Supplementary Submission No 245a

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

Organisation: Bathurst Regional Council

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SUPPLEMENTARY SUBMISSION TO THE PARLIAMENTARY INQUIRY INTO HEALTH OUTCOMES AND ACCESS TO HEALTH AND HOSPITAL SERVICES IN RURAL, REGIONAL AND REMOTE NSW

BATHURST REGIONAL COUNCIL

Introduction

There are two areas of focus in this supplementary submission. The first provides additional data that has been analysed since Council's first submission, which was verbally summarised at the public hearing in Wellington but now provided in a more formal and expanded format. The second is to expand on the theme in the first submission "Something not right in the System", a theme which appears consistent with the submissions of other stakeholders.

The data

This section draws some comparisons between service levels in Bathurst compared to the NSW benchmark and Orange and other localities. The purpose is to substantiate the claim by Bathurst Regional Council that the two hub referral model employed by the Western NSW LHD (Dubbo and Orange) creates significant social and economic disadvantage to Bathurst.

Source: Comm. Dept. Health, Health Workforce Data (2019)

Medical practitioners per 10,000 population	
Bathurst	32.3
NSW benchmark	44.6
Orange	77.7

Medical practitioners per LGA compared to NSW benchmark	
Bathurst	-53
Orange	+141
Dubbo	+4

It is acknowledged the respective base hospitals serve a catchment larger than the LGA. The following is an attempt to compare groupings of Councils that go toward a catchment comparison.

Medical practitioners for LGA group compared to NSW benchmark	
Bathurst + Lithgow + Oberon	-116
Orange + Cabonne	+100

For allied health services, number of practitioners per LGA compared to NSW benchmark	
Physiotherapists:	Bathurst -16, Orange +34
Pharmacists:	Bathurst -15, Orange +19
Dentists:	Bathurst -10, Orange +14

The shortfall in medical practitioners and other health professionals has a direct impact on the economy of Bathurst. Bringing the number of medical, physiotherapy, pharmacists and dental practitioners to NSW benchmark (94 direct jobs) would contribute $8.7m annually and create 137 indirect jobs for the local economy (using National Institute of Economic and Industry Research methodology). Further, admissions data, urgent elective surgery waiting time and presentations to Emergency Department have increased significantly for Bathurst hospital, indicators of growth in demand for health services in Bathurst.

Total admissions (2011/12 – 2017)
Bathurst +24%, Orange +6%

Medical emergency admissions
Bathurst +55% (count at 2017 of 5409), Orange -4% (count at 2017 of 5558)

Urgent elective surgery waiting time (2019/20)
Bathurst 13 days, Orange 9 days

Urgent elective surgery waiting time (2018/19)
Bathurst 14 days, Orange 7 days

Presentations to ED (2011/12 – 2019)
Bathurst +14% (count at 2019 of 28,268), Orange +9% (count at 2019 of 31,146)

Bathurst does not have the following specialist units (compared to Orange): cardiac surgery, geriatric assessment, neonatal intensive care, oncology, to name a few.

In addition, Bathurst Hospital is severely short staffed in anaesthetics, urology and the more highly qualified Fellow of the Australasian College for Emergency Medicine in the Emergency Department.

There is something not right in the system

This seems a consistent theme amongst those making submission to the Inquiry, certainly from the representatives of Bathurst, Dubbo and Warrumbungle Councils that attended the hearing together in Wellington. It is not just about the allocation of additional money. It goes to the role of the Local Health District in fostering better community wellbeing not just through adequate services and facilities but a culture of community service and a workforce of high morale. It goes to the deep divisions between the bureaucracy of health governance and those providing front line services. It is not about the people who work on each side of that divide (they are all good people) but the system itself.

The following descriptors apply to the Local Health District bureaucracy:

The LHD is always right. It is the experience of Bathurst Regional Council that the LHD is not an effective listener. The LHD has a model of operation that sets a course and stubbornly pursues it. The emergency orthopaedic service proposed for Bathurst is a case in point. It keeps to itself matters of significant community interest such as infrastructure plans and budget proposals. Despite repeated attempts by Council and others to seek change, improvement is elusive.

The LHD knows better than the community it serves. It has been said by the LHD CEO that “Bathurst has the hospital it needs for its population” which the previous section of this submission has clearly debunked. The LHD uses data to separate itself from the humanity it serves; that a high proportion of people in a survey seem satisfied with the service they receive reads well unless you are a member of the family of someone who has been forced to travel to receive basic treatment, as thankful as they might be for receiving treatment at all.

