**Submission No 694**

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

**Organisation:** Australian Lawyers Alliance

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Lawyers for the People

AUSTRALIAN LAWYERS ALLIANCE

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

## Public submissions

**1 February 2021**

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## Who we are

The Australian Lawyers Alliance (ALA) is a national association of lawyers, academics and other professionals dedicated to protecting and promoting justice, freedom and the rights of the individual.

We estimate that our 1,500 members represent up to 200,000 people each year in Australia. We promote access to justice and equality before the law for all individuals regardless of their wealth, position, gender, age, race or religious belief.

The ALA is represented in every state and territory in Australia. More information about us is available on our website.[1]

The ALA office is located on the land of the Gadigal of the Eora Nation.

[1] www.lawyersalliance.com.au.

## Introduction

1. The ALA welcomes the opportunity to provide a submission to the Inquiry into health outcomes and access to health and hospital services in rural, regional and remote New South Wales. The Inquiry comes at a time when renewed focus is being given in the media to the nature and extent of inequitable health resourcing.[2]

2. The ALA includes within its membership lawyers – both barristers and solicitors – who act and have acted for the victims of medical and healthcare error and their families. Those lawyers see first hand the impact that inequitable health resourcing and services has on those living in rural, regional and remote areas. Inequity of access leads to avoidable deaths and serious injury.

3. Unfortunately we do not know the extent of the numbers of avoidable death and injury as a result of inequitable health resourcing as access to meaningful health data – including data organised by region – is unavailable. Australia falls well behind other OECD countries in regard to the collection of health data.

4. The authors of this submission are lawyers from the Hunter region of NSW who practise predominantly in the area of health and medical litigation albeit at different legal practices. A very small sample of cases that they have either conducted or aware of are included in the body of this submission – these cases are used to illustrate the social, emotional and financial cost of avoidable errors in rural and regional health services.

5. This submission will focus on the following Terms of Reference being those that are relevant to the work done by ALA members:

    a. health outcomes for people living in rural, regional and remote NSW;

    b. a comparison of outcomes for patients living in rural, regional and remote NSW compared to other local health districts across metropolitan NSW;

    c. access to health and hospital services in rural, regional and remote NSW including service availability, barriers to access and quality of services;

[2] ABC Four Corners "Health Hazard" https://www.abc.net.au/4corners/health-hazard/11493580; https://www.smh.com.au/national/nsw/liz-hayes-reports-on-the-heartbreaking-death-of-her-own-father-20200911-p55uwl.html; "Nurses at breaking point in regional areas" https://www.skynews.com.au/details/_6222968035001.

d. patient experience, wait-times and quality of care in rural, regional and remote NSW and how it compares to metropolitan NSW;

g. an examination of the staffing challenges and allocations that exist in rural, regional and remote NSW hospitals and the current strategies and initiatives that NSW Health is undertaking to address them;

h. the current and future provision of ambulance services in rural, regional and remote NSW;

i. the access and availability of oncology treatment in rural, regional and remote NSW;

k. an examination of the impact of health and hospital services in rural, regional and remote NSW on Indigenous and culturally and linguistically diverse (CALD) communities.

## ToR a) health outcomes for people living in rural, regional and remote NSW; and b) a comparison of outcomes for patients living in rural, regional and remote NSW compared to other local health districts across metropolitan NSW

6. People living in rural, regional and remote NSW routinely experience worse health outcomes than those in metropolitan areas. The starkest example of this the latest data from the Australian Institute of Health & Welfare which shows that – as of 2020 – the median age of death decreases substantially as distance from major cities increases. For males, the difference is a matter of 10 years, for females, the gap is even wider, at 15 years.[3]

7. People in rural, regional and remote NSW also experience higher rates of potentially preventable hospitalisations than those in metropolitan areas.[4] Reaching the hospital system unnecessarily is an inherently poor outcome which is being experienced more by those in rural areas, allowing conditions to develop to a point of greater risk and placing further burden on already overstretched Emergency Departments. The overall burden of disease has also been recorded to increase steadily as the distance from major metropolitan centres increases.[5]

[3] Australian Institute of Health and Welfare 2020. Rural and remote health. Canberra: AIHW. Viewed 07 December 2020, https://www.aihw.gov.au/reports/australias-health/rural-and-remote-health.

[4] Ibid.

[5] Australian Institute of Health and Welfare 2020. Rural and remote health. Canberra: AIHW. Viewed 07 December 2020, https://www.aihw.gov.au/reports/australias-health/rural-and-remote-health; Australian

8. People living in rural and remote areas face stressors unique to living outside large cities. The rate of suicide among men aged 15–29 years is almost twice as high as those living in major cities.[6] Access to mental health care in rural areas is limited. The numbers of psychiatrists, mental health nurses and psychologists in rural and remote areas have been found to be significantly lower than those in major cities.[7]

9. Timely diagnosis, treatment and ongoing management of mental health conditions is likely to occur later in rural areas due to limited access to mental health professionals.

10. It is difficult to make an accurate assessment of the overall health outcomes as very little *detailed* data is made publicly available regarding adverse incidents. Such data should be made readily available to the public and should be sufficiently detailed as to allow analysis of causes, such as the relevant conditions being health treated and personal characteristics which may be of relevance (such as age, race, gender, or disability status). This would be beneficial from a public interest perspective, so that prospective patients have the ability to examine a hospital's record with regard to specific factors which may be of relevance to their outcome.

11. The Harvard study of medical practice – conducted back in 1984 – is the benchmark for estimating the extent of medical injuries occurring in hospitals. [8] That study concluded that medical error was the third leading cause of death in the US. A similar population based study[9] – modelled on the Harvard study – was conducted in Australia and its findings published in 1995. Investigators reviewed the medical records of 14179 admissions to 28 hospitals in both NSW and South Australia in 1995 and found that an adverse event occurred in 16.6% of admissions resulting in permanent disability in 13.7% of patients and death in 4.9%. 51% of adverse events were

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Institute of Health and Welfare 2019; Potentially preventable hospitalisations in Australia by age groups and small geographic areas, 2017–18. Cat. no. HPF 36. Canberra: AIHW. Viewed 14 December 2020, https://www.aihw.gov.au/reports/primary-health-care/potentially-preventable-hospitalisations.

