Submission No 640

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

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Regional public health care is below acceptable standard compared to the cities.

1. There is a catchment system applied to hospitals so that city hospitals reject patients from the regional areas and refer them back to regional health systems. This is even when the regional hospitals have failed that particular patient. Patient outcomes are not considered only the catchment zone. Even doctors who come from the city to work in regional areas cannot get their families into the city hospitals for their own healthcare.

2. Overseas trained doctors whose qualifications are not accepted in Australia are allowed to work in regional areas including specialist work in hospitals. These same doctors are considered not suitable to allow to work in city hospitals.

3. There is a concept that training specialists in regional areas encourages them to stay in that regional area. This has a fault in that the training in a regional hospital is below standard. You simply cannot get good training if the clinical material is not there. You cannot get good training if the supervisory expertise is not present. At the level of specialist training it is doing the work that provides the training not lectures and tutorials. Specialist training needs to be in city hospitals. It is a much better system to then send advanced trainees from the city hospitals to work for a term in the regional hospitals. That way you get good senior registrars from city training programs in regional hospitals. Mainly it is junior trainees that get sent to regional hospitals. There is less supervision in regional hospitals. This means poorer training and patient care. It needs to be doctors at the end of their training not the beginning that get seconded to regional hospitals.

4. Using city models of matching rehabilitation units with acute units does not work for regional hospitals .Acute units are compromised by staff and resources shifting to rehabilitation units which serve little purpose. Cities have multiple hospitals to deal with acute and subacute patients but regional hospitals are stand alone. All care is centered on that one regional hospital . Rehabilitation can be done in the community. Regional funding and resources are wasted on rehabilitation units instead of acute care units with proper follow up. Patient care in regional hospitals is compromised by lack of beds and doctors so patients are rushed out of acute wards. Yet millions are spent on rehabilitation units even situated on hospital grounds. These rehabilitation units take experienced nurses away from acute care because it is much easier work for them for the same earnings. Resources in regional hospitals need to be focused on acute care. Modeling on city hospitals which can have rehabilitation units because there are other plenty of other hospitals available in the cities is a mistake and a waste of resources.

5. Nurses are doing the work of doctors in regional health care when it comes to assessing patients. Specialists on call to regional hospitals practice by proxy asking the nurses what the condition of the patient is. This is negligent. Nurses have experience but not the knowledge of a specialist doctor which is most important when assessing a patient.

6. If patients are prepared to travel to a city hospital after the regional hospital has failed them they need to be accepted with priority care. Not the other way round with rejection back to the regional hospital.

7. Nurses in regional areas have unsupervised responsibility because senior doctors are not available. The nurses often assess patients and the senior doctors give advice without seeing the patients. The power that nurses have when there are no senior doctors actively supervising patient care has led to the concerning abuse in this report on a mid north coast hospital unit . https://www.abc.net.au/news/2020-12-21/former-nsw-health-employees-say-patient-abuse-is-covered-up/12879704