Submission No 660

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

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Forward

It is acknowledged that the delivery of healthcare services to rural, regional and remote NSW poses unique challenges given ageing and shrinking populations, rising levels of chronic disease, the high cost of service delivery, aeromedical emergency retrieval and staff retention challenges. It is also accepted that small rural hospitals cannot, given remoteness and low population density, operate at the same levels of activity as larger urban hospitals.

Reliance on patient surveys conducted by the Bureau of Health Information[1] for endorsement of current healthcare performance in rural, regional and remote NSW (accessibility, appropriateness and effectiveness) does not correspond to reality.

It must also be noted that for healthcare workers living in closed and close communities, there is a fear of reprisal, targeted bullying and intimidation, the threat of job loss, where there are few immediate job prospects, or an adverse report or reference that would compromise future employment particularly within NSW Health. If healthcare workers have the courage to bring their concerns to the attention of NSW Health these concerns have often been met with a deafening silence. Two senior staff at the Mid-North Coast Local Health District claim, in recent court documents, that there is a widespread fear amongst staff in NSW Health in coming forward and that they themselves were punished for speaking up about the alleged serious misconduct of health employees.[2]

Australia has a very poor record in defending complainants and whistle blowers or indeed anyone whose concern for the wellbeing of others and whose integrity, moral and ethical compass urges them to speak out often at huge personal, financial and legal cost. The identity of those who have chosen to relate personal experiences that exemplify the systemic failures in rural, regional and remote health in NSW must therefore be withheld to protect livelihoods, career, colleagues and family. Specific incidents that have been documented in this Submission have been obtained from face-to-face conversations, targeted interviews personal knowledge and experience.

Further, dates and times have also been omitted to protect identity. The author of this Submission can however be contacted for further clarification.

Submission

This Inquiry is welcomed, as is the opportunity to make a Submission, given the clear, measurable and alarming disparities in healthcare provision and health outcomes between 'the bush' and metropolitan centres, and which only increase with remoteness.

In sharp contrast billions have been squandered on careless infrastructure decisions such as an over budget underutilised Sydney Light Rail, the WestConnex freeway, River Class Ferries that won't fit under bridges on the Parramatta River, $2 billion in new trains that are too wide to get through tunnels, the Sydney Football Stadium redevelopment 'designed to make NSW more liveable', which all make a mockery of the principle of equity of services and funding when rural and remote communities are denied the basic human right 'to the enjoyment of the highest attainable standard of physical and mental health' under UN Article 12 ICESC[3]

Between 28%-34% of us live outside major urban areas, that is one third of all Australians, yet rural, regional and remote health services have been under funded, under resourced and understaffed for far too long. Problems of workforce shortages (in outer regional and remote hospitals from 15% to 24%)[4] and equitable distribution of these resources are persistent, as are difficulties with retention rates that are often associated with poor and toxic management practices, rather than location, thus creating a revolving door of health care workers.

As with private aged care and hospital paradigms more generally, the system is replete with agency, short term and casualised staff who are unsupported and unprepared for often isolated and culturally unfamiliar environments. Appropriate remuneration, accommodation, professional development, relief, social support, physical infrastructure, information technology and service coordination is sadly lacking. Any attempt to address workforce shortages with the ad hoc addition and subtraction of various Commonwealth schemes,[5] designed to attract skilled healthcare workers, have only served to entrench rapid workforce turnover.

Funding cuts have disproportionately impacted rural and remote locations where population decline has affected essential infrastructure development, reduced the number of frontline health workers and administrative personnel. In small communities the administrative burden often falls to health professionals who themselves are already overstretched, and stressed, and whose wages are now effectively frozen. Add to this mix the absence of strong leadership, advocacy, competent management and appropriate governance, it is not surprising that system wide deficiencies are inevitable.

The rigorous oversight, regulation, adherence to performance indicators, and accountability that are feature of our excellent public health system in metropolitan teaching hospitals in NSW, have not been replicated in the 'bush', where mismanagement and misbehaviour is tolerated 'out of sight and mind' in a system that at best hides, and at the worst can attract, practitioners with less than competent practice.

