Submission
No 17

INQUIRY INTO HEALTH OUTCOMES AND ACCESS TO HEALTH AND HOSPITAL SERVICES IN RURAL, REGIONAL AND REMOTE NEW SOUTH WALES

Organisation: ONE - One New Eurobodalla hospital

Date Received: 18 October 2020

SUBMISSION

NSW LEGISLATIVE COUNCIL
RURAL & REGIONAL HEALTH CARE INQUIRY 2020

On Behalf of:

ONE - ONE NEW EUROBODALLA HOSPITAL
A Clinical and Community Advocacy Group

Abstract:

Issues of relevance to the Terms of Reference of the Inquiry as demonstrated by the needs of a rural community and its experience of the development of local health services.

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NSW LEGISLATIVE COUNCIL
RURAL & REGIONAL HEALTH CARE INQUIRY 2020

18TH October 2020

Dear Members,

On behalf of the ONE - One New Eurobodalla hospital advocacy group, I submit the following details regarding the needs and provision of health services in the Eurobodalla.

The local experiences are at once individual to our region and representative of common issues shared by other rural and regional communities.

I have 40 years' experience as a medical practitioner, including 37 years in women's health in rural, regional & metropolitan environments.

My experience is one of witnessing common and individual problems and solutions to the provision of health services.

As Leo Tolstoy opened his novel, Anna Karenina; "All happy families resemble one another, each unhappy family is unhappy in its own way."

I have previously met or corresponded with individual members of the Inquiry who have been informed of the local needs and inequity of medical services.

I will provide a reiteration of the history and facts with the implications for rural and regional health services generally.

The local experience of the Eurobodalla community is an example relevant to the Terms of Reference of the Inquiry.

The NSW Ministry of Health commissioned a review of Surgical and Critical Care Services by the Agency for Clinical Innovation in March 2017. The findings recommended development of Accident & Emergency and Perioperative services as well as the establishment of a Close Observation Unit with a view to transition to Intensive Care level services within a proposed level 4 regional hospital.

As a consequence of inaction on this review and concern by senior clinical specialists, representatives of senior medical staff met with a member of the SNSWLHD Board informing the Executive of the critical level of deterioration in the local health services.

Within a three-week period, a formal petition to the NSW Legislative Assembly obtained 3000 signatures. The petition requested that the Minister for Health and Medical Research for:

1 – Provision of immediate improvement to the Accident & Emergency, Critical Care and Perioperative services of the Eurobodalla Shire by funding and upgrading the existing infrastructure and workforce.

2 - Commitment to the funding, planning and building of one new regional hospital for the Eurobodalla Shire, located at a site providing equitable accessibility for the people of the Eurobodalla, which will provide medical services equal to those of the Regional and Base Hospitals within the Southern NSW Local Health District

It was received by Mr Brad Hazzard, NSW Minister for Health and Medical Research on 15th November 2018. The Minister responded to the Clerk of the NSW Legislative Assembly on 18th December 2018.

The petition was followed up in 2019 by letters from approximately 90% of the medical practitioners in the Eurobodalla to the Minister for Health requesting further action on the provision of clinical services in the absence of a completed Clinical Services Plan, date of commencement of hospital works and improvement in Accident & Emergency and Critical Care services.

On the 31st October 2018, the Premier of NSW, Ms Gladys Berejiklian, and Mr Andrew Constance, the Member for Bega, announced the allocation of $150 million towards the development of a single Regional hospital for the Eurobodalla. In June 2020, a further $50 million funding was announced for the new hospital project.

These commitments have been gratefully received by the residents of the Eurobodalla.

However, several restrictions remain towards the development of the new hospital and the satisfaction of the petition to the Minister for Health and Medical Research.

Firstly, despite the recommendations more than three years ago, there has still been no improvement to Accident & Emergency or Critical Care services. Both streams of care need upgrading and development in transition towards level 4 regional hospital.

Secondly, the Minister has equivocally described the starting time for a new hospital as "within the term of the current government". This could potentially not be realised until 2023 with an open-ended date for completion.

Thirdly, I attach a copy and summary of the Eurobodalla Health Service Clinical Services Plan. The CSP has since its development has evolved into a plan to provide level 4 services by 2031, some ten years in the future.