The health bureaucracy is self perpetuating and resource hungry. It consumes a significant proportion of resources that are often diverted away from front line workers stretched to their limit. It is ultraprotective of itself and will shield the Ministry of underperformance or community dissatisfaction. For example, during a meeting between concerned citizens and the Minister in the Ministers office, LHD representatives were in attendance and did not advise the participants

the conversation was being transmitted by phone to others. Such actions do nothing to restore confidence in how the system is controlled.

The LHD has a governance model akin to a corporate structure, which is unfortunate. Such a governance structure is not suitable for critical human services. It appears Board members are selected because of their ability to run the LHD as a business. The size of the LHD footprint does not enable effective input from local areas. Board members seem to be separated from the reality of the daily struggles of workers to do their job properly. Rarely do Board members seek input from or engage with local communities. Communities are therefore not well represented at Board level, with the role of local health councils relegated to being politely listened to.

The above explains the corrosion of confidence in the system experienced by those working there. The drain on morale is palpable. One sample of how it is seen in Bathurst is contained in the attached correspondence from a long-standing doctor and resident of Bathurst.

> *I was on call over the weekend, the busiest I can recollect, with bedblock due to lack of open, staffed beds. This results directly from previous poor planning, previous lack of recognition of bed shortages and now the problem of elderly frail and chronically ill people living at home requiring admission because of falls and other frailty related illness. Those elderly frail and sick patients require an increasing percentage of hospital bed-days, often prolonged because of their rapid loss of strength with even minor illness.*
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> *The aging of the population means that the appropriate increase in the number of beds to provide adequate care will need to exceed the population increase. Hospital in the home and other home based care will only go so far in reducing the need for admission when someone falls over or gets pneumonia or a urinary infection.*
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> *Delays in transferring patients to other hospitals because of gridlock across the whole State hospital system adds extra bed-days and further increases the problems in Bathurst. The lack of Hospital MRI and regular Echo service adds to delays. I had 2 patients in the regular ward over the weekend who would normally be in a coronary care unit, but we no longer have one in Bathurst. Some surgery was deferred today because of the worsening bed crisis and it is not even winter. Bathurst Hospital needs more beds.*
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> *There remains a profound lack of senior staff in Bathurst and the service remains supported in Key areas by Locums and fly in fly out Doctors.*
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> *There have been no new services introduced since the opening of the new hospital 12 years ago, and some services have been lost. Eg In respiratory medicine, ENT and some other surgical services. Morale is poor, the Administration is perceived to be only interested in saving money and the culture prevents improvements and innovation by frontline staff. The insatiable desire for information to be entered into cumbersome IT data systems turns highly trained Drs, Nursing and allied health staff into data entry clerks and reduces productivity.*

The lack of GPs and Specialists in the Town leaves a void for patients who early follow-up and assessment especially after attendance at the Hospital emergency department or discharge from the inpatient ward. Communication, transition to outpatient services and medication prescription at discharge remain an ongoing, seemingly insoluble problem as patients transfer from the State hospital system to Commonwealth outpatient care (GP, aged care and PBS) with duplication and wastage.

It is easy to say that the hospital system simply is in want of more money, but hospital problems are also compounded by State political interests, the authoritarian top down management structure (previously identified by Garling) and a maddening extension of a bureaucratic mindset of endless forms and procedures into the working ward.

It may be a source of wonder that on the whole, outcomes are generally good. I do believe however that the hospital system needs genuine reform to achieve better and more equitable outcomes especially for disadvantaged (including rural) patients. If the inefficiency and waste in the system could be fixed, this could pay for some of the needed improvements. Bathurst Hospital in particular, has suffered from all of the systemic problems detailed above and needs to be "recapitalised" What a pity the Hoyle report was not acted upon! The lack of any political advocacy for improvements in services in Bathurst has been especially damaging. If the reputation of Bathurst as attractive town in which to live is damaged because of inadequate healthcare, the town will not attract new industry or business, and these downstream effects will leave it in economic decline.

I hope these comments are of some value to you in your advocacy, and would be happy for this to be passed on to the council and even submitted to the upper house inquiry if you thought them of some value. These reflections are my own, after working as a consultant in Bathurst for 30 years, and are completely unsupported by any data set, but may still be a type of wisdom.

Also **attached** is an opinion piece published on 25 May in the Sydney Morning Herald by Dr Aniello Iannuzzi, Deputy Mayor of Warrumbungle Shire Council and medical practitioner of long standing. It provides a similar if not more critical assessment.

