Submission No 620

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

Name: Mr Roy Butler MP, Member for Barwon

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ROY BUTLER MP
Member for Barwon

The Hon, Greg Donnelly MLC
Chair
Portfolio Committee No.2 – Health
Parliament House
Macquarie Street
Sydney NSW 2000

Dear Chair,

I write to regarding Portfolio Committee No.2 – Health's Inquiry into health outcomes and access to health and hospital services in rural, regional and remote New South Wales.

The electorate of Barwon is unique in many ways, it is the largest electorate in the State by many hundreds of square kilometers, it has 13 Local Government Areas and the Unincorporated Area, 72 schools and 27 hospitals and multi-purpose services across 4 Local Health Districts.

It is the state of these hospital services, that has kept me up at night – passionate, yet overworked staff, stripped back services, Ambo's driving for hours to get people to a bigger center and sadly the fact that some communities have lost faith that the hospital will be able to help them in their time of need.

Twenty years ago, the average life expectancy of someone living in far western NSW was 80.2 years, compared to 78.2 in Sydney at the time.

Data released by NSW Health in 2016 shows the scenario has now totally flipped, with people in Sydney likely to live to 85.3 while life expectancy for those in communities in Barwon has decreased to 78.8.

This decline did not happen overnight and did not happen without the NSW Government's awareness. The health system is one of the most monitored in the world, the decline in the health of people in rural, regional and remote NSW has been reported on, it is time the Government acted to reverse these statistics.

I thank the Committee for the important work they are undertaking. Should you require any further information, please do not hesitate to contact me.

Yours sincerely,

Roy Butler
Member for Barwon

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

Submission from Mr. Roy Butler MP, Member for Barwon
13 January 2021

The Australian Institute of Health and Welfare (AIHW) sums up the city-country health divide by saying "All is not equal" in its review of Australia's health[1]. This report goes on to state that people living in rural and remote areas experience poorer health outcomes compared to people in major cities.

I raise the AIHW reports as the Terms of Reference for this inquiry, in particular (a), (b) and (c) are addressed in the biannual reports. I would implore the Committee to not replicate the work undertaken by the AIHW as these reports are comprehensive and publicly available. Alongside the AIHW reports, in NSW we have the Bureau of Health Information's data gathering and reporting, along with HealthStats NSW which contains over 200 indicator groups, this data provides information on the health status of NSW, health inequalities and the determinants of health, the major causes of disease and current health challenges and comparisons between geographic locations. I bring these sources of information to the Committee's attention not to diminish this inquiry, in fact I am on the record as calling this inquiry a once in a decade opportunity for people living in rural, regional and remote NSW to share their lived experience of the health system and bring about real change.

It would be totally unsatisfactory to the people I represent for this inquiry to produce a report that rehashes what they already know from their own experiences and that has already been presented to the Government through the sources outlined previously.

People in rural, regional and remote NSW are tired of the system seemingly neglecting their needs and putting the issue of appropriate health care in the 'too hard basket'.

[1] Australian Institute of Health and Welfare. (2020). *Australia's health 2020: in brief*. Canberra: AIHW.

Recommendations from this inquiry that propose, systemic, drastic change is the only satisfactory outcome. We are beyond tinkering on the edges. People in rural, regional and remote NSW understand that and have developed a deep understanding that the change that is required won't be instantaneous and will take time to implement.

The burden of fixing the broken health system in the bush does not sit solely on the shoulders of NSW Health and the NSW Government, there is shared responsibility that the Federal Government must take on. Likewise, our border state partners have a role to play in information and resource sharing across systems. In addition to government, there are numerous health organisations willing and qualified to partner with government to be a part of the solution. I have met with a number of these organisations, and they all have evidence-based solution to the city-country health care divide, I have encouraged them all to contribute to this inquiry.

In addition to meeting with health organisations I have met with countless medical professionals, health professionals and health administrators exploring what's wrong with the regional health care system and how it can be improved.

What's common across the board when I speak to people about health care in the bush is that they all heap high praise on the professionals employed in the health system. I regularly hear about health employees, be they hospital administrators, paramedics, patient transport officers, nurses, doctors or allied health professionals, all being asked to go above and beyond what would be required of them in a metropolitan facility. Without this level of dedication, I question whether the system would be functioning at all. I cannot thank or speak highly enough of those who work in health, it is not an easy job and practicing in the bush adds another dimension of complexity.

