New South Wales

Special Commission of Inquiry into Healthcare Funding

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I refer to the call for submission to the special commission of inquiry into healthcare funding in NSW.

I am head of department of Anatomical Pathology at Royal North Shore Hospital and have been a staff specialist in this department since 2005. When I commenced as a staff specialist, I was employed by the NSLHD at Royal North Shore Hospital. I think this structure appropriately integrated high quality pathology services into clinical care in the LHD, as budgetary, governance and clinical responsibilities were aligned. Unfortunately the structure of pathology services has changed significantly across the state during my employment. This has contributed to increasing staff dissatisfaction, worse budgetary oversight and unmanageable workloads.

In 2012, NSW Health Pathology (NSWHP) was established as an administrative unit of the Health Administration Corporation under section 9 of the Health Administration Act 1982 (NSW). As a result my employment was transferred to NSWHP although I continued to physically work on the same campus at Royal North Shore Hospital and have the same clinical responsibilities to patients in the NSLHD.

However under this arrangement governance of pathology services and budgetary oversight were removed from the LHDs in which they are physically located, and to which they are clinically responsible; and transferred to a centralized bureaucracy based in Newcastle.

In my opinion this change of structure has been to the detriment of patient care and to staff morale. There have been repeated examples of poor decision-making (both financial and clinical) and unaccountability. There has been an emphasis on being seen to be consultative rather than actually consulting with clinical staff. Key decision makers are separated from the consequences of their decisions. There has been an ‘over bureaucratization’ of simple day to day tasks.

Attempts to save money in the pathology budget, often cost more money to the health care system as a whole. ‘Operations teams’ are separated from ‘clinical teams’ and clinical teams are commonly over-ruled by operations teams that lack clinical insight. Key decision makers, remote from the clinical interface, often defer to costly external consultants or committees rather than make decisions themselves or seek local expertise. Far from leading to a cost benefit, I believe this centralized structure has led to ongoing financial wastage; and predisposes to poor financial and clinical decisions.

In my opinion much of this could be addressed by returning pathology services to the governance of the LHDs.

Key experiences which I would like to explore with the committee as examples of these broader systemic problems:

1. As head of department, I have significant responsibility to deliver safe care to the patients in my LHD and for the welfare of my staff. However despite this responsibility, I lack any authority to make decisions on key matters such as budgeting, testing repertoires, staffing levels and expenditure. I suggest a return to a governance structure where clinicians with clinical responsibilities have more authority over budget and staff levels.

2. There is a critical shortage of pathologists in my field, Anatomical Pathology, across the state.
There has been an unsustainable workload for anatomical pathologists in NSW for many years. After literally years of protest and union involvement, an independent consultancy firm Paxton Consulting was commissioned to review pathologist staffing levels in 2018. This report was not made public, but I believe NSWHP then re-reviewed this report to justify much lower increases in staffing levels than recommended staffing levels.

In 2023 a similar process repeated. There was a review of workload in anatomical pathology, this time conducted entirely internally by NSW Health Pathology. We were initially told that this would be "*a snapshot of the Lab's current activity*" however the review was subsequently changed to be based solely on FY 20/21 and 21/22 activity. Throughout this time period there was very markedly reduced activity in anatomical pathology because of COVID. I believe that it is likely that these years were knowingly chosen so that staffing recommendations would be kept to a minimum -certainly there was no desire to adjust the data to account for the rebound in work after COVID.

Most concerningly this recent review was deliberately structured not to determine what is a safe workload level for anatomical pathologists across the state. Rather it was designed solely to *rank the degree of understaffing* of the units.

I think the intention, and indeed the result, of staffing reviews being conducted in this way is to normalize under-staffing and under-resourcing.

3. Rather than being seen to say no to health care expenditure in pathology, expenditure is often delayed by unnecessarily prolonged recruitment processes and seeking business cases, committee approvals, and external audits; many of which give the appearance of not being conducted in good faith.

4. Pathology services should be re-integrated into the LHDs which they serve for greater financial efficiency, clinical accountability, improved staff morale and optimal patient care.
As a pathologist I see multiple examples where the statewide governance structure of pathology causes significant delays and inefficiencies. Under a governance structure where pathology is separated from the LHDs, in essence money is often 'saved' from the pathology cost centre (for example by batching/delaying results or not offering certain tests) which costs the LHD and overall healthcare budget more money. In addition to financial wastage, this structure is often to the detriment of patient care. A structure where clinical responsibility and budgetary governance are separated simply lacks the ability to be responsive to the changing needs of individual patients at different campuses.

In summary there is a widespread view amongst Anatomical Pathologists in NSW that the speciality is critically underfunded and understaffed. Furthermore there is a belief that previous reviews into workload have been quite deliberately slanted in such a way as to minimize the apparent deficit in staffing and resources. I believe that clinically responsible clinicians should be granted more budgetary authority so that decisions on staffing levels can be made closer to the clinical interface.

It is my opinion that returning pathology services to the governance of the LHDs would save money, improve the responsiveness of management to the local conditions, benefit staff morale, lead to greater clinical accountability and improve patient care.

Thank you for the opportunity to make this submission. I would be happy to speak to the submission and address any questions from the Committee.

Regards

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