric Emergency Medicine Liverpool Hospital, South Western Sydney Local Health District. Snr Lecturer University of Sydney and UNSW Clinical Research Fellow SWERI and Simpson institute.
Professor Suzanne Hodgkinson Previous Chair MSC Specialist Neurologist , Liverpool Hospital, Director of Multiple Sclerosis service. .

Figure 1 : Socio-Economic Indexes for Areas (SEIFA) Advantage Disadvantage scores by greater Sydney LGAs 1

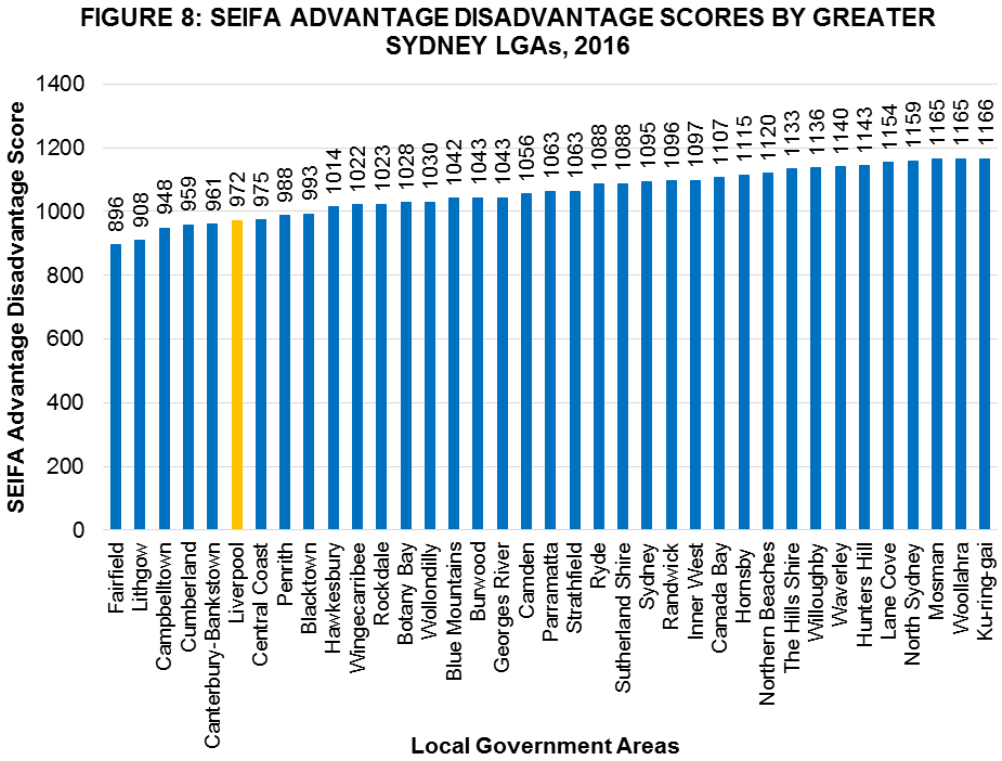


Figure 2 :English Proficiency – Highest rates not speaking English well or at all (blue)