I implore you to seek out and listen to as many of these dedicated health professionals as you can as part of this inquiry. Grant them the ability to speak frankly with you about what is happening in the system and what needs to change. It is these front-line workers, who, in my opinion, hold solutions for fixing the broken system. It is these workers who throughout COVID-19 we have listened to, respected, and followed their guidance. I ask that the Committee apply the same process to this inquiry and listen to the health professionals, listen to those with real life experience of what is going on.

The opinions I put forward in this submission stem from numerous meetings with health professionals, administrators in the four Local Health Districts covering Barwon – Murrumbidgee, Far West, Western and Hunter New England, academics, charities, volunteers and community members.

Social determinants of health

What needs to change in the bush to achieve better health outcomes for people will not be a simple one-sized-fits-all solution, and an answer won't be found by looking at a checklist of the health services that are and aren't available in a town, the problem is much broader than that.

The 'social determinants of health' which are the conditions in which people are born, grow, live, work and age were defined by the World Health Organization in 2003[2]. These are the building blocks for a person's health and include (but are not limited to), education, housing, transport, social inclusiveness and social support, food security, a stable health natural environment (clean air, water, safety and protection from climatic events), employment and occupation, and access to health care[3]. Many of these determinants are outside the responsibility of NSW Health but are NSW Government and in some cases Federal Government responsibilities.

The National Rural Health Alliance, Australia's peak non-government organisation for rural and remote health, who have the purpose of improving the health of people who live and work in country areas, provide this explanation:

> *The health of people living in rural, regional and remote Australia is influenced by a range of complex factors, not just the availability of health services….Access to education, opportunity for a career, social interactions, physical and social development and emotional support during the first years of life all contribute to a sense of control over one's life. Access to healthy food, safe and secure housing and the cost of living are all relevant factors[4].*

[2] World Health Organization (2003). *Social Determinants of health*. [online] Available at: https://www.euro.who.int/__data/assets/pdf_file/0005/98438/e81384.pdf.
[3] National Rural Health Alliance LTD (2018). *The indicators of, and impact of, regional inequality in Australia*. [online] Available at: https://www.ruralhealth.org.au/sites/default/files/documents/nrha-policy-document/submissions/nrhasubmission-indicators-and-impacts-regional-inequality-inquiry-final2.pdf.
[4] Ibid

These social determinants can strengthen or undermine the health of individuals and communities. The AIWH states that the higher a person's income person's income, education or occupation level, the healthier they tend to be—a phenomenon often termed the 'social gradient of health'[5]. They say that in general people from lower socioeconomic groups are at greater risk of poor health, have higher rates of illness, disability and death, and live shorter lives than those from higher groups.

The Australian Bureau of Statistics' Socio-Economic Indexes for Areas (SEIFA) Index of Relative Disadvantage (IRSD) identifies and ranks Local Government Areas in terms of their relative socio-economic disadvantage based on information from the Census. The IRSD scores each area by summarising attributes of their populations, such as low income, low educational attainment, high unemployment, and jobs in relatively unskilled occupations. Of the 13 Local Government Areas in Barwon, 9 are in the 'most disadvantaged' category, with 3 in the 'disadvantaged' category[6].

The 'social gradient of health' is evident when you look at the data around the prevalence of chronic disease in the Local Government Areas described as being most disadvantaged. AIHW analysis shows that the burden of disease for remote areas is nearly twice that when compared with the city. I will touch on the burden of disease and health inequalities between the country and the city further down in this submission.

Once you start to explore the broader social determinants of health and what's going on in Barwon communities you gain an understanding of why I plainly stated that the solution to health inequality in NSW is not a simple one. Moving the dial requires a whole of government coordinated approach in partnership with community and industry.

Health in All Policies

Health in All Policies (HiAP) is a Finnish approach to public policies across sectors that systematically takes into account the health and health systems implications of decisions,

[5] Australian Institute of Health and Welfare (2016). *Australia's health 2016 – Health across socioeconomic groups.* [online] Available at: https://www.aihw.gov.au/getmedia/405d9955-c170-4c39-a496-3839059149f7/ah16-5-1-health-across-socioeconomic-groups.pdf.

