Submission No 183

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

Organisation: Gulgong Petitioners

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Submission to the Legislative Council's Inquiry into Regional Health

Gulgong Petitioners Group

Background

Gulgong is a smallish rural town with a population of around 2600 and located 30 kms north of Mudgee. Gulgong, like Mudgee and other towns in the region, is burgeoning. Until the end of June 2020 our local GP, Dr Nebras Yahya, was the VMO at the Gulgong MPS. In early July Sharelle Fellows began asking questions of the Western Local Health District (WLHD) and the local MLA, Mr Dugald Saunders, as to why the MPS no longer had a doctor. She was told that there was 'a contractual dispute' and that 'doctors were greedy' but was given no factual information because the whole matter was said to be 'commercial in confidence'. Having received no satisfactory response about when an appointment to the MPS might be expected, Ms Fellows was considering launching a petition to demand a doctor when she learnt of a friend's experience at the MPS. That friend's husband, who suffers from dementia and is no longer able to speak, was experiencing pain. She took him to the MPS where he had a Telehealth consultation with a doctor in Geneva, but the interview failed to diagnose the problem.

Our Change.Org petition was launched on 12 September 2020 and really gained momentum after the community learned of the death of Dawn Trevitt at the local MPS on 15 September. A short while later Kathryn Pearson organised a paper petition to supplement the online version, arguing that many residents did not have internet access. A little later again we asked the community to share their experiences at the MPS. (Some of these stories are cited below and fuller versions are to be found in Appendix 1. Other comments made in the online petition appear at Appendix 2.) By the beginning of November, 2850 people had signed one or other version of the petition.

Media interest in the issue intensified following Mrs Trevitt's death. Despite warnings that media involvement would be 'unhelpful', it was the publicity that brought about action. On 18 November, the WLHD finally announced that it had once again contracted Dr Yahya to be the VMO at the Gulgong MPS. The very next day Mr Saunders presented our petition to the Legislative Assembly.

While the re-appointment of Dr Yahya alleviates our most urgent concern—that is, a medical presence at the MPS—and is most welcome, we do not know the terms of his contract. Is he to be available at the MPS 24/7? Is he obliged to attend all categories of triage or only the most urgent? The community needs such information if we are to continue to use the MPS.

Issues Arising

Adequate coverage

Dr Yahya runs a very busy practice. It is difficult to understand how he can sustain both his GP practice and his VMO obligations in the long term. We understand WLHD has advertised for an additional doctor for the MPS and that the position is to be offered on a fee-for-service basis. If that is so, the position is unlikely to be filled.

We read with great interest of the contracts recently let to Ochre Health to provide medical services for Bourke, Brewarrina, Collarenabri, Coonamble, Lightning Ridge and Walgett. As an aside, we do wonder how it is that Ochre can attract doctors to such far-flung places, while WLHD seems to have little success in recruiting medical staff.

The recruitment of doctors to towns like ours would certainly be easier if young doctors—and especially those on rural medical scholarships—were required to serve their first years in actual rural and remote places, rather than in 'regions' adjoining major cities by the coast, usually referred to as Monash Modified Model 2. We fully endorse the recent statement by Dr John Hall, the President of the Rural Doctors Association:

> Rural intended funds should be invested in truly rural and remote areas — that means reclassifying rural to be recognised as MMM 3-7 communities. Not MMM 2-7 as currently applies across many government programs.

(Dr Hall's full statement is available at Appendix 3.)

Wrong model

The more we have read and thought about the issue, the more we are persuaded that reliance on VMOs/locums for rural hospitals is unworkable. We understand that the Health Departments in both Queensland and Western Australia abandoned the VMO/locum model of care for rural and regional areas some years ago and have opted to directly employ full-time doctors for rural public hospitals. We would be intrigued to have a cost-benefit analysis of the two modes of employment, but this is beyond our expertise. Suffice to say the Queensland Department of Health considers it worthwhile to provide a full-time doctor to the hospital in Kilcoy, which has a population of 1900.

The following table demonstrates the use of the Gulgong MPS by triage category over six years.

Total Emergency Department Presentations at Gulgong MPS

Year	T1	T2	T3	T4	T5	Total
	Resuscitate	Emergency	Urgent	Semi-urgent	Non-urgent	Presentations
2013-14	<5	51	266	781	1055	2153
2014-15	6	52	273	799	1152	2276
2015-16	<5	65	197	656	1322	2240
2016-17	<5	49	210	561	949	1769
2017-18	<5	91	296	756	946	2089
2018-19	5	154	351	774	691	1970

Source: Australian Institute of Health and Welfare, Myhospitals (20/9/2020)

We believe that this data clearly demonstrates an ongoing need for a doctor at the MPS. We would argue further that if a doctor were stationed at the MPS full time there would be even greater demand for his/her services.

