New South Wales

Special Commission of Inquiry into Healthcare Funding

Submission Number: 162

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This is a formal submission to the Special Commission of Inquiry into Healthcare Funding. For background I am a senior emergency physician at Nepean Hospital and have been working on the frontline for more than 20 years. My current role includes the Director of Emergency Medicine Research at Nepean Hospital and am a clinical associate professor with the Nepean Clinical School.

Several areas at Nepean Hospital are below key performance indicator targets. Failure to meet these KPIs is not through lack of commitment to providing high quality care to the community of NBMLHD. Clinical staff – medical, nursing and allied health are all committed and working hard to achieve what is possible within available resources.

Nepean Hospital itself is currently at crisis point. The emergency department is routinely completely overwhelmed. This is a function of increasing ED presentations, patients presenting to the ED being sicker than prior to Covid, and the significant lack of inpatient bed capacity to support the ED as well as the significant elective surgical load of the area.

All departments and all disciplines, both clinical and non-clinical and at every level, are burning out. Management of patient flow is simply a matter of getting through the crisis each day and hoping for something better tomorrow, for example through reduced presentations or cancelling of elective surgery. We look forward to school holidays purely because of a predictable drop in ED presentations. There is no long-term solution on the horizon.

Nepean Hospital is underfunded both compared to similar peer hospitals performing the same workload and compared to the needs of the local community. This deficiency of funding is systemic and long-standing. It is also associated with increased mortality rates and other poor health outcomes in the Nepean Blue Mountains LHD compared to peer LHDs to the east. Without hyperbole, we can say that the current New South Wales funding model for public hospitals is associated with increased patient mortality and worsening patient outcomes in the Penrith LGA and Nepean Blue Mountains LHD.

1. Current funding

Nepean Hospital has for many years been funded at a level which has been insufficient to meet community needs. The Emergency Department patient waiting times are routinely high compared to its peers with up to 40 admitted patients in the ED every morning waiting for a bed on the ward, even up to 50 patients at its peak. These numbers are equivalent to two inpatient hospital wards. Elective surgical waiting times are some of the longest amongst the Sydney metropolitan hospitals.

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Until Stage I of the redevelopment was delivered and private facilities near Nepean Hospital opened, there was no opportunity to increase Nepean Hospital's inpatient bed capacity. Last year we opened the $550 million stage I, which included a new ED and 13 floors of new hospital wards, but were only funded for an extra 8 inpatient beds.

Currently Nepean Hospital has fewer Emergency Department accessible beds than peer hospitals despite having amongst the highest numbers of presentations to the ED (table 1). This inequity results in the delays to getting patients out of Emergency Department and into an inpatient bed.

For example, the Director of ED at Nepean was asked to visit St George hospital, as their ED was seeing similar numbers of patients but have much better performance with regards to waiting times and the Emergency Target Performance (the so-called 4 hour rule). However, what became clear was that St George hospital had 70 more ED accessible inpatient beds than Nepean and on average had twice the number of medical staff on shift in the ED at any one time.

Having an Emergency Department with all its treatment spaces occupied also impacts the ability to offload ambulances in a timely way. Not being able to offload ambulances then results in patients waiting on ambulance stretchers inappropriately long times and prevents ambulances getting back on the road causing delays to respond to other calls.

Given staff desire to provide the best possible care to patients, when patients are unable to be offloaded from ambulance stretchers, they are assessed, history taken, physical examination performed, investigations such as blood tests, x-rays and even CT scans are performed and treatment commenced as best as possible. It is not uncommon for patients to receive the entirety of their Emergency Department care on an ambulance stretcher before being wheeled up to their hospital ward bed on that same ambulance stretcher, without having been offloaded at all in the Emergency Department.

At Nepean Hospital, we have coined the term "cycle of poverty". Attached is a map of the Sydney metropolitan area with the location of each public hospital marked on the map (figure 1). To highlight the "cycle of poverty", a line has been drawn running North-South through Westmead Hospital, which is the approximate centre of the Sydney metropolitan population. As you can see, there are twice the number of hospitals to the east of this line than there are to the west.

Compounding this problem is the "almost" service provision at Mount Druitt hospital. This hospital has a functioning 24 hour ED but does not admit medical or surgical patients. Patients requiring admission are transferred to Blacktown Hospital inpatient care. Ambulance officers and local residents know this, so these patients do not present to Mount Druitt hospital. The outcome of this is that Nepean Hospital is seeing more and more patients from the Mount Druitt catchment area, which is part of the Western Sydney LHD. It is usual for patients from Rooty

Hill nursing home to arrive at Nepean ED via ambulance, instead of them undergoing the 2 minute drive to Mount Druitt hospital. Ambulance have also been quoted saying that Nepean Hospital covers an area from Katoomba to Blacktown. This puts additional strain on Nepean which is already stressed dealing with the population of NBMLHD.