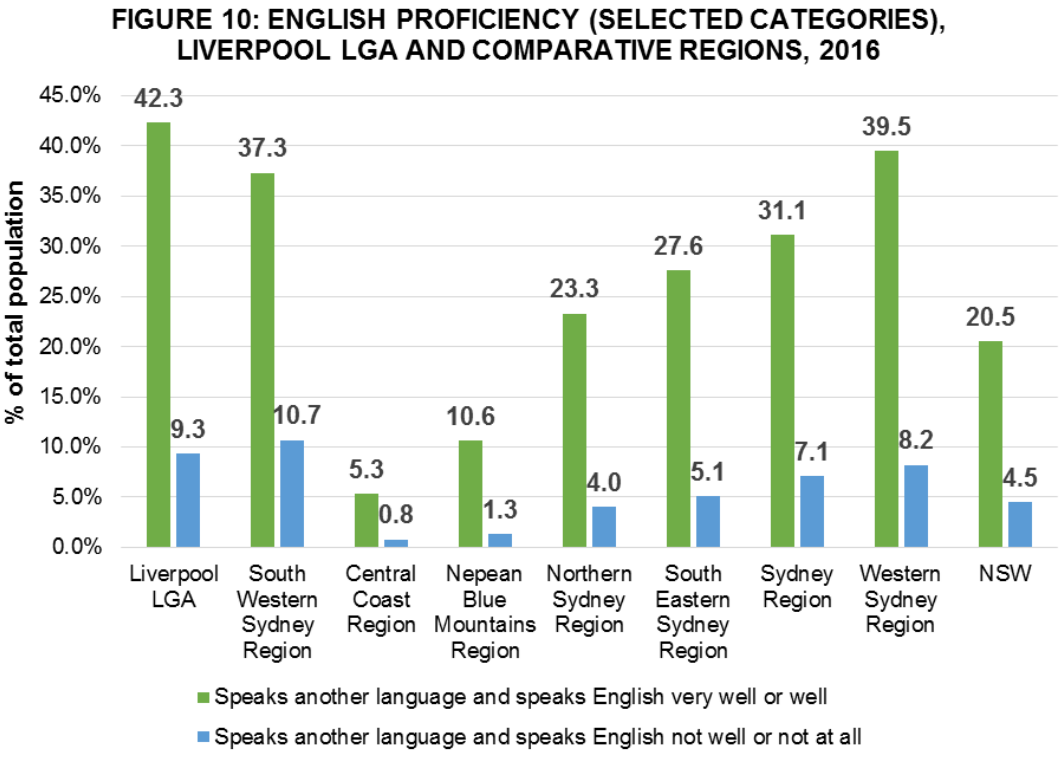


Figure 3: Relative Number of General Practitioners and Resident