OPINION

The labyrinth of bureaucracy behind our country hospitals' horror stories

Dr Aniello Iannuzzi
Visiting medical officer at Coonabarabran District Hospital
May 25, 2021 — 5.30am

After 25 years as a doctor in rural NSW hospitals, I can attest to the scandals and horror stories emerging from a state parliamentary inquiry into regional, country and remote health services: a teenager with an infected toenail dies of septic shock after being turned away three times from an an emergency department; "tea ladies" check in on newborn babies because there are not enough nurses; doctors threaten to quit en masse because their working conditions are so dangerous.

Naturally, it is the alarming stories from the front line – from the patients, families, doctors and nurses – that capture the headlines. Now we must address the causes.

Dr Aniello Iannuzzi, who is also deputy mayor of Warrumbungle Shire, giving evidence at the inquiry into regional, rural and remote health services. CREDIT:*LOUISE KENNERLEY*

Chief among them, I have come to learn, is the labyrinthine bureaucracy running NSW Health and the local health districts. The inquiry has come about because communities and health workers are sick and tired of managers in NSW Health and the LHDs stubbornly denying there is a problem.

That is why, when the inquiry came to Wellington, I testified that the principal problem is one of governance. Until that is cleaned up, nothing will improve.

NSW Health's management structures are bulky and opaque. To progress up the hierarchy, one needs to pledge undying support to the organisation, often needing to bend personal, clinical and ethical standards along the way. When a patient or clinician at the coal face raises a concern, makes a suggestion or files a complaint, management usually activates to ignore, frustrate, bury, lose or deny. It's like dealing with a big bank, telco or insurance company.

This explains why a CEO of a local health district or senior manager in NSW Health can be technically honest when denying knowledge of adverse patient outcomes, missing medications or the shutting of essential services. The labyrinth has done its work and protected the organisation. Plausible deniability. Spin.

It is at least heartening that the inquiry involves most NSW political parties – because the problems are chronic and systemic and have festered under the watch of Labor and Coalition governments.

No. 1 is understaffing, which puts pressure on rosters and over-reliance on locums and agency staff. There are not enough beds, which causes "bed block", and there is an inability to divert ambulances when that happens. Administrators are detached from clinical care and managers are overly concerned about ticking boxes for performance indicators rather than ensuring adequately resourced and safe facilities. Investigations meant to analyse system failure are too often weaponised to shift blame onto clinicians, leaving administrators untouched.

To some extent these problems are encountered in cities, but Australia's geography is cruel. When one runs out of basic antibiotics, there is not a pharmacy supplier in the next suburb or a courier the next day. When a patient drives 100 kilometres to an emergency department to discover there is only a video service, it can be another 100 kilometres or more to a town with a doctor. When a surgery or pharmacy shuts, the ripple effect on a small district's economy and social capital is devastating.

At the inquiry we heard powerful evidence from Bathurst Council: even in such a large regional city, a lack of health workers has negative economic and social impact. Imagine what it means for a town like Dunedoo, population 750.

We've had inquiries before, and recommendations, yet rural health continues to atrophy and the decision-makers are never to blame.

All too often NSW Health assumes good clinical practice can be made more efficient by curtailing or omitting critical steps: making the time to take a patient's accurate history, perform an adequate examination, consider and investigate the possible diagnoses, and properly inform the patient about the management plan. Hence we see understaffing, poor stocks of medicine and medical equipment and the promotion of telemedicine at the expense of in-person clinicians.

For those of us left in the small hospitals, we turn up to work to find new forms to complete and more data to report. Management's priority, it often appears, is that staff attend to these tasks ahead of real patient care.

Of course, we need more money, more beds, better medicine and equipment, more staff. The states often blame federal governments for these problems. There is certainly a place for more federal money but we should not exonerate NSW Health on this account. Without better governance the money will remain poorly spent, the equipment misdirected and the clinicians unwilling to work and give their best.

While we always need to recruit more health workers to the bush, there are plenty in the bush who make a conscious decision not to work for NSW Health.

Earlier this year, senior managers of our LHD and the Rural Health Commissioner were in Dunedoo for a community forum organised by the Warrumbungle Shire Council. They suggested the Dunedoo community should be more welcoming to health workers. Oh? So it's the community's fault? It was nothing short of insulting and outrageous. All NSW residents should be outraged.

Dr Aniello Iannuzzi is chairman of the Australian Doctors Federation, deputy mayor of Warrumbungle Shire Council and a clinical associate professor at the University of Sydney and University of New England. He has been a visiting medical officer at Coonabarabran District Hospital since 1997.