Attached to the end of this letter are a series of graphs (figures 2-15). These are all available on the HealthStats website published by New South Wales Health. The link is https://www.healthstats.nsw.gov.au/%23/topics

The graphs compare either Nepean Blue Mountains, Western Sydney and Northern Sydney LHDs, or when able, Penrith, Parramatta and North Sydney LGAs. The information generally focuses on mortality rates, but data such as amputation rates, maternal obesity rates and mental health presentation rates to ED are particularly enlightening. These graphs also highlight the underlying health of the population, such as smoking rates, data around infant feeding and perinatal mortality. Nepean Blue Mountains LHD has an underlying first nations population proportion of about 4.4%, compared to 2% in other metropolitan LHDs, so the perinatal mortality figures are particularly informative.

What is clear is the increased mortality rates for people living in either the Penrith LGA Nepean Blue Mountains LHD compared to the other two areas illustrated. The inequity highlighted by this is both morally and legally questionable. In some cases mortality rates are either double or even triple what they are in the North Shore. The clear causes relate to the lower socio-economic status of our local LHD and LGA and the concomitant lack of health infrastructure and resources.

2. Redevelopment

Nepean Hospital is currently undergoing a $1 billion redevelopment with stage I having recently been completed and stage II currently in progress with demolition works having been commenced a couple of months ago. However, we must point out that this funding is insufficient to plan for our current needs.

We were simply given a pot of money and told to build a new hospital. Unfortunately, this funding was received in two parts, close to two years apart, with a significant delay to the confirmed commitment of the funding for stage II. Because of this lack of commitment, we were only able to plan for half a hospital. Therefore we had to make strategic decisions 6 years ago about which services would be in the new tower and which services would have to stay in older parts of the hospital, built more than 30 years ago, which currently do not meet hospital facility guidelines. The length of the redevelopment project has inevitably led to increased costs, particularly relating to Stage 2.

Radiology is a particular example of this with the bulk of radiology currently being performed in the old hospital and a new satellite radiology unit built to supply services to the ED and after-hours services to the ward. There was also an almost 12 month delay in opening the satellite radiology unit because of the inability to recruit the increased numbers of radiographers required in the middle of the year, which lead to delays opening the new ED and cardiac catheterisation suite. Furthermore, because of cost overruns, the Radiology Department may not be able to completely move to tower 2, with the possibility of nuclear medicine staying in the old part of the hospital, causing further inefficiencies of inpatient care.

The refurbishment of the older parts of the hospital is also being funded out of the total $1 billion, further reducing how much new hospital we can build. Remediation of these spaces is complicated by the fact that a number of unplanned issues have been identified during demolition, further increasing costs. Finally, inflation, supply chain issues, and issues stemming from COVID have all increased costs even further.

Because of cost increases over time there is a significant shortfall between Stage II tender prices and available funding. This is necessitating the prioritisation of services and the reduction of or exclusion of some services, for example inpatient dialysis services, nuclear medicine imaging (as discussed above) or intensive care capacity and the elimination of one entire floor.

3. Renal-Dialysis Services

The current funding of renal dialysis services for local patients with chronic kidney disease is an example of how the chronic and systemic underfunding of local district leads to poor services and poor patient outcomes, including increased mortality.

Dialysis is an essential life-saving and life-prolonging treatment for people with kidney failure. Currently, the Renal Service at Nepean Hospital does not have enough capacity to be able to provide haemodialysis treatments to patients with kidney failure that live within Penrith and Hawkesbury LGAs. This results in patients either having to wait to commence these life-saving and life-prolonging treatments or receiving less than clinically recommended treatments, both of which lead to poor patient outcomes. To fill this shortfall, we are contracting private dialysis capacity which unfortunately is out of district and causing increasing travel for patients. Importantly, NBMLHD does not receive any funding for home dialysis: patients with kidney failure suitable for home dialysis from across the LHD must travel to Blacktown Hospital.

An increase in community dialysis capacity is planned as part of the Community facilities being delivered as part of the Redevelopment plus Health One funding which is being added to the Redevelopment funds. However, this additional capacity will be approximately three years away. Also with home dialysis for local residents being run by Blacktown Hospital, we worry that much needed funds will be prioritised to patients in Western Sydney LHD.

As you can see from the data available on the HealthStats website (figure 2), deaths from chronic kidney disease in the Penrith LGA is double that of the North Sydney LGA and 33% higher than in the Parramatta LGA. The current funding arrangements for renal-dialysis services

at Nepean Hospital is directly leading to increased requirements for inpatient care and premature deaths in the community.