[6] National Rural Health Alliance Inc ('NRHA'), Fact Sheet, Mental Health in Rural and Remote Australia, December 2017.

[7] https://mhsa.aihw.gov.au/resources/workforce.

[8] Reported in Brennan TA, Leape LL, Laird NM, Hebert L, Localio AR, Lawthers AG et al Incidence of adverse events and negligence in hospitalized patients, New England Journal of Medicine 1991, v 324, 370-376; see also Saul N Weingart, Ross McL Wilson, Robert Gibberd and Bernadette Harrison Epidemiology of medical error, British Medical Journal March 18 2000, v 320 (7237) 774-777.

[9] Wilson RM, Runciman WB, Gibberd RW, Harrison BT, Newby L, Hamilton JD The quality in Australian health care study Medical Journal of Australia 1995 v 163 pp 458-471.

considered to have been preventable[10] – a very substantial amount of medical error. Both studies concluded that errors most often occur when clinicians are inexperienced and new procedures introduced.

12. A sense of the extent of poor medical outcomes can be gleaned from the occasional press reports on the numbers of claims and litigation payouts. Data provided by the state's local health districts under freedom of information legislation show the extent of the problem. Although data integrity might be questioned, the press reports claim that country hospitals more likely to be sued than their city counterparts and the John Hunter – followed by Maitland District Hospital – being the state's most sued public hospital.[11] Information accessed via the *Government Information (Public Access) Act 2009* reveals that negligence claims cost the NSW government self-insurer Treasury Managed Fund $69m during the 2 year period from 1 October 2016 to 1 October 2018.[12] There has been increased resistance to providing breakdowns according to specialty and practice area.[13]

13. The main sources of federal public data are the Australian Health Practitioner Registration Agency ('AHPRA') – which does not provide remoteness analysis for the data it collects – and the Australian Institute of Health and Welfare ('AIHW'). Until late 2015, a different Federal body with a health data collection role existed – the National Health Performance Authority ('NHPA'). At that time, the NHPA was closed by the Federal Government and its operations and activities transferred to the AIHW.

14. At a state level and in the period following the release of the NSW government's Special Commission of Inquiry into Acute Care Services in NSW Public Hospitals ('the Garling Report'), a Bureau of Health Information was established. This Bureau produces a quarterly report – the Healthcare Quarterly – but these reports do provide data on numbers of adverse errors focussing instead on numbers of patients utilising hospital services and emergency department waiting times.

15. Historically, there have been issues with the collection of health data in this country. Regarding death rates, no state or the federal government routinely publishes such data across Australian

[10] Ibid.

[11] "NSW hospital blunders have cost state taxpayers more than $262m in damages", The Daily Telegraph, 31 January 2016.

[12] "Mistakes and medical negligence claims in Hunter New England Health cost taxpayers $69m in two year" Newcastle Herald, 29 June 2019.

[13] Experience of health journalists writing stories and reported to the authors.

hospitals. Reporting death and serious injury data is vitally important as it provides a starting point for processes to review hospitals – and health providers – with unusually high rates of death in order to improve our health care system. The point has been made that had deaths in the intensive care unit of Bundaberg Base Hospital in Queensland been available for distribution it may have been possible to detect the poor performance of one of its surgeons, Dr Patel. [14]

16. Comparable OECD countries have been producing statistics concerning deaths – and statistics that provide comparisons of death rates across hospitals – for some time. For example in England and the United States adjusted death rates for a range of local hospitals can be obtained by simply typing the relevant postcode or zipcode into a government website.[15]

17. In the case of rural and remote health services, data collected by AHPRA is not available at sufficient specificity. So, whilst AHPRA provides regular data on the number of health practitioners registered in Australia, it provides no analysis by remoteness area. We can see, for instance, that there has been an increase in number of full time equivalent medical practitioners across *all* remote areas but this is not specific as to area and the increases are in line with increases in major cities and inner regional communities resulting in an increase in the inequity of access for those living in remote and very remote communities.[16]

18. We need to be able to critically examine inequality of access to health care professionals in rural and remote Australia and cannot do so without access to data analysed by jurisdiction and by remoteness. The ALA supports the position of the National Rural Health Alliance Inc in this regard.[17]

[14] Philip Clarke and Peter Sivey "Why don't we know how many people die in our hospitals" in The Conversation 19 January 2017.

[15] "Why don't we know how many people die in our hospitals?" The Conversation, 19 January 2017.

[16] National Rural Health Alliance Inc ('NRHA'), Discussion Paper, Why we need a new rural and remote health strategy, June 2017, p 14.

[17] Ibid.

## ToR c) access to health and hospital services in rural, regional and remote NSW including service availability, barriers to access and quality of services

19. People living in rural, regional and remote NSW report difficulty accessing healthcare at a higher rate than their counterparts in metropolitan areas.[18]

20. One of the major reported barriers to access to health services is the associated cost. A slightly lower proportion of people in outer regional and remote areas reported this as an issue than those in major cities or inner regional areas. However, across NSW 12% of people have reported foregoing health care due to the cost – an unacceptably high number.[19]

21. As outlined in more detail in response to term of reference d), wait times at hospitals do not appear to be particularly prohibitive to people in rural, regional and remote NSW accessing emergency services. This is not however the case with other health services. A general shortage of specialists, allied health and primary care professionals means that people in regional, rural and remote areas are waiting longer periods than those in metropolitan areas to access care.[20] This in turn can contribute to the number of people presenting for potentially preventable hospitalisations and unnecessarily inflating wait times for others.

[18] Bureau of Health Information. The Insights Series – Healthcare in rural, regional and remote NSW Sydney (NSW); BHI; 2016. Viewed 07 December 2020, https://www.bhi.nsw.gov.au/__data/assets/pdf_file/0005/339143/report-insights-Healthcare-in-rural-regional-and-remote-NSW.pdf; National Rural Health Commissioner. Final Report June 2020. Canberra: Office of the National Rural Health Commissioner. Viewed 1 December 2020, https://www1.health.gov.au/internet/main/publishing.nsf/Content/National-Rural-Health-Commissioner-publications.