The clinical needs of the Eurobodalla and inequity with other hospitals within the SNSWLHD are self-evident.

The local health service is only 56% self-sufficient for general health services.

This reduces to 25% for adult mental health and paediatric services.

The region has the second largest population (39,000) in the SNSWLHD behind the Queanbeyan-Palerang region which neighbours the ACT.

It has the largest Indigenous population in the LHD (6.3%), forty-six per cent of whom are aged less than 20 years and make up 10% of the maternity service.

The population triples during the holiday periods.

One hundred patients are transferred outside the region each month by road ambulance or aeromedical retrieval.

The Eurobodalla has the highest number of children and families affected by the social determinants of need according to the attached Targeted Intervention Program (Department of Communities and Justice November 2019).

The region has;

1: the highest proportion of vulnerable children aged 0-5 years

2: the highest number of children at risk of significant harm

3: the highest number of children affected by mental illness.

4: the highest number of children developmentally vulnerable in at least one way.

5: the highest unemployment rate in Southern NSW

6: the lowest average family weekly earnings

7: the highest number of low-income households

8: the highest number of reports of domestic violence

These figures pre-date the recent effects of a bush-fire disaster which had a severe social and economic effect of the region as well as demonstrating the vulnerability and inadequacy of local hospital services.

The statistics available on the Australian Institute for Health and Welfare – My Hospitals data base, www.aihw.gov.au, are axiomatic demonstration of the clinical needs and inequality of services relative to smaller neighbouring hospitals which have been built or redeveloped in preference to the Eurobodalla region.

Semi-urgent, urgent, emergency and resuscitation activity are consistently greater in the Eurobodalla compared to the South East Regional Hospital, Bega and Goulburn Base Hospital.

Patient admissions (medical emergency, medical non-emergency and gynaecological surgery numbers) exceed both SERH and Goulburn Base Hospital.

The birth rate exceeds both other hospitals.

Accident & Emergency

Total;
Eurobodalla 25,503
South East Regional Hospital, Bega 15,395
Goulburn Base Hospital 16,983

Semi-urgent;
Eurobodalla 12,847
SERH 7555
Goulburn 7748

Urgent;
Eurobodalla 9424
SERH 5975
Goulburn 7019

Emergency;
Eurobodalla 3169
SERH 1812
Goulburn 2139

Resuscitation;
Eurobodalla 163
SERH 53
Goulburn 77

Patient Admissions

Eurobodalla 15209
SERH 12265
Goulburn 11362

There had been a 17.5% increase in total activity in the Eurobodalla Health Service in the five years from 2011/12 to 2016/17

In contrast to the other hospitals in the SNSWLHD;

Elective Orthopaedic surgery 2018/19

Eurobodalla 48
SERH 599
Goulburn 411

Adult Mental Health 2016/17

Eurobodalla 0
SERH 366
Goulburn 890

There is no resident physician, paediatrician, psychiatrist or orthopaedic surgeon in the Eurobodalla.

It is self-evident that the Eurobodalla's needs exceed those of the Bega and Goulburn regions.

The solution is to develop Accident & Emergency and Critical Care services immediately in transition to the completion of a new level 4 regional Eurobodalla hospital.

This will result in increased self-sufficiency of clinical services with a reduction in outflow of patients to remote clinical services.

The immediate development of physician-led Critical Care services will enable the development of Intensive Care services on the opening of a new hospital and enable a level 4 role delineation on completion rather than by the proposed ten-year plan of 2031.

Relevance to the Terms of Reference of the NSW Legislative Council Inquiry into Rural and Regional Health Care 2020.

The Eurobodalla experience demonstrates that the clinical need of a community is not reflected in the timing and funding of medical services.

Despite evidence of high level of clinical activity, low self-sufficiency of many services and, indeed, absence of some clinical services which are provided within the same LHD, the community has been presented with a 10-year plan for a problem which is some 20 years old.

Eleven pages of comments from a Change.org petition of 2019 to the Minister for Health, the Premier of NSW and the Member for Bega are attached.