The answer to the Terms of Reference (a) and (b) 'health outcomes for people living in rural, regional and remote NSW' is undeniably avoidable suffering, (not only for the individual but family, friends and community), ongoing and unnecessary health problems and preventable death.

The concerns that frame the current Inquiry Terms of Reference have been identified by decades of research and the subject of the numerous earlier inquiries, committees and reports. Academic investigation has provided a comprehensive analysis of the issues that underpin serious health and health care inequalities for Australians living outside large metropolitan centres as well as cogent suggestions for the necessary transformations. Strategic plans and statements of intent by Governments to redress health outcome inequalities are laudable but have not produced the positive changes required.[6]

While it is not possible to quantify the 'social determinants of health' and contextual factors in rural, regional and remote NSW, much has been made of factors such as lower incomes, lower levels of education and employment, substandard housing, less secure and costlier access to transport, fuel, fresh food and water, greater exposure to inherently dangerous occupations, behavioural factors and lifestyle choices in determining poor health outcomes.[7]

These social and economic factors, living standards and conditions in rural and remote NSW, are inextricably linked to poor health outcomes particularly for Aboriginal and Torres Strait Islander populations, with Australians in the lowest socioeconomic areas living 3 years less[8]. For indigenous Australians the life expectancy gap is 8-9 years, and in remote areas as much as 14 years.[9] Just as alarming is the prediction that a baby girl born in a remote or very remote area in NSW in 2012 can expect to live for 72 years while a baby girl born in a major city can expect to live for 86 years.[10]

A 'social determinants' explanation for poor health outcomes in rural, regional and remote NSW can however be cynically manipulated to deflect attention away from the substantive reasons behind poorer health outcomes in these communities, that is the failure to address the shortcomings in properly funded, quality, consistent, regular and supported healthcare provision. In remote areas where disadvantage is amplified, the Australian Bureau of Statistics' National Health Survey, which provides information on the prevalence of long-term health conditions and health risk factors, does not even include the very remote areas of Australia.

Rural and remote communities sustain those of us who live in metropolitan areas, and contribute approximately 67% to the value of Australia's exports.[11] They therefore should attract more of our healthcare resources, services, skilled personnel, and access to affordable care, not less, as they face many more physical and mental challenges as well as the far-reaching implications of a changing much hotter climate and the associated health effects.

Primary healthcare provided by generalist practitioners whose training and scope of practice is based on local not metropolitan needs should be the mainstay of rural, regional and remote health. Yet despite having to care for a diverse range of patients with a broad

spectrum of illnesses they are, in the majority, without collegiate or specialist support, remuneration commensurate with skills or practice, and without clinical privileging or tertiary professional development that enable them to keep up with latest clinical practice.

According to the Australian Medical Association (AMA) there is funding crisis where GP services currently only receive about 8 per cent of total government funding on health, when need is growing with an ageing population and the rise in the number of patients with long term chronic illness and co-morbidities.[12] The AMA has also identified the misconceived budgetary and population based decisions to close and downgrade healthcare facilities as a key impediment to the scope of generalist practice which can have significant consequences for local communities, the sustainability of the medical workforce and ultimately patient outcomes.

In addition, many communities, where income is 20% below that of metropolitan residents, still pay a premium for basic health care with no bulk-billed GP services. They are thereby denied access to initial screening, referral, physical, psychological and social care with primary health care needs unmet in 14% of outer regional and remote areas. Of surveyed respondents in outer regional and remote areas 39% find it difficult to access out-of-hours primary care. [13] For example, Wee Waa has GP services only 3 days a week and a doctor at the local hospital on occasional weekends. At the time of writing urgent calls have been made to fill immediate GP locum vacancies in Young (2), Albury, Warialda, Bourke, Barraba, Gunnedah, and Jerilderie

Whilst the Terms of Reference (c), (d) and (g) will examine access to health and hospital services, patient experience and staffing challenges, these issues are not mutually exclusive but inclusive.

Little attention has been paid to the needs of the dedicated healthcare workers in our rural and remote regions and in turn the impact lack of care for *their* well-being and welfare has on patient access, experience and outcomes. NSW Health has responsibility not only to ensure the health and wellbeing of its staff in order to attract dedicated professionals trained to deliver quality patient centred health care and to ensure there are sufficient health care professionals to deliver the required care safely and without delay. This is currently not the case.