[19] Bureau of Health Information. The Insights Series – Healthcare in rural, regional and remote NSW Sydney (NSW); BHI; 2016. Viewed 07 December 2020, https://www.bhi.nsw.gov.au/__data/assets/pdf_file/0005/339143/report-insights-Healthcare-in-rural-regional-and-remote-NSW.pdf.

[20] National Rural Health Commissioner. Final Report June 2020. Canberra: Office of the National Rural Health Commissioner. Viewed 1 December 2020, https://www1.health.gov.au/internet/main/publishing.nsf/Content/National-Rural-Health-Commissioner-publications; Bureau of Health Information. The Insights Series – Healthcare in rural, regional and remote NSW Sydney (NSW); BHI; 2016; Australian Institute of Health and Welfare 2020. Rural and remote health. Canberra: AIHW. Viewed 07 December 2020, https://www.aihw.gov.au/reports/australias-health/rural-and-remote-health.

22. A similar proportion of people in each area of remoteness have reported that wait times have been prohibitive to accessing General Practitioners, which is a clear problem state-wide.[21] Results from outer regional and remote area however reported a much higher rate of people who had unmet GP needs due to a fear or dislike of the service.[22] This may reflect the difficulty in establishing a relationship with a general practitioner when so few people in rural areas are able to consult with the same doctor repeatedly, particularly due to reliance on locums. It may also reflect a lack of cultural sensitivity to Indigenous and Torres Strait Islander patients, who form a larger portion of a rural general practitioner's patient base.[23]

23. The ALA supports the three directions listed in the NSW Government NSW Rural Health Plan – Towards 2021.

24. Strategy One in the NSW Rural Health Plan is to enhance the rural health workforce by seeking to attract and retain a skilled workforce in rural areas. The ALA strongly supports this objective and encourages the implementation of these strategies.

25. Strategy Two in the NSW Rural Health Plan is to strengthen rural health infrastructure, research and innovation by investing in regional and rural capital infrastructure, implementing best practice models in rural settings to expand and support the delivery of high quality health services. The ALA supports the implementation of this strategy.

26. Strategy Three in the NSW Rural Health Plan is to improve rural eHealth solutions in rural NSW. Whilst eHealth services can be beneficial there is no substitute for face-to-face treatment and, in our submission, greater focus should be placed on enhancing the rural health workforce and rural health infrastructure.

[21] Australian Institute of Health and Welfare 2020. Rural and remote health. Canberra: AIHW. Viewed 07 December 2020, https://www.aihw.gov.au/reports/australias-health/rural-and-remote-health.

[22] Ibid.

[23] Bureau of Health Information. The Insights Series – Healthcare in rural, regional and remote NSW Sydney (NSW); BHI; 2016. Viewed 07 December 2020, https://www.bhi.nsw.gov.au/__data/assets/pdf_file/0005/339143/report-insights-Healthcare-in-rural-regional-and-remote-NSW.pdf.

## Case studies

Avoidable death of 13 year old boy due to negligent paracetamol overdose by hospital staff in remote NSW

A 13 year old boy was given an overdose of paracetamol for pain control – 62 tablets over 14 days – following a routine hip operation at a hospital in rural NSW. As his condition deteriorated, the boy was also given intravenous antibiotics for suspected chest infection. He became increasingly aggressive and irritable, began to vomit and eventually fell into a coma. He was transferred to Westmead Children's Hospital where it was determined that that an urgent liver transplant would not be viable. Reviewing the case for the Office of the State Coroner, a specialist gastroenterologist said that whilst early stages of liver failure could be difficult to detect, no attempt had been made to assess the boy's liver function. The specialist was also of the view that a contributing factor to the outcome was the delay in transfer to the Children's Hospital in Sydney.

15 month old boy suffers avoidable brain injury following mismanaged head injury at Emergency Department

The boy was taken to the Emergency Department of a regional hospital with a history of having been hit by a heavy board that had fallen at home. Emergency staff at the hospital discharged the boy without conducting appropriate testing including ordering a CT scan and referring to a neurological ward. He was taken by his parents to the hospital again 2 days later and during this admission – and despite presenting symptoms consistent with a serious bacterial infection – no steps were taken to institute a septic workup and hospital staff failed to diagnose a left occipital and mastoid fracture nor developing meningitis. The boy had just taken his first steps and suffers permanent brain damage.

Emergency Dept staff fail to properly treat 15 year old girl and diagnose developing bacterial meningitis during the course of 2 presentations

A teenage girl with some intellectual delay and mild autism spectrum syndrome became unwell and was treated by her GP for ear infection. When her condition worsened, the GP advised the family to take the girl to hospital. She shortly thereafter developed bacterial meningitis and remained as a patient at for 8 months. She has severe deficits including spastic quadriplegic significantly decreased communication – nil vocalisation. Her family sought legal advice and a claim brought against the hospital. Expert evidence obtained in the case was to the effect that the girl was not properly assessed nor treated and that the outcome was avoidable.

Lawyers involved in the case have worked on several similar cases of misdiagnosed meningitis against – each involving an avoidable catastrophic outcome.

Emergency Dept doctor at hospital in remote NSW fails to arrange transfer of 54 year old man to a larger hospital with appropriate coronary care facilities leading to avoidable death

A man in his 50s living in developed shortness of breath, coughing and sweating and was taken by his partner during the course of an afternoon to the Aboriginal Medical Service where she was employed as a nurse. She then took him to the Emergency Department at the where he was admitted for overnight observation. His symptoms deteriorated overnight and he was observed to be markedly hypertensive, had significant episodes of shortness of breath and required oxygen therapy. His symptoms continued into the next morning – he was noted to have a raised pulse rate and on blood testing had a raised white cell count. At 3 pm his condition declined, he was moved to the resuscitation room and shortly thereafter died. Independent expert evidence stated that the hospital doctor ought to have suspected cardiac failure and that the man should have been transferred on the day of first presentation to a larger hospital with a specialist cardiac care and coronary care or intensive care for treatment.