Medical Officers

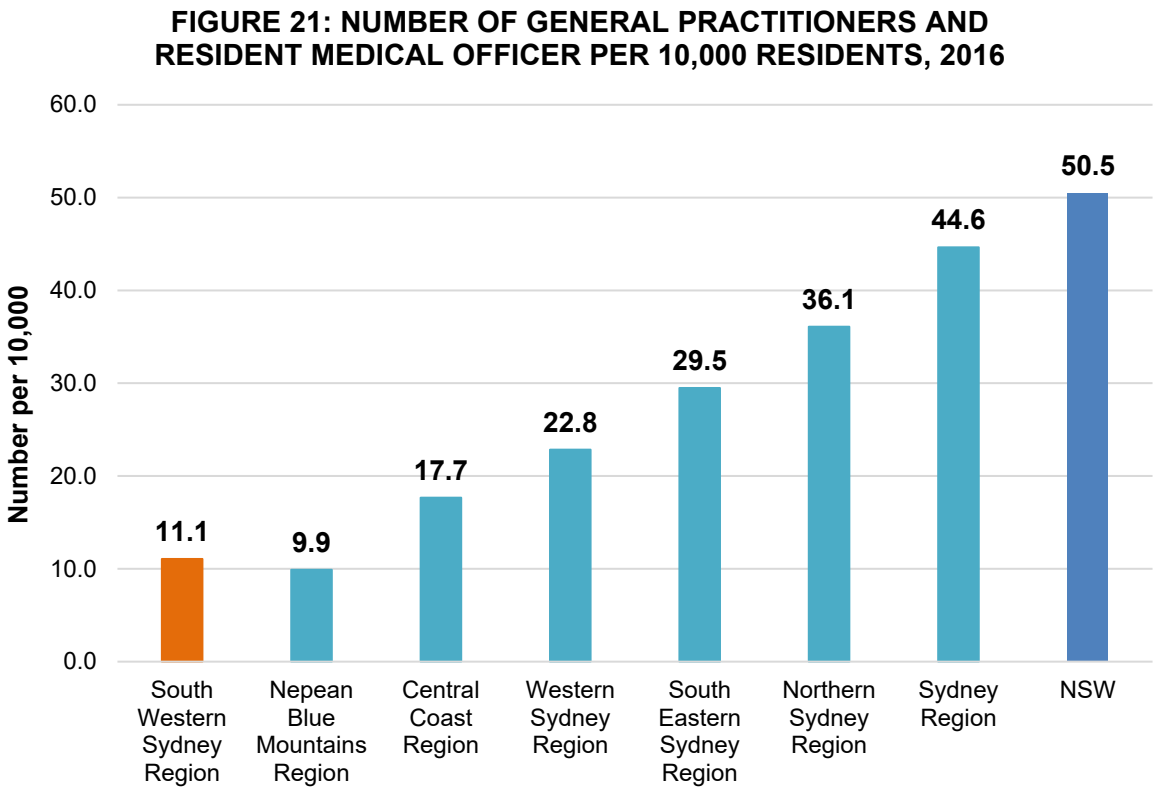
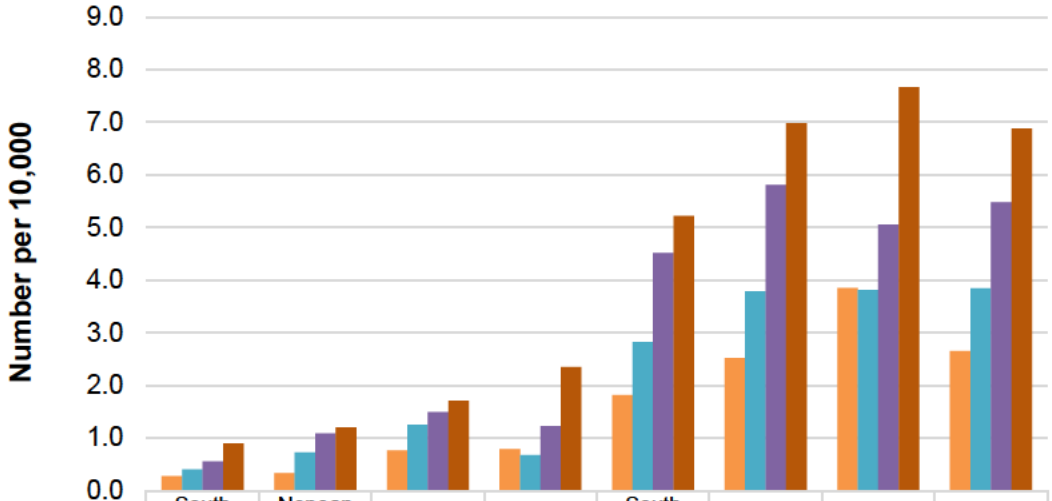