[6] Australian Bureau of Statistics (2016). ***Census of Population and Housing: Socio-Economic Indexes for Areas (SEIFA).*** **[online] Available at: https://www.ausstats.abs.gov.au/ausstats/subscriber.nsf/0/756EE3DBEFA869EFCA258259000BA746/$File/SEIFA%202016%20Technical%20Paper.pdf**

seeks synergies and avoids harmful health impacts, in order to improve population health and health equity[7].

The HiAP approach aims to create healthier and productive populations whilst reducing health inequalities. It is a framework that sees health as a benefit and outcome from all government policies. If the NSW Government were to adopt this approach, health would be central in the thinking of all departments, recognising that their actions can go toward achieving health goals.

HiAP has been successfully implemented in several countries and has been part of the South Australian Government's approach to addressing escalating health care costs, the growing burden of an ageing population and an increasing incidence of chronic disease since 2007[8].

Implementing a HiAP approach would require a whole of government shift, requiring work across government departments including transport, agriculture, water, education, communities, health and regional NSW. It is the large-scale shift that is required to address this multi-generation issue.

Health outcomes

Twenty years ago, the average life expectancy of someone living in far western NSW was 80.2 years, compared to 78.2 in Sydney at the time[9].

Data released by NSW Health in 2016 shows the scenario has now totally flipped, with people in Sydney likely to live to 85.3 while life expectancy for those in communities in Barwon has decreased to 78.8[10].

The Barwon electorate is also home to a number of people who identify as Aboriginal – approximately 16% of the population. When it comes to health, Aboriginal Australians suffer

[7] Ministry of Social Affairs and Health, Finland (2013). *Health in All Policies*. [online] Available at: https://www.euro.who.int/__data/assets/pdf_file/0007/188809/Health-in-All-Policies-final.pdf
[8] SA Health (2013). *South Australian Health in All Policies Initiative – Case Study.* [online] Available at: https://www.sahealth.sa.gov.au/wps/wcm/connect/f31235004fe12f72b7def7f2d1e85ff8/SA+HiAP+Initiative+Case+Study-PH%26CS-HiAP-20130604.pdf?MOD=AJPERES&CACHEID=ROOTWORKSPACE-f31235004fe12f72b7def7f2d1e85ff8-niPMMbV
[9] HealthStats NSW (2020) *Life expectancy at birth by Local Government Area.* [online] Available at: http://www.healthstats.nsw.gov.au/Indicator/bod_lexbth/bod_lexbth_lgatrend
[10] Ibid

worse health outcomes. In the AIHW's *Closing the Gap targets* report the stark 10-year gap in life expectancy was highlighted[11]. So subtract another 10 years from the figures above.

Put simply, people living in the country are more likely to die at a younger age than their counterparts in the city.

Data complied by the AIHW shows that due to our geographic isolation in the bush people often have poorer health outcomes than people living in the city. In the country we have higher rates of hospitalisations, deaths, injury and also have poorer access to primary health care services[12].

It is a mistake to assume that these issues are the result of workplace injuries on remote farms. Rather the hospitalisations and early deaths are due to the high disease burden. The fatal burden of disease is at least 20% higher in regional areas and at least 50% higher in remote areas[13]. For Aboriginal Australians, the burden of disease is 2.3 times the rate of non-Aboriginal Australians[14].

When you look at the data on chronic disease in the bush, a picture starts to form about why health inequalities in the country cannot be fixed with a focus on building new hospitals.

One of the major challenges to improving chronic disease outcomes is addressing the health risks that contribute to the development of chronic diseases. Compared with people living in cities people in the country are more likely to smoke, be overweight, engage in risky alcohol consumption and not exercise[15].