## ToR d) patient experience, wait-times and quality of care in rural, regional and remote NSW and how it compares to metropolitan NSW

27. In the most recent surveys (2020) conducted by the Bureau of Health Information, emergency department patients in rural NSW hospitals were actually more likely to rate their care as "very good" (the highest rating) when compared to responses to the same question for patients of all emergency departments in NSW (78% and 58% respectively).[24]

28. Average waiting times in Emergency Departments have also been reported as similar across NSW hospitals at all levels of remoteness, with Outer Regional and remote hospitals reporting slightly

[24] Bureau of Health Information. Snapshot: – Results from the 2018-19 patient survey Emergency Department Sydney (NSW); BHI; 2020. Viewed 07 December 2020, https://www.bhi.nsw.gov.au/BHI_reports/patient_survey_results/emergency_department_patient_survey_2018-19; Bureau of Health Information. Snapshot: – Results from the 2019 patient survey Rural Hospital Emergency Care Sydney (NSW); BHI; 2020. Viewed 07 December 2020, https://www.bhi.nsw.gov.au/__data/assets/pdf_file/0012/595596/BHI_Rural_EC_2019_Snapshot.pdf.

better time between arrival and treatment.[25] Outer regional and remote hospitals have also reported higher rates of patients spending less than four hours total in the emergency department.[26] Furthermore, the rate of patients who left the Emergency department without treatment also declines as distance from major cities increases.[27]

29. However, patients in rural areas experience greater delays for non-emergency care. Wait times for specialist appointments and surgery have been reported to increase with distance from major cities.[28]

## Case study

55 year old dies on elective surgical waiting list instead of being referred for urgent cardiac surgery

A 55 year old man who suffered from almost all possible risk factors for vascular disease was left waiting from February 2019 – the date of an abnormal ECG – until his death in October 2019. He had presented to the Emergency Department of the with a TIA and an ECG performed. This was highly abnormal and indicated underlying cardiac disease – cripple vessel coronary artery disease with left ventricular dysfunction. He was referred to An independent cardiologist has expressed the opinion that at multiple time points between his first consultation at until his death at home, the follow-up, the communications, the timing of investigations, the treatment offered and his inappropriate placement on an elective surgical waiting list instead of priority urgent cardiac surgery fell alarmingly far short of competent medical practice. On multiple occasions, the urgency of his case was not recognised nor acted upon.

[25] Bureau of Health Information. The Insights Series – Healthcare in rural, regional and remote NSW Sydney (NSW); BHI; 2016. Viewed 07 December 2020, https://www.bhi.nsw.gov.au/__data/assets/pdf_file/0005/339143/report-insights-Healthcare-in-rural-regional-and-remote-NSW.pdf.

[26] Ibid.

[27] Ibid.

[28] Ibid.

## ToR g) an examination of the staffing challenges and allocations that exist in rural, regional and remote NSW hospitals and the current strategies and initiatives that NSW Health is undertaking to address them

30. It is widely recognised that the availability of sufficient numbers of medical practitioners, particularly specialists, in the rural, regional and remote areas of NSW presents the most significant challenge to the provision of healthcare.[29]

31. Rural, regional and remote communities in NSW experience a disproportionate lack of primary care and allied health professionals,[30] which has led to the rate of potentially preventable hospitalisations and adverse events increasing with distance from metropolitan centres.[31] Very remote areas experience potentially preventable hospitalisations at a rate of 2.5 times as high as in major cities.[32]

32. A 2018 Health Report[33] by the Australian Institute of Health and Wellbeing demonstrated that people in very remote areas are two and a half times more likely to suffer a potentially avoidable death compared to those living in major cities.

33. Inordinate pressure is subsequently put on rural, regional and especially remote hospitals to handle these additional admissions, with a disproportionately low number of staff and levels of

[29] Australian Institute of Health and Welfare 2020. Rural and remote health. Canberra: AIHW. Viewed 07 December 2020, https://www.aihw.gov.au/reports/australias-health/rural-and-remote-health; Bureau of Health Information. The Insights Series – Healthcare in rural, regional and remote NSW Sydney (NSW); BHI; 2016. Viewed 07 December 2020, https://www.bhi.nsw.gov.au/__data/assets/pdf_file/0005/339143/report-insights-Healthcare-in-rural-regional-and-remote-NSW.pdf.

[30] Australian Institute of Health and Welfare 2020. Rural and remote health. Canberra: AIHW. Viewed 07 December 2020, https://www.aihw.gov.au/reports/australias-health/rural-and-remote-health.

[31] Australian Institute of Health and Welfare 2019; Potentially preventable hospitalisations in Australia by age groups and small geographic areas, 2017–18. Cat. no. HPF 36. Canberra: AIHW. Viewed 14 December 2020, https://www.aihw.gov.au/reports/primary-health-care/potentially-preventable-hospitalisations.

[32] Ibid.

[33] Australian Institute of Health and Welfare: Australia's Health 2018 in Brief https://www.aihw.gov.au/reports/australias-health/australias-health-2018-in-brief/contents/about.

experience and expertise. The lack of staff and specialists in rural hospitals is a recurring theme in surveys of patients[34] and doctors alike.[35]

34. The challenges with staffing rural hospitals have some roots in emerging patterns in medical education. More students are choosing to pursue careers as specialists, while rural and remote healthcare is far more suited to and reliant on generalists.[36] Training hospitals, universities, and specialist accreditations are also far more prevalent in major cities.[37] It has been well documented that students and residents tend to form social and professional connections at this stage in their careers, and are therefore far more likely to remain in the area where they undertook their training, rather than electing to move to rural, regional or remote areas to practice.[38] Even if practitioners do elect to move away from major cities, it is often expected that they will eventually have to return for further training and specialisation due to a lack of such opportunities outside of the city.[39]

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[34] Bureau of Health Information. The Insights Series – Healthcare in rural, regional and remote NSW Sydney (NSW); BHI; 2016. Viewed 07 December 2020, https://www.bhi.nsw.gov.au/__data/assets/pdf_file/0005/339143/report-insights-Healthcare-in-rural-regional-and-remote-NSW.pdf.