In remote physically challenging environments where living standards are compromised, small grievances can be personalised and amplified. Health care workers also face the same lifestyle constraints and stressors as their patients including: excessive living costs, including for air-conditioning where temperatures in summer in some towns are often over 45^{o}, the purchase of drinking water and the expenses incurred in travel to large centres to visit family and friends, to service vehicles, purchase or replace equipment and household items, mental and physical isolation and limited opportunities for crucial social engagement.

The call on reserves of personal resilience to then meet the demands (professional, physical, social and psychological) placed on them by community 24/7 is enormous. In centres such as Brewarrina, Walgett and in Bourke LGA with a population 2,634 people in the 2016

census, 31.5% of whom are indigenous, additional personalised support is required but not forthcoming to meet the important cultural and linguistic needs of these communities.

Face to face dedicated counselling and emotional support is not provided, with online EAP at the instigation of the individual healthcare worker. Debriefing following attendance to horrific injuries, is not assumed nor is account taken of the personal trauma experienced when trying to save lives that could have been saved, or suffering alleviated, were it not for the lack of resources, access to emergency and specialist care, the right equipment, drug regimens, the accredited skills to deliver the needed care, or indeed the presence of a doctor in a hospital with an Emergency Department to attend to critical injuries or illness.

Ongoing professional training to retain, update or enhance skills is limited or non-existent.

In regard to the Terms of Reference (h) 'the current and future provision of ambulance services in rural, regional and remote NSW' paramedics in remote NSW have an irregular case load and when on duty can be called out at any time in a 24 hour period with irregular sleep a health issue. Roads can be dangerous after rain and the presence of stock, feral and native animals, particularly at night, pose a further hazard.

The forced posting of junior paramedics to less desirable rural and remote locations often without the necessary understanding or experience to manage the social and environmental challenges often results in a more rapid rotation of staff.

A seriously ill or critical patient may require strong pain relief, sedation, needle chest decompression for tension pneumothorax, or intraosseous access in the case of cardiac arrest. These procedures are essential to treat life threatening illness or injury in remote locations, and fundamental where delayed interventions can make the difference between life and death.

These additional skills are available and remunerated for Intensive Care Paramedics (ICPs) who work in in metropolitan areas where access to large teaching hospital is minutes away but denied to remote area paramedics where the need is critical.

Although the Inquiry Terms of Reference preclude individual investigations or case reviews, the individual experiences of healthcare professionals who work, and have worked in Bourke and Bourke LGA expose serious systemic failures that are documented in the Case Study that follows.

Bourke a Case Study

Although any general description of rural and remote health in NSW must take account of many diverse locations and communities, the disadvantage in access and quality of healthcare delivery for those living and working a remote NSW town is exemplified in many ways, though not all, by Bourke. Typically occupational and physical risk in remote communities is high, as is economic disadvantage and higher rates of chronic disease. When exacerbated by under resourcing, operational and administrative shortcomings negative health outcomes are almost guaranteed.

Bourke does have a basic hospital facility, an airfield, a medical centre run by RaRMS (Rural and Remote Medical Services) an Aboriginal Medical Service (AMS) and Bourke Community Health which is located, as is aged care, within the Hospital precinct. Primary care is bulkbilled, as many residents are unable able to afford a gap payment. Access to ancillary services such ultrasound, x-ray and pathology are currently available with a mobile CT scanner promised.

At a glance access to healthcare in Bourke would appear reasonable, relative to isolation and population. However, those who have historic knowledge having lived and worked in Bourke for a number of years, report a progressive scaling back and withdrawal of healthcare services that were earlier available but already in decline. They maintain the more recent perceived addition of services, in response to community concerns, have not enhanced service provision but have masked entrenched deficiencies in care, reported but never addressed, that both compromise patient safety and inevitably result in poor short and long-term health outcomes. There are effectively no emergency, gynaecological, obstetrics or maternity facilities.