The Far West and Orana region, which includes Dubbo, Broken Hill, Gilgandra and Bourke, has the state's highest rate of obesity (44.4 per cent). This is more than double the rate of North Sydney and Hornsby (18.6 per cent), which has the lowest[16]. The Far West and Orana also tops the state, with a smoking rate of 21.2 per cent – three times higher than the

[11] Australian Institute for Health and Welfare (2017). *Closing the Gap targets: 2017 analysis of progress and key drivers of change* [online] Available at: https://www.aihw.gov.au/reports/indigenous-australians/closing-the-gap-targets-2017-analysis-of-progress/contents/summary
[12] Ibid
[13] Ibid
[14] Ibid
[15] Ibid
[16] Heart Foundation (2020) *Australian Heart Maps* [online] Available at: https://www.heartfoundation.org.au/health-professional-tools/australian-heart-maps

lowest-ranked region (North Sydney and Hornsby, 7.1 per cent). Of the 10 regions with the highest smoking rates, all but one are in regional and rural areas.

One of the key reasons for the results above is limited access to quality and timely primary care through a local, consistent, general practitioner (GP). A consistent GP is essential to intervene before a person develops a chronic disease or to guide people towards diagnosis and care. While the regulation of GPs is a Federal responsibility, Local Health Districts have a role to play in the attraction and retention of doctors in country towns through their recruitment of Visiting Medical Officers. In regard to GPs it is important to take note of analysis undertaken by the Rural Health Alliance that shows that rural GPs work longer hours – this they put down to managing patients with chronic diseases, the requirement for them to perform a broader range of tasks as they do not have ready access to a health professionals network, and their often dual role as a GP and Visiting Medical Officer at the local hospital[17]. Burnout in the medical profession is a well-documented occurrence, and regulations should be looked at to prevent this occurring in rural practice to improve the attractiveness of practicing in the bush.

In the majority of rural and remote communities' nurses are playing an increasingly vital role in the prevention and management of chronic disease. It is common to see primary care functions that would be delivered by a GP or an allied health professional in the city being delivered by a nurse. I recognise the important work that has been done by the NSW Ministry of Health in supporting more nurses to become qualified as Nurse Practitioners and other significant training in order to meet needs that nurses are identifying as areas of need in their communities.

These nurses while highly qualified do still suffer from the unjust criticism that they are 'just a nurse' and the perception that being seen by a nurse is second rate to being seen by a doctor.

There is work there to be done by the NSW Ministry of Health to explain the levels of qualifications held by nurses, and their scope of practice.

[17] National Rural Health Alliance (2015) *Submission: Inquiry into Chronic Disease Prevention and Management in Primary Health Care.* Available at: https://www.ruralhealth.org.au/sites/default/files/documents/nrha-policy-document/submissions/inquiry-chronic-disease-prevention-and-management-primary-health-care.pdf

The chronic shortages of health professionals in the bush is well documented. The major consequence of the primary health care professional shortages is that people are unable to access the health care they need when they need it.

One of the indicators that can be looked at to see if there is adequate primary health care in a community is the number of potentially preventable hospitalisations (PPH). PPH is often described as the proxy measure of primary care effectiveness as they are the hospital admissions that potentially could have been prevented by timely and adequate health care in the community[18].

Analysis of HealthStats data on PPH, shows that the 13 Local Government Areas and the Unincorporated area in the Barwon electorate all have PPH rates above the NSW average. When comparing the PPH by remoteness, the more remote the higher the rate of avoidable hospitalisations per 100,000.

Major cities	Inner regional	Outer regional	Remote	Very remote
2094.7	2334.6	2421.0	3195.2	3328.6

Potentially preventable hospitalisations, Rate per 100,000 population, Comparison by remoteness, 2018-19[19]

The Federal Government's Primary Health Networks (PHNs) established in 2015, were set up independent of government to commission, not provide services. As they are not part of the NSW Health system the ability of this inquiry to review the PHNs is limited however I hold concerns based on the data gathered by the NSW Government regarding avoidable hospitalisations about whether or not the PHNs are meeting their mandate to 'target and prioritise health services to meet the identified needs of the local community in a continuous cycle of improvement'[20].

[18] Australian Institute of Health and Welfare (2019). ***Potentially preventable hospitalisations in Australia by age groups and small geographic areas, 2017–18*** **[online] Available at: https://www.aihw.gov.au/reports/primary-health-care/potentially-preventable-hospitalisations/data**
[19] HealthStats NSW (2020). *Potentially preventable hospitalisations by category* [online] Available at: http://www.healthstats.nsw.gov.au/Indicator/bod_acshos/bod_acshos_comparison
[20] Department of Health (2018). *Fact Sheet: Primary Health Networks* [online] Available at: https://www1.health.gov.au/internet/main/publishing.nsf/Content/Fact-Sheet-Primary-Health-Networks+

Doctor shortages

I have met with many originations to talk about the problem of Doctor shortages across the state, many of them have said the system is broken and it must be rebuilt with the State and Federal Governments working together with Doctors on a solution.