[35] Australian Medical Association. 2019 AMA Rural Health Issues Survey: Improving Care for Rural Australia. Barton: AMA. Viewed 5 December 2020, https://ama.com.au/sites/default/files/documents/AMA%202019%20Rural%20Health%20Issues%20Survey%20Report.pdf.

[36] National Rural Health Commissioner. Final Report June 2020. Canberra: Office of the National Rural Health Commissioner. Viewed 1 December 2020, https://www1.health.gov.au/internet/main/publishing.nsf/Content/National-Rural-Health-Commissioner-publications.

[37] Australian Medical Association. 2019 AMA Rural Health Issues Survey: Improving Care for Rural Australia. Barton: AMA. Viewed 5 December 2020, https://ama.com.au/sites/default/files/documents/AMA%202019%20Rural%20Health%20Issues%20Survey%20Report.pdf.

[38] National Rural Health Commissioner. Final Report June 2020. Canberra: Office of the National Rural Health Commissioner. Viewed 1 December 2020, https://www1.health.gov.au/internet/main/publishing.nsf/Content/National-Rural-Health-Commissioner-publications.

[39] Australian Medical Association. 2019 AMA Rural Health Issues Survey: Improving Care for Rural Australia. Barton: AMA. Viewed 5 December 2020, https://ama.com.au/sites/default/files/documents/AMA%202019%20Rural%20Health%20Issues%20Survey%20Report.pdf.

35. The lack of permanent, local practitioners has led to an over-reliance on locums to fill the gaps left.[40] This system, while essential to meet the needs of rural communities, is far less efficient, and cost effective than services provided by local practitioners.[41] It also prevents patients from forming working relationships with any one doctor as they are rotating constantly, which can cause a reluctance to attend.[42] Lack of continuity of care is also a risk management issue.

36. Staffing shortages lead to increased pressure on those staff who are available to fill gaps and meet the demands of the community. Some rural, remote, and regional hospitals have reportedly transitioned to being staffed purely by nurses at times, without any doctors physically present, putting undue pressure on nursing staff especially in emergency situations.[43] Doctors have also reported that the lack of doctors, and tendency towards part-time rather than full-time work, have led to doctors being overstretched on rosters which do not allow sufficient time to recuperate between shifts.[44] These additional pressures on rural practitioners, being overextended in both time and responsibility, are well known and likely do little to attract students and practitioners to work in rural, regional and remote areas, further exacerbating the situation.[45]

37. There is little financial incentive for doctors to accept this additional burden, with rural, regional, and remote health workers receiving little, if any, income supplements to account for the remoteness and increased responsibility.[46] While some measures have been taken, particularly

[40] Bureau of Health Information. The Insights Series – Healthcare in rural, regional and remote NSW Sydney (NSW); BHI; 2016. Viewed 07 December 2020, https://www.bhi.nsw.gov.au/__data/assets/pdf_file/0005/339143/report-insights-Healthcare-in-rural-regional-and-remote-NSW.pdf.

[41] Ibid.

[42] Ibid.

[43] Carrie Fellner, 12 October 2020. 'We couldn't believe it': Woman bleeds to death in NSW Hospital with no doctors on site. Sydney: The Sydney Morning Herald. Accessed 2 December 2020, https://www.smh.com.au/national/we-couldn-t-believe-it-woman-bleeds-to-death-in-nsw-hospital-with-no-doctors-on-site-20201011-p563z1.html.

[44] Australian Medical Association. 2019 AMA Rural Health Issues Survey: Improving Care for Rural Australia. Barton: AMA. Viewed 5 December 2020, https://ama.com.au/sites/default/files/documents/AMA%202019%20Rural%20Health%20Issues%20Survey%20Report.pdf.

[45] Peter Garling SC. 2008 Final Report of the Special Commission of Inquiry: Acute Care in NSW Public Hospitals, 2008 – Volume 1 (print).

[46] Australian Medical Association. 2019 AMA Rural Health Issues Survey: Improving Care for Rural Australia. Barton: AMA. Viewed 5 December 2020,

the introduction of the General Practice Rural Incentive Program and the Practice Nurse Incentive Program, it is notable that payments under these programs are not indexed, and their appeal could be expected to decrease over time.[47] The current system of training general practitioners also causes many to miss out on accumulating leave and other work entitlements due to working for numerous employers over the course of their training.[48]

38. One area of focus to address the overall staffing concerns has been the push to formally recognise the specialist practice of rural generalists. Rural generalists are general practitioners, often coupled with a subspecialty, and are well suited to the unique challenges of rural practice and the wide variety of medical conditions that they can be required to treat on any given day.[49] To promote this speciality, the National Rural Generalist Training Pathway has been established, and it has been suggested that Rural Generalists should be recognised as a protected Specialised Field.[50] This would help to ensure that appropriate training is undertaken to accredit a practitioner as a rural generalist and establish a career pathway with opportunities for recognition and advancement.[51]

39. The need to establish viable training networks and options in rural, regional and remote areas has been recognised and steps are being taken to address this need.[52] Just as students who undertake training in the city are more likely to remain in the city, it has been shown that students who undertake training in rural areas are four times more likely to decide to practice in rural areas.[53]

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https://ama.com.au/sites/default/files/documents/AMA%202019%20Rural%20Health%20Issues%20Survey%20Report.pdf.

[47] Ibid.

[48] National Rural Health Commissioner. Final Report June 2020. Canberra: Office of the National Rural Health Commissioner. Viewed 1 December 2020, https://www1.health.gov.au/internet/main/publishing.nsf/Content/National-Rural-Health-Commissioner-publications.

[49] Ibid.

[50] Ibid.

[51] Ibid.

[52] Ibid; Australian Medical Association. 2019 AMA Rural Health Issues Survey: Improving Care for Rural Australia. Barton: AMA. Viewed 5 December 2020, https://ama.com.au/sites/default/files/documents/AMA%202019%20Rural%20Health%20Issues%20Survey%20Report.pdf.

