Submission No 155

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

Name: Name suppressed

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SUBMISSION

NSW Government Inquiry into health outcomes and access to health and hospital services in rural, regional and remote New South Wales

TERMS OF REFERENCE: (l) any other related matters.

Dear Committee

In reference to the inquiry into health outcomes and access to health and hospital services in rural regional and remote NSW:

I am a qualified medical practitioner who of NSW in 1974 and I have worked in tertiary hospitals and subsequently country hospitals in Australia since 1991. I have worked as a specialist paediatrician in outer regional and remote NSW most often as the only specialist in the region and with tertiary facilities up to 500 Kms away. I have many hours working in and being witness to the public health system of NSW.

This important inquiry must deal with the processes of health delivery for country patients if the desperately needed changes for both patients and clinicians are to occur, which are to lead to a decrease in avoidable death and morbidities for country people.

Patients and clinicians must be heard.

This inquiry should not be led by management of Local Health Districts (LHDs) or the NSW Ministry of Health, which in my opinion seems to be less interested in looking for solutions to problems in the Public Health System, than in obfuscation and controlling the narrative.

Hopefully this inquiry will be independent.

The Terms of Reference of this inquiry are significantly limited and show a lack of understanding of the causes of poorer outcomes for country people.

The first three issues raised that is (a),(b) and (c) have already been addressed and published on a number of occasions by The Australian Institute of Health and Welfare (AIHW) .The reports published are comprehensive and compare health outcomes ,mortality and the burden of disease across Australia and compare metropolitan NSW with inner and outer regional NSW and remote NSW. It doesn't need to be redone and what is clear is that people in country NSW do worse in most areas of health including mental health. Most of (c) is covered in these publications.

What has been left out are probably the most important issues which contribute heavily to poor outcomes.

Transport to Tertiary Facilities

The first of these is the support of critically ill country patients on site and their transfer to tertiary facilities in a coordinated and expeditious way. There is no overacting coordinator of such a service which then leaves patients taking up

to10 hours (as seen recently for a pregnant woman in Ballina to RPA in Sydney). NETS (Newborn Emergency Transport System) is the coordination service for retrieval of newborns and children from country areas but my personal experience has had me at the bedside of a critically ill child for 6 hours on many occasions and 9 hours on one occasion. Not only does this place the seriously ill child at risk for lack of tertiary resources and sub specialists but it takes an experienced clinician "out of the loop" for many hours. Often that clinician is the only specialist for that region in their field. Cross border transfers are always problematic with different cultures and policies. This is such a significant problem but I am not aware of data collected that looks at the role of retrieval services for all country patients in NSW as part of a systemic approach to healthcare. If Air Ambulance services are to be privatised this will compound the problems as budget will be factored into the retrieval process.

Mental Health

Access and availability of mental health services for country people should be addressed. There are many experts in this field whose experience and problem solving abilities could be sought. In particular clinicians who have many years of experience attempting to provide services to country people when those services are thin on the ground to non existent. There are higher levels of mental health issues for residents of country NSW including indigenous people who frequently live in relative poverty and have poorer experiences with the health care interface.

Management Culture of Regional and Remote hospitals

Addressing systemic failures in Health Care in NSW has not been addressed and yet this is at the centre of poor outcomes in Health Care. There are many sections to this problem.

Structure of NSW Health into LHDs which are authorities but do not necessarily have the ability to manage clinical governance (which is good clinical care) and may not be responsive to analysis and correction locally. This has been publicly illustrated both in the television and print media over the past twelve months starting with the Four Corners Programme titled " Health Hazard "in September 2019 followed by a number of articles recently in the SMH about Dubbo and Cobar Hospitals and most recently the 60 Minutes report concerning the avoidable deaths of two older country men. These matters of clinical governance should have been dealt with satisfactorily at an LHD level (but were not)and failing that at Head Office that is the Ministry of Health (but was not).This structure appears to protect the local and state Health Bureaucrats at the expense of Governance both Clinical and Corporate.

Clinicians are part of a system which provides health care to patients. Yet when an adverse event such as an unexpected death occurs clinicians may be held solely responsible. This is outmoded thinking but recognition that a safe work environment which includes the diminution of risk (such as for example a "Fatigue Management Plan" so that clinicians are not working excessive hours

and that the numbers of clinicians and their skill set is appropriate to the environment) is not yet in the mindset of health managers and executive who are not called to attend sick people at all hours of the day. Risk Transference is a term used in Risk Management.

Failure to address this concept can be seen for example when the budget dictates that two nurses per shift on a ward will not occur because the budget can't cope. Then the onus for care is put back on the clinician for a decision made a managerial or executive level which is clearly not in the best interests of patient or clinician.

Risk Management

Accountability for risk transference is not held by managers and executive staff because" systems" are not examined when there has been a failure in health care. Yet in the transport industry for example accountability for failures goes to the top.

The lack of a Health Regulator:
This is pivotal to the improvement of health and risk management in health care. There is a an independent regulator in the UK. There is no independent regulator in Australia. AHPRA looks at clinicians worthiness to practise their craft and provides licenses at the direction of medical boards. HCCC is a complaints body and can refer matters to the medical board but does not overlook the health system. The Secretary of Health in NSW is the Systems Manager by Job description but takes no part in effecting change when it is required so does not act as a systems manager in effect.

Aged Care has an independent regulator as does the Insurance Industry as does the Transport Industry and these industries are the better for it. (ICare is an example where the actions of the regulator has made a significant impact)

CLINICIAN INVOLVEMENT IN DECISION MAKING:

Finally the area of Clinician input into decision making is not addressed. Over 10 years ago the Garling Report commissioned by the Carr Government recommended increased clinician engagement within hospitals and representation on Boards. An Auditor General report in April 2019 notes 10 years down the track that this is not happening. Clinicians continue to feel alienated in regional and remote NSW Health decision making and often feel if they question, raise concerns they will be considered "troublemakers" Yet clinicians know intimately how the system works or doesn't and are essential to the health care industry. They are the glue. The culture of an organisation is inversely proportional to outcomes. Culture in many LHDs (I have worked in 5 of them) is frequently one of distrust between clinicians and administrators and until that changes patients and clinicians will remain at risk.

SUPPORT FOR RURAL AND REMOTE CLINICIANS:

Our metropolitan colleagues have all manner of physical support and backup within the larger hospitals with junior medical staff and nursing staff and senior

staff. They have sub specialists on site and resources that our patients often have to wait weeks to months to access.

Yet rural and remote clinicians have often only themselves without physical or psychological support in conditions that are unique, isolated and with clinicians representing to the community the local face of public health which can be onerous. The hours are long and exhausting and sleep often interrupted. Debriefing after clinical events which is frequently necessary is frequently not done. The work environment in any other situation would not be regarded as safe.

The executive and managerial staff frequently demonstrate a lack of respect for clinicians who are not local people and who are not seen to “fit” or who challenge the status quo as was demonstrated with a group of clinicians I was part of who repeatedly challenged the poor clinical governance of a particular LHD where we worked. We were regarded as “disgruntled” not as experienced clinicians who were attempting change clinical “culture”.

The concept of a rural generalist who will be trained in all aspects of acute health care and therefore feel comfortable in remote communities is superficial and does not consider some of the challenges I have raised above.

Every clinician in regional and remote health deserves respect and support from the LHD and in my experience this is far from reality.