The split responsibilities between the State and Federal Governments, the responsibility of hospitals and staffing sitting with the NSW Government and the funding of general practice sitting with the Federal Government exacerbates the Doctor shortage problem.

Successive governments have stated that they intend to address the issue of Doctor shortages, and yet we have seen no real change to the availability of well-trained General Practitioners who are willing to set up a practice in a country town and take up the position of Visiting Medical Officer at the local hospital.

We know that when there is no local Doctor the health outcomes in a community are significantly worse, a small problem becomes a bigger problem. A health issue that could have been, and would in the city be attended to by a General Practitioner becomes a presentation at the Emergency Department, an Ambulance ride to another, bigger town. The cost on the family is enormous, the cost on the health system is significant.

In 2002, the then President of the Australian Medical Association Dr Kerryn Phelps, at the NSW Summit on the Rural Doctor Shortage said “we are well past the band-aid stage”[21] when it came to addressing the Doctor shortage issue.

Nearly 19 years down the track we’re still rummaging around in the medicine cabinet looking for a band aid when what the system needs is lifesaving surgery.

Telehealth

Telehealth cannot and should not ever replace in-person medical care in rural and regional hospitals. The Australian Salaried Medical Officers' Federation (ASMOF) has expressed that the assessment of critically ill patients without a Doctor present is causing unacceptable risks to patient safety and high levels of stress and anxiety for medical

[21] Australian Medical Association (2002) *Dr Kerryn Phelps, AMA President, to the NSW Summit on the Rural Doctor Shortage, Tamworth, New South Wales* [online] Available at: https://ama.com.au/media/dr-kerryn-phelps-ama-president-nsw-summit-rural-doctor-shortage-tamworth-new-south-wales

professionals[22]. They point to the tragic experience in Gulgong last year as evidence to the extremity of what can happen when there is a reliance on telehealth in an Emergency Department. Telehealth Doctors cannot physically save a life, to rely on them to do so via a computer screen should be seen as an unacceptable and risky practice by NSW Health and immediately addressed. The reliance on telehealth in Emergency Departments is also placing undue amounts of pressure on nursing staff, with many nurses across the electorate expressing their concerns to me. It is also disappointing to note that these nurses do not feel heard when they express these concerns to health management.

In October 2020, Rural and Remote Medical Services Ltd released their report *Rural & Remote Community Healthcare Snapshot 2020, Community attitudes to the quality of health & hospital care and use of Telehealth*[23]. The Survey found that while rural, remote and Indigenous people were comfortable using primary care led Telehealth services for routine matters such as medical certificates, repeat scripts from their own doctor and treatments for minor ailments, they drew the line at using telehealth as a replacement for local on-call GPs in hospital and emergency care.

I do not object to telehealth models being a part of health care services in Rural, Regional and Remote NSW, however they can never be a replacement for in-person care. Telehealth in primary health care settings has the potential to improve long term health outcomes for people, providing consistency of care – when a person can have repeat appointments with the same Doctor remotely, greater access to specialist appointments without the burden of long travel times and overnight stays, and the ease of simple follow up appointments being done from a person's home. Improving the use of telehealth in primary care has the potential to impact positively on hospitals with decreases in presentations to emergency departments for low acuity presentations – those presentations that are best managed through a General Practitioner.