[53] Australian Medical Association. 2019 AMA Rural Health Issues Survey: Improving Care for Rural Australia. Barton: AMA. Viewed 5 December 2020,

For this purpose, it has been recommended that students should be encouraged to undertake a rotation to regional, rural or remote areas in their postgraduate training,[54] with some suggesting that this should be mandated as part of the curriculum.[55] More focus should also be placed on establishing training hospitals and programs in regional areas.[56]

40. Finally, the ALA repeats its earlier comments concerning mental health treatment and limited access to mental health professionals which compromises timely diagnosis, treatment and ongoing management. It has been claimed that the Hunter New England region has had a disproportionately large share of avoidable deaths within the cohort of those with acute mental illness and receiving treatment under the *Mental Health Act 2007* (NSW).[57]

## Case studies

Young 18 year old girl suicides in mental health unit with hospital nursing staff found to have provided inadequate care

A patient at the Mater Mental Health Centre was able to take her own life at the Mater Mental Health Unit in Newcastle despite repeatedly preparing to do so, telling staff about her plans and attempting suicide in the same way days earlier in another ward. An investigation report commissioned by the NSW Health Care Complaints Commission found that the young woman should have been observed at least every 15 minutes however, mental health nurses were conducting

https://ama.com.au/sites/default/files/documents/AMA%202019%20Rural%20Health%20Issues%20Survey%20Report.pdf.

[54] Ibid.

[55] National Rural Health Commissioner. Final Report June 2020. Canberra: Office of the National Rural Health Commissioner. Viewed 1 December 2020, https://www1.health.gov.au/internet/main/publishing.nsf/Content/National-Rural-Health-Commissioner-publications; Australian Medical Association. 2019 AMA Rural Health Issues Survey: Improving Care for Rural Australia. Barton: AMA. Viewed 5 December 2020, https://ama.com.au/sites/default/files/documents/AMA%202019%20Rural%20Health%20Issues%20Survey%20Report.pdf.

[56] Australian Medical Association. 2019 AMA Rural Health Issues Survey: Improving Care for Rural Australia. Barton: AMA. Viewed 5 December 2020, https://ama.com.au/sites/default/files/documents/AMA%202019%20Rural%20Health%20Issues%20Survey%20Report.pdf.

[57] Discussions with ABC journalists in the course of preparation of Background Briefing programme; see e *Hunter Area Health Service & Anor v Presland* (2005) 63 NSWLR 22; *Hunter New England Local Health District v McKenna* (2014) 314 ALR 505; numerous unreported matters resolved via settlement conducted by the authors of this submission.

observations at a distance and from the nurse's station. The Mater Mental Health Service in apologising to the family told them that they had made changes to the wards to make the bedding and furniture safer. Two of the nurses involved in the woman's care – controversially – had their registration revoked as a result of the matter.[58]

## Woman has laryngeal nerves severed during unnecessary thyroidectomy performed by general surgeon in rural NSW

A woman in south coast NSW consulted a general surgeon after the finding of a nodule in her thyroid gland reported as suspicious of being a papillary carcinoma. The surgeon advised the woman to undergo a total thyroidectomy. The woman sustained severe injury and permanent damage to her vocal cords including impaired capacity to breathe, speak and swallow. In a subsequent negligence case, independent evidence was to the effect that the general surgeon should not have performed the surgery, had no experience or training in thyroid surgery and should have referred the woman to a specialist thyroid surgeon for appropriate management and advice.

## Woman died following bariatric surgery performed by a general surgeon

A regional surgeon performed a gastric bypass procedure on a woman with a BMI of only 33.6 – regarded as "borderline for any bariatric surgery". Three surgical procedures were performed in close succession when the woman vomited bile stained fluid following the first surgical procedure. Independent expert opinion was to the effect that the surgery was not indicated and that non-operative conservative measures should first have been attempted, the technique used to access the proximal small bowel was not appropriate and likely to cause obstruction – which did eventuate – and the third and fourth surgical procedures were either not indicated nor appropriate. The surgeon describes himself as a "general surgeon with a special interest in advanced laparoscopic surgery". In city practices, those practising in bariatric surgery are likely to be upper gastrointestinal surgeons.

## Woman bled to death in Hospital with no doctor on-site

On 12 October 2020, the *Sydney Morning Herald* reporting a tragic event occurring in Western New South Wales Local District where a woman haemorrhaged to death in the Gulgong Hospital, also known as Gulgong Multi-Purpose Centre, which had no doctors physically present because the Health District had replaced face-to-face doctors with treatment via videolink. The 66 year old

[58] "Ahlia Raftery suicide: Unreleased report confirms hospital failed to give adequate care" https://abc.net.au/news/2017-08-25/investigation-confirms-failures -in -suicide-death-of-18-year-old/8841620.

suffered a gastrointestinal bleed that sent her into cardiac arrest, being treated by a doctor over teleconference, who was obviously helpless to assist. The Herald reports that the Gulgong Hospital had not had a doctor present since June, when the town's doctor was informed by the Health District that his contract with the hospital would not be renewed. The Health District was reported to have also failed to renew a contract with Rural and Remote Medical Services ('RARMS'), a non-profit organisation that provided doctors to regional hospitals. Following this tragedy death, locals petitioned to re-employ a doctor. The incident has led to a review of telehealth.[59]

## ToR h) the current and future provision of ambulance services in rural, regional and remote NSW

41. Mobilising the paramedic workforce has the potential to improve health outcomes for people living in rural and remote Australia and reduce the level of adverse outcomes.

42. The percentage of paramedics working in rural and remote areas varies significantly across different jurisdictions and are. However, again there is a lack of data that could be utilised to provide a more detailed analysis of the number of paramedics by remotes area.

43. Paramedicine is becoming increasingly a popular choice of career study. There are more students graduating annually than positions and these add to the already substantial surplus graduates in excess of jurisdictional service demand. It has been observed that this situation offers the opportunity for excess paramedic personnel to be used in roles and settings where there is a dearth of other medical and health personnel.[60]

44. Volunteer ambulance officers certified to provide first aid and other first responder services are able to be used in the transportation of patients – an issue for rural and remote individuals as already noted. Ambulance service volunteer personnel are not able to operate in the same way as registered paramedics due to their lack of qualifications and experience and need to be closely supervised by registered paramedics.