Figure 4 Number of Specialists per 10,000 residents

FIGURE 22: NUMBER OF SPECIALISTS PER 10,000 RESIDENTS, 2016



	South Western Sydney Region	Nepean Blue Mountains Region	Central Coast Region	Western Sydney Region	South Eastern Sydney Region	Northern Sydney Region	Sydney Region	NSW
Psychiatrists	0.3	0.3	0.8	0.8	1.8	2.5	3.9	2.7
Anaesthetists	0.4	0.7	1.3	0.7	2.8	3.8	3.8	3.8
Surgeons	0.6	1.1	1.5	1.2	4.5	5.8	5.1	5.5
Specialist Physicians	0.9	1.2	1.7	2.3	5.2	7.0	7.7	6.9

Figure 5 Number of Residents with Private Health Cover

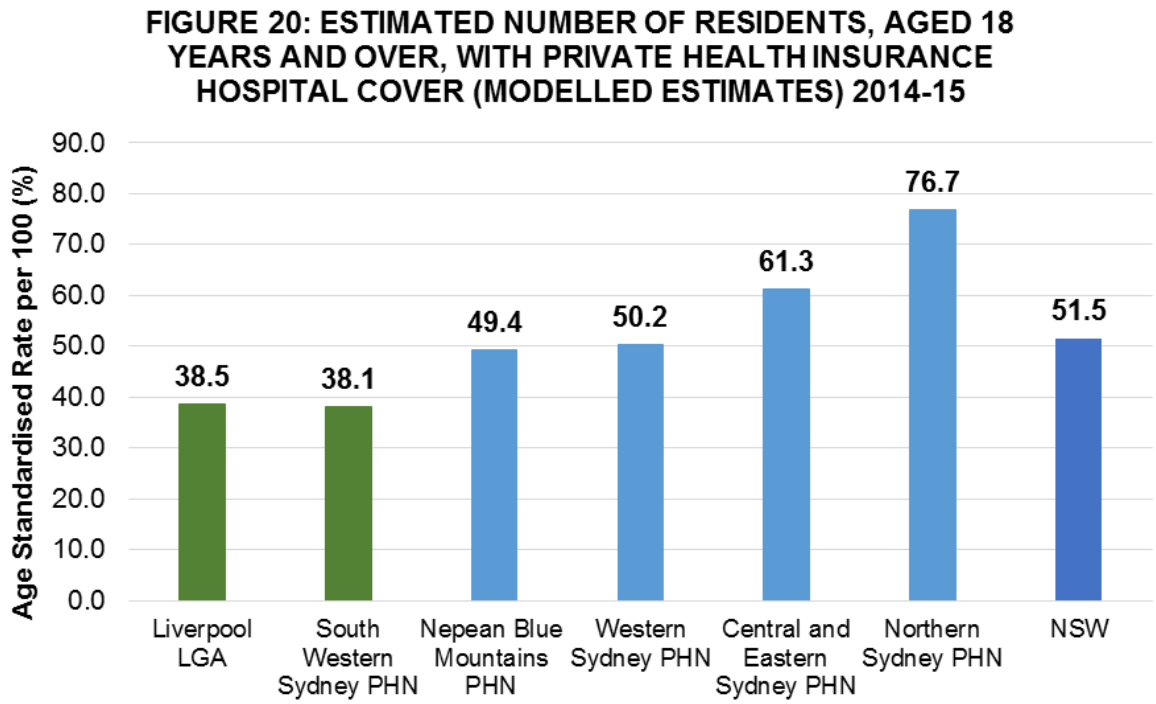


Figure 6 Annualised budget per resident

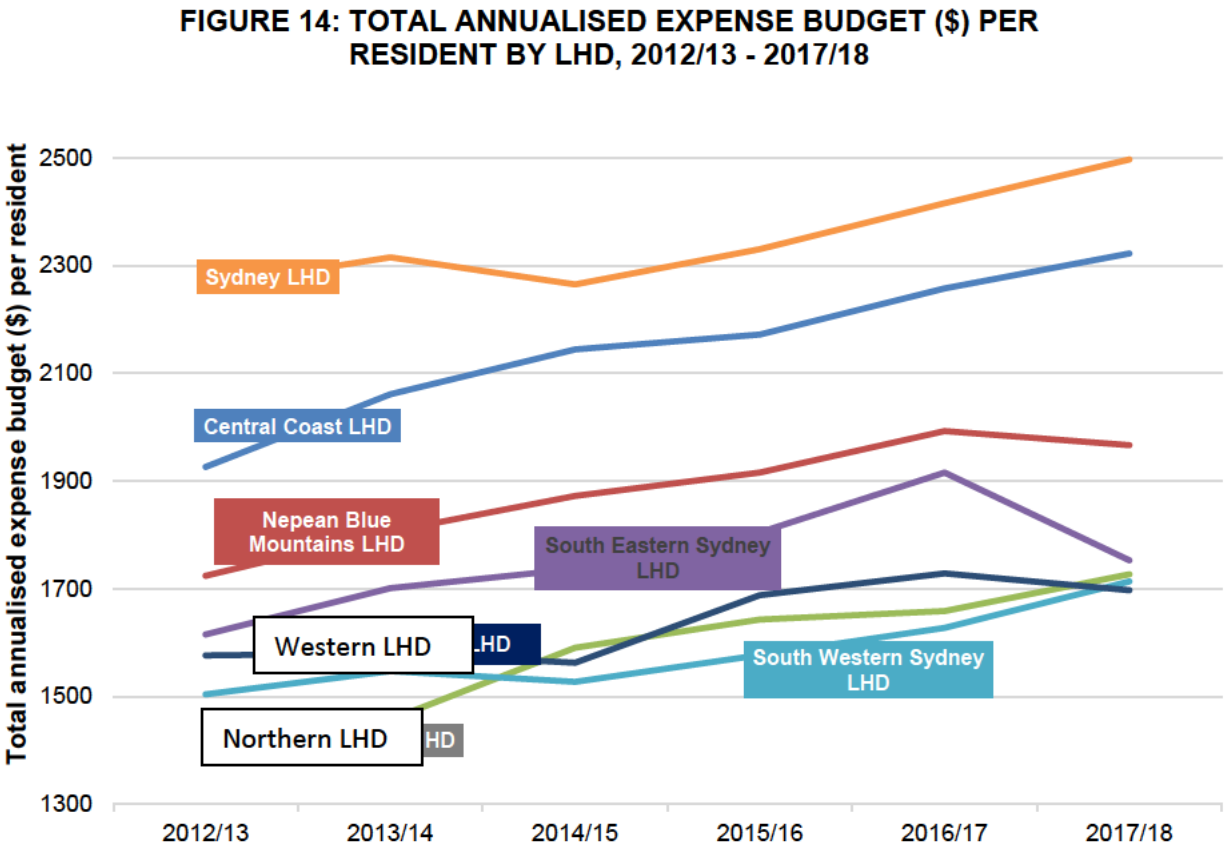


Figure 7 : Cascade of problems that are most severe in South Western Sydney LHD