1. **Delays in receiving medical attention** in Bourke town as opposed to Bourke LGA where emergency transport is required and distance inevitably results in delay. There is no onsite doctor at Bourke hospital. A GP locum is urgently required at the time of writing. A GP (one permanent only) must balance consultations in the Medical Centre with the on call demands of the Hospital. The decision to call a doctor to attend the Hospital is at nursing staff request. A substantial burden is placed on nurses who are both aware of doctor fatigue (eg after 2 weeks on call without a break), and who may not have the requisite diagnostic skills to determine the severity of a patient's injury or health condition. Doctors have not always been competent, and have either elected not to attend to a patient at the request of nursing staff or have provided remote advice without examining the patient.

3. **Delays in transport out of Bourke**. Virtual Care Dubbo (V Care), off site tele consultation using camera only assessment has resulted in clinical assessments that have failed to take account of patient deterioration over the short term, with the result that V Care has put patients at risk by not authorising the required retrieval in a timely manner.

There has also been more than one occasion when urgent air transport was required where mechanical failure, bad weather or lack of aircraft availability resulted in considerable delays and adverse patient outcomes. A confirmed heart attack victim waited 4-5 hours before being transported. On another occasion a patient with severe mental health issues waited two days for transport to Dubbo Base Hospital. There is a currently a system wide focus on retrieval, rather than dedicated patient care at the local Hospital that is able to provide appropriate and immediate care whether by an emergency physician, nurse practitioner or GP specialist.

4. The provision of **mental health** support is not proportionate to the high number of mental health presentations and rates of suicide that increase with remoteness and disproportionately affect indigenous communities. A large share of mental health presentations are drug related with aggressive patients requiring sedation. Smaller regional hospitals are ill-equipped to safely manage these patients. One mental health nurse is on duty during business hours Monday to Friday 9am to 5pm with all presentations outside these hours referred to a phone counselling service in Dubbo 400 kilometres away. Staff at Bourke Hospital who have been present and supporting a mental health patient at the time of a referral to Dubbo, report that interactions are simplistic, limited to single questions related to suicidal ideation and on occasion seem focused on persuading a patient *not* to be transported from Bourke to Dubbo rather than addressing their immediate mental health needs and concerns. Often if transported to Dubbo or Orange, follow up in the community on their return to Bourke is inadequate and ongoing care is rarely a consideration.

5. There are **organisational and communication issues** between RaRMS doctors and the Hospital, AMS and Community Health. In addition, a system of private rather than public specialist and allied healthcare clinics operate infrequently once a month. All patients must organise appointments and consultations themselves or doctors may refer. Although aged care residents are cared for by nursing staff in Bourke Hospital, regular podiatry attention is arranged by the doctor not the Hospital.

6. According to healthcare workers on the front line there is **limited follow up and ongoing monitoring or care of patients** who are recovering from health related incidents or who suffer from chronic conditions. Patients must be sufficiently knowledgeable and competent to self-refer to monthly clinics. There are no health workers who can provide regular rehabilitation services that are essential for patients post fracture and stroke, no face to face physiotherapists or occupational therapists (OTs) and no speech pathology for those in aged care suffering from dysphasia.

7. The deployment of trained professional healthcare workers is an ongoing and critical issue particularly at Bourke Hospital where there is **an acute and persistent shortage of nurses**. Twenty nursing staff are required per week to cover 3 day shifts (4 nurses per shift) and one night shift (2 nurses) on a 5 day rotation.

   At the time of writing, there were only 12 nurses, 4 RNs and 2 Enrolled Nurses (ENs) had not been replaced for some time. Nursing staff have therefore been forced to fill the roster with additional shifts.

   In the past there have been instances of agency staff willing to come to Bourke who have had their applications rejected, or if they have made the effort to come to Bourke, have then not been given work with existing nurses asked to cover shifts.

   In the past nursing rosters have been filled with non-nursing staff including hospitality and hotel services workers.

   There have been multiple incidents of understaffing on a shift.

   On one occasion the Hospital was staffed at night with one RN unqualified to triage, one EN and one AIN (Assistant in Nursing) and therefore effectively no staff to triage an emergency admission.