Telehealth

At best Telehealth is intended to complement or supplement a face-to-face consultation, not to replace it. Telehealth could be an invaluable resource for young doctors starting out in a rural or remote practice. They might, for example, consult senior colleagues on correct procedures or difficult symptoms. Telehealth would also be very useful for rural GPs when consulting specialists about a patient's ongoing treatment. No doubt, Telehealth delivers optimum outcomes when physical examinations are not required, as in, for instance, mental health counselling.

At the Gulgong MPS over the past five months Telehealth has been used, in our opinion, inappropriately since it has been deployed in the absence of a medical officer. Not only can this result in poor or inconclusive diagnoses, as the following examples show, but it can also place undue pressure on nursing staff who are not necessarily trained in the use of the video equipment or in procedures requested by the virtual doctor.

As already noted, Telehealth was used on a patient who was incapable of responding to questions put via video conference by a very remote doctor. In another case, the camera could not be positioned in such a way that the virtual doctor could see the source of the patient's pain, an ingrown toenail. Telehealth also proved inadequate in diagnosing a brain tumour. Further, Mrs Trevitt died during her Telehealth consultation.

Chronic conditions require timely and consistent treatment, which Telehealth cannot guarantee. One resident who has a brain tumour told us that he feared seeking relief from agonising headaches after hours at the MPS: he would be expected to repeat his medical history to an unknown virtual doctor who might refuse to prescribe the steroids needed to ease the pain. Such a circumstance would waste valuable time; moreover, the patient might not be believed.

Ambulance and Other Services

Only after Mrs Trevitt's death did we learn that, with a few exceptions such as a major trauma, ambulances were obliged to transfer patients to the nearest facility and that to go to a more appropriate facility (e.g. with an attending doctor) required approval of the 'modified bypass guideline'. This to us seemed absurd, since paramedics should be able to exercise their professional judgment as to the appropriate place to deliver a patient. Two months after Mrs Trevitt's death local ambulance crews are finally permitted to take a patient to Gulgong MPS, Mudgee hospital or Dubbo hospital as appropriate.

A number of residents have told us of inordinate delays in having an ambulance transfer them from either Mudgee hospital or Gulgong MPS to Dubbo hospital. After waiting 26 hours in Mudgee hospital for an ambulance, Bill discharged himself and had his wife drive him to Dubbo. Angela's friends—two women aged about 70—were told no ambulance was available to take her from Gulgong MPS to Dubbo and so the friends drove her there. They made the 100-km return trip, reaching Gulgong at 9 pm. The next day Angela, now diagnosed with a brain tumour, was airlifted to Sydney. Imagine if she had had a seizure while being driven to Dubbo by her friends!

Where a hospital orders an ambulance, it is the hospital that bears the cost. We are at a loss to know why an ambulance does not arrive when summoned and can only assume that hospitals are reluctant to deplete their tight budgets on such things. Adequate provision must be made in hospital budgets to ensure patients are transferred quickly and safely.

Gulgong MPS used to offer a range of other services, including physiotherapy, transfusions of blood and gamma globulin and pathology testing. Most of these services have been withdrawn this year and patients are now obliged to find their own way to Mudgee for such treatment. Like the availability of ambulances, the suspension of these services appears to be part of an effort to save money.

Western Local Health District

The WLHD seems disposed to a siege mentality, unwilling or unable to communicate with its constituent residents. We have only ever sought accurate information and sufficient explanation from the LHD but have often encountered a lack of transparency and a seeming reluctance to address our concerns. We have heard that its response to the recent publicity has been to hire an additional six publicists!

In our opinion, the WLHD would do itself an immense service if it offered meaningful information on its website. Perhaps the committee would care to compare the WLHD website with that of the Far West LHD. There, for example, you will find details such as the name and contact details of the manager of every facility, the name and contact details of every health council and the services offered at every facility. Such basic information is not available on the WLHD site. Other LHD websites—for example, those of the Northern and Hunter New England LHDs—include details such as the previous experience of their executive teams. The WLHD does not do this; in fact, the information for its executive team is out of date. The committee might like to compare the entries for the various Directors of Medical Services.

Corporate Governance Attestation Statements may satisfy the Ministry of Health, but they do not impress users of health services. For starters we need detailed information about the amount of money allocated to each facility and the number of staff employed at each facility. In short, we need the WLHD to be transparent and accountable. This is the least citizens should expect from any organisation that is funded by the taxpayer.

In conclusion, these principles should underpin the delivery of health services to rural communities:

- In order to change the outcomes, the system needs to change.
- Health services should be equitably distributed between urban and rural locations.
- State and federal governments must collaborate to ensure the training and recruitment of doctors is targeted to staff outer regional and remote areas.
- Every rural hospital and/or MPS must have a full-time medical officer and sufficient nursing staff to meet local demand.
- Relying on the local GP with VMO rights is an unsatisfactory solution.

- Telehealth should only be seen as a tool to complement or supplement face-to-face consultation.
- Residents of rural towns and those in outlying districts should have to travel a minimum distance to receive medical attention.
- Those living in rural, regional and remote places require credible and reliable information about their local health services, and this in turn requires honest communication between health districts and their constituents.