The recurrent themes are;

- Lack of services including paediatrics, orthopaedics, psychiatry and oncology
- Waiting times for services
- Distance of travel for services outside the Eurobodalla, notably to other hospitals within the LHD such as SERH and Goulburn Base Hospital, as well as to the ACT
- Needs of an ageing population

The Eurobodalla Health Service conducted a number of community consultation meetings during the development of the Clinical Services Plan.

Feedback from the residents of the Eurobodalla indicated;

- The need for easy and free access to specialist services

- Long wait times for allied health appointments and access to community health services and the lack of social workers in particular

- Lack of communication and education of services available

- The need to provide more services locally to reduce travel

- That all services need to be inclusive of all

- The need for more/better transport options
- Lack of GP services
- Lack of orthopaedic and paediatric services

These themes are a local reflection of the general state of rural and regional health care across NSW.

Planning

There needs to be equitable distribution of clinical services within and between LHDs.

Regions with populations equivalent to the Eurobodalla require level 4 clinical streams across:

Accident & Emergency
Critical Care/Intensive Care
Medicine
Surgery
Child, Youth and Family (Maternity & Paediatrics)
Aged Care
Rehabilitation
Palliative Care
Mental Health/Drug & Alcohol

Networking of services results in concentration of services in a centralised system. This leads to a perpetuation of the need for travel for both elective and emergency services. It should be considered only for highly specialised services such as radiation oncology and cardiothoracic services which require critical numbers for capital expense and clinical expertise.

Planning needs to be based on clinical activity data as opposed to population statistics as an aged community may have slow growth but a rapid rise in clinical activity.

With the existence of the Medicare Levy Surcharge, there is the expectation of many rural residents to have access to private health services.

Despite this, many rural and regional heath areas have no private hospital facilities. The inability to have elective surgery within the local hospital at a time of your choice is a disincentive for rural patients to use their private health cover. This results in a lack of income for the health service and medical practitioner as well as a deterrent for considering rural or regional practice.

In areas without private hospitals, unused theatre sessions should be opened for private operating lists.

In respect to equitability, hospital-based clinics need to be provided for free medical services. From a medical professional perspective, this model of care has existed in a complementary manner in metropolitan regions.

Transport

Aged persons, younger persons and the unemployed have restriction to private transport.

Improvements in patient transport services need to be supported by Local Government and State Government public transport services.

Transport services need to be affordable and appropriately scheduled and distributed for hospital attendances.

Staffing

Retention and recruitment of medical, nursing and allied health professionals should be based on existing successful models of care.

Rural and regional communities have strong ties to their local health services including their local General Practices.

Highly committed and well trained procedural General Practitioners have always provided the foundation of health care in rural and regional areas.

Their services support Accident & Emergency, General Medical, Anaesthetic and Obstetric departments often in collaboration with local specialists.

This mutual arrangement has made specialist services sustainable as well as providing professional satisfaction with a compatible quality of life for both parties.

Innovative contractual arrangements are necessary to attract and maintain General Practitioner and Specialist VMOs.

Appropriate professional income to attract health professionals requires the support of private practice options in both the community and the local hospitals.

Recruitment and succession planning are enabled by undergraduate and postgraduate exposure to rural and regional health care.

This requires medical, nursing and allied health students, residents and registrars experiencing time in local communities.

Remoteness from metropolitan centres affects Continued Professional Development for all health professionals.

HETI and associated Universities should provide centres for continued education with effective Information Technology resources.

Indigenous health services

The provision of Indigenous health services should be informed by local Indigenous health workers and community members across all clinical streams.

This specifically needs to occur within paediatric, maternity, aged care, palliative care and mental health services.

It should be mandated that there is an Indigenous representative on any rural or regional LHD Board.

Conclusion

I thank the members of the Legislative Council Inquiry into Rural and Regional Health Care 2020 for your consideration of these facts and opinions.

I hope that the example of the development of the Eurobodalla Health Services informs the Committee of the experience shared by rural and regional community members and health professionals.

I also request that you advocate for the immediate action on necessary improvements in our local health services and the acceleration of the development of regional level 4 clinical services in the Eurobodalla.

Yours sincerely,

Dr Michael Holland