Submission No 561

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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Partially Confidential

Terms of Reference of the Inquiry.

1a) Health outcomes for people living in rural, regional and remote NSW.

In many cases the health outcomes for non-metropolitan NSW are very poor. Hospitals are poorly staffed and often have very poor and limited facilities. Many areas have no GP's, or very overworked ones, and wait times for appointments are often very long. There are very few specialists, particularly any with lots of experience and people have to travel long distances for many services. Travel is often very costly, and, in many cases impractical, particularly for older people.

1b) Comparison of outcomes for patients living in non-metropolitan areas compared to metropolitan areas.

Patients in metropolitan areas have a variety of medical services within a few kilometres of their homes and usually without long waiting times for appointments. They have a huge number of specialists to choose from and treatment is often fairly quick.

1c) Access to health and hospital services including service availability, barriers to access and the quality of services in non-metropolitan areas.

The availability of many hospital services in non-metropolitan areas have been continually on the decline over recent years. As the running of small hospitals has been taken over by larger district organisers, local needs have been neglected.
There seems to be roll on effect, where, because some service is not provided something else also closes down. Our local town now has NO doctor after having had 2 until 6 months ago, and as a consequence of no doctor, a visiting podiatry service has now also pulled out. Many are expecting that the pharmacist will also have to close because people will have to travel out of town to go to a GP and will get their scripts in that larger town.
There are also economic reasons, why quality providers stay in the metropolitan areas. In many cases, specialists in the city are able to work in more affluent areas and patients are happy to pay the large gaps they often charge.

1d) patient experience, wait-times and quality of care comparing both types of areas.

Patients used to have pleasant experiences in local small hospitals, because staff were part of the local community and treated as friends. However now, with staff shortages, agency staff visit for a couple of weeks and do not relate to the members of the local community. As mentioned in 1c), the top medical providers, and those with the most experience, choose to stay in metropolitan areas, so quality is down. Also because of often having to travel long distances and limited numbers of services provided, wait-times are far too long.

1g) Examination of staffing challenges and allocations that exist in non-metropolitan.

As a number of qualified staff wish to stay in the busy metropolitan areas, it is more and more difficult to encourage them to leave the metropolitan areas. To improve these numbers, incentives need to be offered.

1h) Current and future provision of ambulance services.

There is a need to revert the system back to being able to ring your local ambulance station directly, when needed, rather than going through a central call centre. As speed is essential, it is much more expedient to have people answer the phone who know the people and the area they have to travel to. In metropolitan areas, despite the fact there might heavy traffic, ambulances do have right of way which makes a trip quicker.

1i) Access and availability of oncology treatment, and
1j) Access and availability of palliative care.

At the present time, there is nowhere near enough regional areas providing these very important treatment and services. It is important that these patients can receive the help they need as close as possible to home, family and friends.