   Pay for required overtime is ignored unless at the insistence of staff, and if finally agreed then delayed or declined. As a result nurses frequently do not claim for the many hours of overtime worked.

Nursing staff are frequently expected to work through a shift without tea or lunch breaks.

Nurses stated that they feel it is easier to comply rather than have their annual leave rejected or receive an unfavourable reference.

Nurses are overstretched and burnt-out, morale is low and pervasive in a toxic work environment which has important consequences for patient care.

Front line health care workers in Bourke experience considerable stress knowing that while the local populace is grateful for existing services, they are ignorant of how fragile their life and their care is should they experience a serious illness or injury.

NSW Health Human Resources has been alerted to problems at Bourke Hospital

Nurses receive one isolation and climate allowance of $7 per week.

8. **Security**. In 1994 a young nurse was abducted whilst on duty from Walgett Hospital, raped and brutally murdered. Despite the more recent murder of Gayle Woodford, a remote SA area nurse and escalating acts of violent incidents in hospitals which increased by 44% in NSW between 2016-19, there were until late last year still no dedicated security officers at Bourke Hospital. There were historically 3 security officers covering two shifts 7 days a week. There is currently one trained security guard who has recently been appointed for 10 shifts a fortnight on afternoon and evening shifts to replace the cleaner who was tasked with security and whose cleaning duties often meant he was unavailable when called to assist.

   The hospital is locked at night. Nurses are directed by management not to answer the entrance bell alone thus in theory Workplace Health and Safety requirements are met. As there are only 2 nurses on night shift they may however not be able to answer the bell whilst attending to the needs of other patients, and never know

what they will confront if they do, but in the absence of security staff, they has been no other option. Lives are put in danger and it may not just be that of the patients, as nurses are also aware that tension can be heightened by delays in answering the night bell as patients can be accompanied by a group of angry or intoxicated relatives. In this scenario any support or assistance is two locked doors way.

9. Attending to the needs and **care of aged residents** creates additional challenges for nursing staff. There are currently 15 aged care patients, 10 high care needing double assistance, 3 single assistance and 2 are independent. As manually handling of high care aged care patients requires both nurses on a night shift and the RN to administer medications the provision of care can easily become unmanageable when there are only 2 nurses on duty, with an average of 3-4 outpatients per shift, an average of 4 up to 11 acute patients, and beds are full in the acute section of the Hospital.

10. The **absence of vital equipment, basic hospital stores and essential consumables** has enormous consequences for patients. There is a perception that management see any expenditure as their own rather than for patient well-being, with budgetary priorities overriding patient welfare and staff stores requests. Stores orders have often been limited, not been made or filled. The Hospital has relied on NSW Ambulance to fill urgent stores orders. For example there have been no ECG dots in the Hospital for a town where half the population has cardiovascular problems. Vital equipment such as tourniquets, body bags or syringes for drawing drugs in theatres have also been the subject of urgent requests to Ambulance as have requests for basic cleaning products.

    It took staff 12 months to acquire a laryngoscope blade which was requested numerous times and not ordered.

11. New South Wales Ambulance is well resourced in Bourke, however I have been given to understand that current staffing policy does not incentivise career progression in the Western Division with ICP Training confined to Metropolitan areas and the earlier Level 4 designation no longer applicable. Salaried and trained paramedics with the additional skills commensurate with an ICP would save lives and alleviate suffering where distance and delay are impediments to critical care.

Personal Experience

Having always had privileged access to both healthcare providers and hospitals in Sydney my personal experience of regional care in Mudgee Hospital earlier in 2020 was very distressing and concerning despite The Western NSW Primary Healthcare network boasting a patient satisfaction rating of 8:10.[14] One evening earlier this year I experienced a sudden onset of what appeared to be neurological symptoms. My husband transported me without delay to Mudgee Hospital Emergency Department which was empty at the time and staffed

by two nurses. There were no local doctors on call. My husband was denied entry in an abrupt and dismissive manner but accompanied me at his insistence.

During a three hour stay numerous attempts were made to contact an emergency physician remotely without success. Neither nurses had the skills required to operate the equipment required for a remote visual consultation. A simple phone conversation without clinical observation resulted.