Acceptance of telehealth in certain circumstances will increase over time as more people come into contact with it (in appropriate, non-life-threatening circumstances) the funding of

[22] Australian Salaried Medical Officers' Federation (2020) *The Doctors Union opposes inadequate telehealth model in Regional Emergency Departments* [online] Available at: http://www.asmofnsw.org.au/latest-news/the-doctors-union-opposes-inadequate-telehealth-model-in-regional-emergency-departments

[23] Rural and Remote Medical Services Ltd (2020) *Rural & Remote Community Healthcare Snapshot 2020, Community attitudes to the quality of health & hospital care and use of Telehealth* [online] Available at https://www.ruralandremotehealth.org.au/post/a-big-no-to-replacing-rural-emergency-doctors-with-telehealth-survey

these upgrades should come from dedicated sources. It is entirely inappropriate for funding to be redirected away from frontline health staff to the funding of telehealth services. In addition, funding should be allocated to programs to improve people's understanding of telehealth and when it may be an option for them to use, for example rather than travelling to a larger centre for a routine appointment requesting a telehealth appointment if that is suitable for the patient. NSW Health and the Local Health Districts should also invest in communicating with the community about services that are available via telehealth for example appointments with dieticians which may not be available locally.

Ambulance Services

Put simply we need more intensive care paramedics in the bush. If you were in a serious car accident in the city an intensive care paramedic would be at the scene in a matter of minutes. In the bush, you might get one if you're lucky enough to crash near one.

Intensive care paramedics' attendance greatly increases the survivability of accidents as they have an increases scope of practice[24]. This is vitally important in the bush where access to definitive care will take longer.

Paramedics are also routinely called upon to move patients between hospitals, which means in some communities that the town is left without any on-duty paramedics, placing people in the town at unnecessary risk. The distance that these paramedics are being asked to travel can often mean an entire shift is committed to ferrying people between facilities.

Isolated Patients Travel and Accommodation Assistance Scheme (IPTAAS)

In 2007, the Federal Senate referred the operation and effectiveness of Patient Assisted Travel Schemes to the Community Affairs Committee for inquiry and report. This inquiry culminated in the report *Highway to health: better access for rural, regional and remote*

[24] Maddock A, Corfield AR, Donald MJ, et al (2020). *Prehospital critical care is associated with increased survival in adult trauma patients in Scotland* Emergency Medicine Journal 2020;37:141-145.

patients[25], which provides comprehensive analysis of patient assistance travel schemes across the country.

In their submission to this inquiry the Country Women's Association of NSW summarised why a well-functioning, people focused travel assistance scheme is needed.

> *With the downgrading of country and regional hospitals it is now necessary for patients to travel greater distances. In the past it was not unusual for specialists to regularly visit country and regional hospitals which meant that patients were able to access locally many of the services for which they now need to travel vast distances*[26].

It is for this reason that the demand for assistance will only continue to increase, and as such will continue to require higher funding from the Government.

The Isolated Patients Travel and Accommodation Assistance Scheme (IPTAAS) is the NSW Government scheme providing financial assistance towards travel and accommodation costs when a patient needs to travel long distances for treatment that is not available locally[27].

The current IPTAAS subsidies of 22 cents per kilometre for private vehicle travel, and $43 per night for the first 7 nights per financial year fall well short of covering even a quarter of the costs associated with travelling for medical appointments. With the paltry amount of assistance received a large number of people in my electorate don't bother with the paperwork required to receive the money.

There is a compelling case for increasing the level of rebate people receive, number one country people are not able to access the care they once received at their local hospital and number two saving money by not funding increases rates is a false economy as the most likely outcome is additional health spending for more chronic health care needs. In the long run if we make it easier for people to decide to access care early, we reduce the need for acute care which places more pressure on more service, It comes down to this prevention is better than cure, if we can get people to see a specialist sooner rather than later there is

[25] Commonwealth of Australia (2007). *Highway to health: better access for rural, regional and remote patients* [online] Available at: https://www.aph.gov.au/Parliamentary_Business/Committees/Senate/Community_Affairs/Completed_inquiries/2004-07/pats/report/index
[26] Ibid
[27] NSW Health (2020). *Isolated Patients Travel and Accommodation Assistance Scheme* [online] Available at: http://www.iptaas.health.nsw.gov.au/home

a cost saving. Expenditure on IPTAAS should be seen as an investment in future productivity and reduced health spending, rather than merely as a current fiscal liability.

NSW Health is on the record saying that it is not the IPTASS rebates that effect people's decision to access care rather other factors such as 'access to carers for children' and 'potential loss of income' impact on people's decisions about how, when and if to travel to receive health care[28]. While this may be true, the Government must be doing everything it can to remove the barriers to accessing care rather than pushing blame for the barriers onto the individual.