[59] "We couldn't believe it': Woman bleeds to death in NSW hospital with no doctors on site" https://www.smh.com.au/national/we-couldn-t-believe-it-woman-bleeds-to-death-in-nsw-hospital-with-no-doctors-on-site-20201011-p563z1.html.

[60] National Rural Health Alliance Ltd Fact Sheet October 2019 The Paramedic Workforce in Rural, Regional and Remote Australia.

45. What is known as community paramedicine – remotely located registered paramedics who recruit, train and supervise or mentor volunteers – is a model that could be developed further to assist in improving health outcomes for people living in rural and remote areas.

46. The wider use and expanded scope of paramedic roles is generally seen as a viable means of changing health workforce structure with improved work practices for the benefit of those in rural and remote services and needs to be given priority from a policy development perspective. However, vigilance in the training and appropriate rostering of volunteer or underqualified paramedics needs to be maintained from a risk management perspective.[61]

## Case studies

Avoidable death due to negligent paramedic care

A 55 year old man's death is likely to have been prevented had he been taken to hospital by the two ambulance officers who attended his home in regional NSW in mid 2020. Paramedics were called to the man's home by his wife following episodes of vomiting in the early hours of the morning. There were key findings noted in the history –notably bile stained vomit – which should have been regarded as a 'red flag' with transportation to hospital recommended – as requested by the man and his wife - in ambulance protocol. Comprehensive physiological testing was also not conducted. During a second presentation later that day, the man was found unresponsive and in cardiac arrest. He died 24 hours later. The cause of death was acute bronchopneumonia leading to cardiac arrest and hypoxic brain damage.

Death waiting for ambulance

In 2015, a man died waiting for an ambulance to arrive in Canowindra, making it the sixth death in the same year, that occurred when ambulances were unable to reach patients in time. The dangerous delays were link to resource shortages. It was noted that the Ambulance Service of NSW has fewer paramedics per head of population compared to other major Australian states.

[61] Australian Health Care Reform Alliance Position Paper on Health Workforce 2017 lain.

## ToR i) the access and availability of oncology treatment in rural, regional and remote NSW

47. Cancer is reported as Australia's largest disease burden with one third of those affected by cancer living in rural, regional and remote areas. Sadly, people with cancer who live in rural areas have poorer survival rates than Australians in the major metropolitan centres. The lower survival rates has been demonstrated as directly related to the quality and availability of services. [62] These inequities need to be addressed by targeted actions in order to close the gap between cancer outcomes and survival for people in rural Australia and those in metropolitan areas.

48. The factors that contribute to lower survival rates include diagnosis at a later stage, less access to specialised treatment, the relative shortage of health care providers in rural and regional areas and the higher proportion of disadvantaged groups such as Aboriginal and Torres Strait Islander peoples. [63]

49. Initiatives that aim to substantially improve the accessibility, quality and coordination of cancer services for people in regional and rural areas include the construction of new regional cancer centres and the development of networks linking regional and metropolitan cancer services. Both of these approaches involve a change in thinking about health care delivery – shifting the focus from getting patients to city centres to developing "hubs" of cancer care expertise in regional areas and linking and supporting services in rural centres.

50. The authors see many cases of negligent of misdiagnosis of skin cancers by rural and remote GPs. The issues are skill-based and although there is concern about unnecessary excisions, the primary principle of competent general practitioner medicine – to remove suspicious lesions which include cancer – is often not adhered to. The additional transport problems for rural and remote individuals when receiving treatment is also an issue.

51. There has been some commitment from government to capital grants for regional cancer centres – however, the success and sustainability of regional cancer centres depends – again – on the availability of properly trained medical and allied health personnel and specialist services.

[62] Clinical Oncological Society of Australia. Mapping rural and regional oncology services in Australia, March 2006 http://www.cosa.org.au/cosa/File/publications/Mapping_regional_oncology_serices_MARO6.pdf.

[63] Ibid p 1.

## Case studies

Death following negligent management of cancer treatment

A woman was to receive 6 cycles of adjuvant chemotherapy at a regional NSW hospital following surgery for bowel cancer – rectosigmoid type, Dukes B. After the third cycle, she developed diarrhoea and vomiting and was afebrile. She presented to the Emergency Department of the hospital where pathology testing was undertaken. Hospital staff failed to recognise symptoms of significant dehydration and the woman was not administered appropriate or adequate quantities of fluid. Hospital staff also failed to recognise the presence of neutropaenia and a low white call count. There was inadequate communication between staff with responsibility for oncology treatment at the hospital and the Emergency Department. The woman developed sepsis and died within a fortnight of the third cycle of chemotherapy treatment. The woman's family brought a negligence claim against the hospital relying on evidence that the woman's death was caused by the treatment and but for that treatment her life expectancy was reasonable.

Death following negligent administration of chemotherapy

A woman was receiving chemotherapy as an outpatient at a regional hospital since the diagnosis of metastatic bowel cancer. During a portocath insertion done by two trainee registrars at the hospital for the purpose of administering chemotherapy, the portacath traversed the internal jugular vein entering the adjacent subclavian artery. The procedure had to be aborted and the woman transported to a large tertiary referral hospital so the artery could be repaired. The woman was not well enough to continue the chemotherapy treatment and developed other conditions including pulmonary embolism and haemorrhagic stroke. The woman had a limited life expectancy but the timing of her death and the quality of her remaining life was impacted significantly by the negligent treatment.

# ToR k) an examination of the impact of health and hospital services in rural, regional and remote NSW on Indigenous and culturally and linguistically diverse (CALD) communities

52. The focus here is on the Indigenous population (also known as First Nations People).

53. The ALA supports and endorses the submission of the National Justice Project which deals extensively with the discrimination within the health system leading to negligent or inadequate health care for Indigenous communities.

54. In addition, the ALA notes that the gap in health status between Indigenous and non-Indigenous Australians has always been unacceptably wide. This issue was identified as a human rights concern by United Nations Committees.