During this process little attention was paid to myself as a patient with both nurses disengaged and focused on their own tasks and personal interactions. They were made aware, I had had a brain tumour excised and a number of post-operative MRIs as the type of tumour involved can recur or be bilateral. There were neurological concerns therefore given the sudden onset and severity of symptoms. I was discharged without any discharge notes, advice on possible causation or the need for a follow up consolation which I undertook myself through a Sydney GP. The nurses were unprofessional, the care inadequate and could have resulted in a catastrophic outcome. Further, I understand from subsequent conversations with other nursing staff, that the new Mudgee Hospital does not have sufficient beds or sufficient skilled professionals to provide the necessary services to cater for current or expected population growth.

Demography should not however determine the provision of quality patient centred healthcare nor should it be driven by numbers, budgetary decisions or clever accounting. In fact, liveability, excellence in health care and education are the foundation stones that *grow* community.

Aside from the individual stories that inform and exemplify the failure to adequately fund, resource and staff healthcare facilities outside major urban centres, this Inquiry must ask and answer, are we as a society and community simply prepared to accept the burden inadequate healthcare funding places on health and well-being on fellow Australians who live and work in the 'bush'.

Will we continue to ignore the committed and professional healthcare workers who feel unsupported by NSW Health and who make a substantial personal sacrifice to work in rural, regional and remote NSW, or are we ready to transform their workplaces and their working conditions.

Will we act now to make systemic changes and resolve the well-documented disadvantage and inequality in the provision of quality, patient-centred healthcare to the people of rural, regional and remote NSW.

Health care is a right not a private privilege. The answer is, we must and urgently.

[1] Bureau of Health Information 'Healthcare in rural, regional and remote NSW' https://www.bhi.nsw.gov.au/__data/assets/pdf_file/0005/339143/report-insights-Healthcare-in-rural-regional-and-remote-NSW.pdf

[2] https://www.abc.net.au/news/2020-12-21/former-nsw-health-employees-say-patient-abuse-is-covered-up/12879704

[3] International Covenant on Economic, Social and Cultural Rights Article 12 1. The States Parties to the present Covenant recognize the right of everyone to the enjoyment of the highest attainable standard of physical and mental health.

[4]ibid

[5] https://www1.health.gov.au/internet/main/publishing.nsf/Content/rural-regional-health-australia-list-programmes

[6] Accessibility and quality of mental health services in rural and remote Australia
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Ensuring equity of access to primary healthcare in rural and remote Australia – what core services should be locally available? Susan L. Thomas, John Wakerman and John S. Humphreys

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Mind the gap: is it time to invest in embedded researchers in regional, rural and remote health services to address health outcome discrepancies for those living in rural, remote and regional areas?
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https://www1.health.gov.au/internet/main/publishing.nsf/Content/national-strategic-framework-rural-remote-health

https://www.ruralhealth.org.au/advocacy/knowing-the-issues

https://www.westernalliance.org.au/2016/06/the-great-health-divide-why-rural-australians-have-poorer-health-outcomes-than-their-urban-counterparts

[7] 'The Determinants of Health in Rural and Remote Australia' National Rural Health Alliance INC 2011

[8] https://www.aihw.gov.au/reports/australias-health/australias-health-2016/contents/determinants

[9] https://www.aihw.gov.au/reports/australias-health/indigenous-life-expectancy-and-deaths

[10] Bureau of Health Information 'Healthcare in rural, regional and remote NSW' https://www.bhi.nsw.gov.au/__data/assets/pdf_file/0005/339143/report-insights-Healthcare-in-rural-regional-and-remote-NSW.pdf

[11] National Rural Health Alliance, https://www.ruralhealth.org.au/book/economic-contribution-regional-rural-and-remote-australia

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[13] https://www.bhi.nsw.gov.au/__data/assets/pdf_file/0005/339143/report-insights-Healthcare-in-rural-regional-and-remote-NSW.pdf

[14] 'Phn Western NSW Health Profile', http://www.wnswphn.org.au/uploads/documents/corporate%20documents/PHN%20Health%20Profile%20A4%20Full%20FINAL.pdf