When we have people making the decision between putting food on the table and seeking medical care in Australia in 2020, we know there is a problem that needs to be fixed.

'Just' safety culture and clinician engagement

Mistakes happen in every job, in every industry. In health these mistakes have a human face and a story. When mistakes are made in health, there is a hunt for where to lay blame and attempts to deflect the blame. The blame game often means families never get a proper explanation, and nothing changes. We see action taken to fix these problems once people approach the media. We can only look to the reporting in the year proceeding this inquiry for examples.

When discussing this reporting and this inquiry with a clinician that has worked and is still working in the NSW Health system, they said the problem is that clinicians are part of a system which provides health care to patients, yet when an adverse event like an unexpected death occurs the clinician may be held solely responsible, not the system they are a part of.

In the aviation industry, when mistakes are made, the 'just culture' kicks in. They avoid blaming a pilot. Instead they examine the system for faults – what it is about the system that allowed the incident to occur in the first place. The industry respects that people are going to make mistakes, so the focus is on how system design might prevent mistakes from

[28] Ibid

happening, In health care is it more common for blame to be directed toward the clinician and for the wagons to be circled.

When things go wrong, the Health Bureaucracy kicks into gear, with a feeling among a number of clinicians that I have engaged with that these bureaucrats are too far removed from the reality of frontline medical care. The culture in the Local Health Districts has been described to me as one of distrust between clinicians and administrators.

In 2008, the Garling Report (the Final Report of the Special Commission of Inquiry into Acute Care Services in NSW Public Hospitals) prepared by Peter Garling, SC following a series of high-profile medical mishaps in the New South Wales public hospital system recommended increased clinician engagement within hospitals and on hospital boards[29]. In 2019, the NSW Audit Office found that better clinician engagement in Local Health District decision making...has not met the expectations and requires attention as a priority[30]. As reported to me, clinicians feel alienated in regional NSW Health decision making and fear raising their head above the parapet concerned they'll be branded a troublemaker. This is a disappointing culture given our clinicians know how the system works and could work better.

Until this culture changes people will remain at risk.

Planning needs to see people

Health service planning in my opinion fails to see people, and the needs of people and how those plans will impact lives.

I have met on a number of occasions senior bureaucrats in the Local Health Districts across Barwon to discuss health needs in my communities. Often it is me approaching them because my team has identified a demand for a service in a particular town. Take for instance the need for renal dialysis chairs, chemotherapy chairs, cardiac clinics, or more aged care beds. We're often told they need to run the numbers and then that the demand isn't high enough, the cost is too great. Now I understand that I have had to balance budgets before in the public sector, I understand the pressure. But I don't see the budget

[29] Garling, P (2008). *Final Report of the Special Commission of Inquiry Acute Care Services in NSW Public Hospitals* [online] Available at: https://www.cec.health.nsw.gov.au/__data/assets/pdf_file/0011/258698/Garling-Inquiry.pdf
[30] Audit Office of New South Wales (2019). *Governance of Local Health Districts* [online] Available at: https://www.audit.nsw.gov.au/our-work/reports/governance-of-local-health-districts

pressures when it comes to health. I see a system that says we need 9 people in this community to need renal dialysis before we look to setting up a unit in the town, but we've only got 7 so they'll have to keep loading themselves into the car 3 times a week, paying for fuel, spending hours on the road and a whole day out of town. Now is that a life well lived? Is that a system that looks and sees people? Or is a system that looks at 'minimum viable numbers' and spreadsheets and cost benefit ratios? Isn't health care about simply that – care?

We in the bush aren't asking for a full trauma centre in every town, or large cancer centres every 100kms, but what we are asking for is the system to stop looking through a lens of 'minimum numbers' that are based on the metropolitan areas. The numbers in the bush will always balance out to be cost of delivery higher, number of users lower. But those users are people, and they have families.

In the bush, we want to be able to have babies at our local hospital, because that's where generations of our family were born. We want our kid's growth and development checked on by someone we know and trust. We want health advice delivered to us in person not over a computer screen. We want our parents and grandparents to be able to live safely in their hometowns with access to doctors. We want our nurses to be able to go to work and be safe and supported. We want our paramedics to be not be burnt out by overtime. We don't want more avoidable deaths. We want to trust the health system again.