55. Measuring regional, rural and remote communities' access to healthcare is a complex issue. "Access" includes physical proximity to healthcare services, financial aspects such as affordability of services and cultural aspects. Access to primary health care services is the key to good quality service because it is usually a person's first contact with the health system.

56. The Australian Institute of Health and Welfare ('AIHW') Australia's Health 2016 report identified areas where there were critical primary health care gaps for the Indigenous population.

57. Indigenous women are disproportionately represented amongst those experiencing stillbirth pregnancy. In Australia, about 6 babies are stillborn every day. For Indigenous women, that rate is doubled. President of the Australian College of Midwives, Professor Caroline Homer, called the disparity a "national disgrace".[64]

58. The authors of this submission have conducted multiple cases involving poor obstetric management involving Indigenous women residing in rural and remote NSW.

59. Discrimination based on race is often a feature of these cases coupled with lack of antenatal and maternity services in rural and remote areas.

60. Data released from the Heart Foundation has demonstrated that deaths from heart disease are 60% higher in rural and remote areas, compared to cities. The data showed that hospitalisations due to heart attack are double those in cities and heart disease risk factors such as smoking and obesity are increased in disadvantaged, rural and remote areas of the Australia. Indigenous people are known to experience heart disease 70% more frequently than non-Indigenous Australians and experience double the rate of hospitalisations due to heart attack and heart failure.

61. Indigenous Australians are more likely to experience mental health issues, chronic diseases such as respiratory diseases, cardiovascular disease, diabetes and chronic kidney disease than non-Indigenous Australians. Trachoma (bacterial infection of the eye) and rheumatic heart disease are also prevalent.

[64] https://www.aph.gov.au/Parliamentary_Business/Committees/Senate/Stillbirth__Research_and_Education/Stillbirth/Report/c02.

62. Indigenous-specific health services are important providers of primary health services for Indigenous Australians.

63. In 2011, the NSW Government developed, in partnership with the Aboriginal Health and Medical Research Council developed the NSW Aboriginal Health Plan 2013–2023 to Close the Gap in Aboriginal people health outcomes by spreading responsibility across all NSW Health Operations for achieving health equity for Aboriginal people in NSW. The Health Plan underwent a mid term evaluation in May 2019. The finds of the evaluation suggest that there was moderate progress with the strategic directions of the Plan. The mid term evaluation recommended six areas of improvement[65]. It is recommended the NSW Aboriginal Health Plan be further evaluated to ensure greater improvement in health outcomes and access to healthcare for Indigenous people.

## Case study

Death following negligent management of abscess leading to sepsis in regional hospital

The husband and two daughters of an Aboriginal woman suffered extreme psychological distress as a result of the untimely death of their wife and mother and brought action against the local health district in regard to what they saw as pure neglect by hospital staff. The woman – who was only 50 at the time – had multiple co-morbidities including chronic renal failure. Nonetheless she had been cared for at home and had undergone an elective procedure for her renal condition. During the surgery, she suffered a cardio-respiratory arrest. She was resuscitated and an arterial line was inserted in her thigh to monitor her blood pressure while in ICU. When the line was removed, a haematoma developed but there was significant delay by hospital nursing and medical staff in diagnosis. The hospital's own internal investigation noted poor handover and poor communication were contributing factors to the timing of the woman's death.

[65] https://www.health.nsw.gov.au/research/Pages/ahp-mid-term-main-report.aspx.

## Recommendations

64. The ALA's recommendations are below:

1. Develop protocols to be managed and monitored by existing agencies requiring meaningful health data as to adverse events to be recorded and publicly available;

2. Introduce changes to data recorded on death certificates in cases where death has occurred as a result of an adverse event or the death was not the reasonably expected outcome of medical treatment;

3. Strengthen health promotion, disease prevention and community health services to improve outcomes for those in rural communities are health;

4. Improve access to health services as close to home as possible and enable the provision of high quality care in local rural health services;

5. Ensure services and networks work together, are patient-centred and planned in partnership with local communities and health service providers and provide better continuity of care;

6. Adopt a radical new approach to information technology with real time tracking data and public disclosure;

7. Make the development of a rural health workforce a national and state priority;

8. Continue programmes to attract and retain nurses with seniority;

9. Introduce a compulsory rural training term for employed junior medical officers;

10. Continue and improve the General Practice Rural Incentive Program and the Practice Nurse Incentive Program;

11. Formal recognition of the specialist practice or rural generalists ensuing that appropriate training is undertaken to accredit a practitioner as a rural generalist and establish a career pathway with opportunities for recognition and advancement;

12. Identification and implementation of further steps considered necessary to ensure the adequacy of the training of such junior medical officers undertaking a rural term;

13. Increasing efforts to establish scholarships and access to bonded placements, early practice and specialist training through prevocational and rural and remote health placements and other incentive programmes;

14. The establishment of training hospitals and programmes in regional areas and associated with this the development of education facilities and programs which ensure that clinicians working in rural and remote areas of NSW are provided with adequate education and training;

15. Developing availability of cancer treatment services in regional and rural areas;

16. Maintain and improve the capital grants programme for regional cancer centres;

17. Continue to develop networks linking regional and metropolitan cancer services;

18. Explore the mobilisation of the paramedic workforce to rural and remote areas including the utilisation of volunteer ambulance officers for the transportation of patients;

19. Develop appropriate measures to improve transportation issues for individuals from rural and remote areas by way of a non urgent transport service so that transportation of patients from or to metropolitan or rural hospitals and health providers assists with the provision of treatment;

20. Initiating a full review of the IPTAAS scheme including the personal contribution and administration charge for all qualifying IPTASS claims;

21. Make improved access to mental health services in rural and remote areas a state priority; and

22. Move towards an amendment to the *Mental Health Act 2007* (NSW) to permit suitable remote facilities to operate safe assessment rooms for mental health patients on the basis that 3 hourly reviews of patients may be undertaken by a senior nurse or psychiatrist over video link.

## Conclusion

65. The Australian Lawyers Alliance (ALA) has welcomed the opportunity to have input into the Inquiry into health outcomes and access to health and hospital services in rural, regional and remote New South Wales.

66. We would be happy to address the Committee on these important issues.