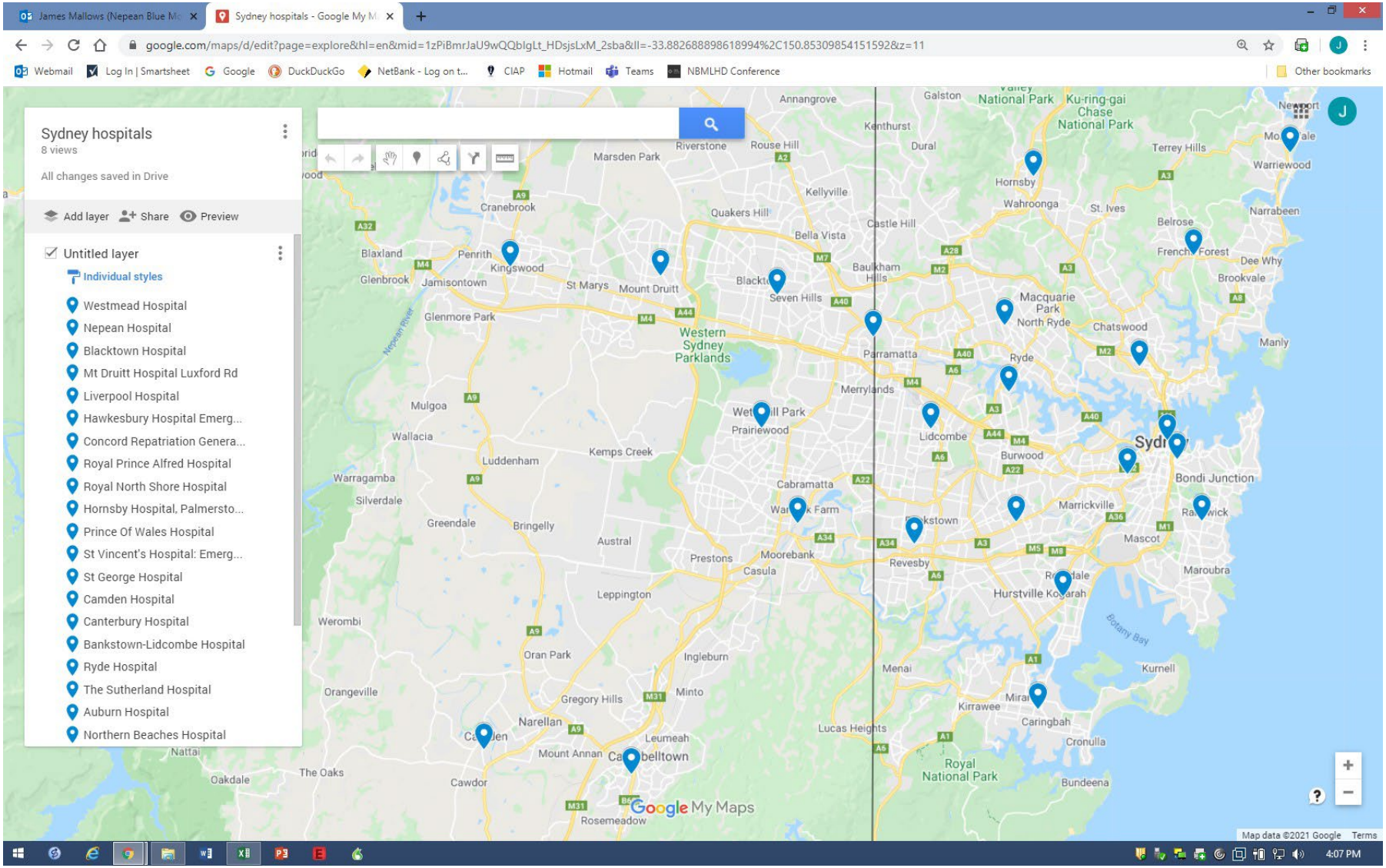
This submission is not as long as it could or should be. There are many other examples where chronic and systemic underfunding of Nepean Hospital is leading to poor outcomes and increased patient mortality. We are unable to run programs that have become the standard of care, such as multidisciplinary treatment for cancer patients, rapid access outpatient clinics to allow patients to avoid the emergency department and innovative models of care that simply require money and resources to implement. Of particular interest is the significant lack of commitment to funding obesity management despite the problem being concentrated in the western suburbs of Sydney especially in our local district.

Lastly, with such poor health outcomes in the Western suburbs compared to the east, equitable funding can only be a starting point. Health outcomes are linked to socio-economic status, highlighted by the high rates of obesity and smoking in our local district, and with a clear divide between west and east, the aim should be to have equitable health outcomes and not purely equitable funding outcomes.

However, through the accompanying data, I hope I have started to highlight the underlying causes and results of this chronic and systemic underfunding and the divide between east and west in the Sydney metropolitan area which is only exaggerated when you cross the Blue Mountains into the west of New South Wales.

Peer facilities

* Since midnight	Nepean Hospital	Westmead Hospital (all units)	Liverpool Hospital	Royal Prince Alfred Hospital	Royal North Shore Hospital	Gosford Hospital	John Hunter Hospital	St George Hospital	Wollongong Hospital	Concord Hospital	Prince of Wales Hospital	Bankstown / Lidcombe Hospital	St Vincent's Hospital, Darlinghurst	RPAH Institute of Rheumatology & Orthopaedics
Summary *														
Facility Step	1	2	2	1	2	3	3	1	2	2	3	2	2	?
ED Step	?	?	?	?	?	?	?	?	?	?	?	?	?	
Admitted ETP *	13.6%	16%	9.1%	28.8%	34.2%	11.5%	18.6%	29.4%	12.7%	34.7%	14.3%	42.9%	28.6%	
Non-admitted ETP *	40.9%	37.5%	37.6%	46.3%	70.3%	36.2%	37.3%	73.9%	53.8%	82.1%	40%	83.2%	57.3%	
Overall ETP *	33.9%	29.6%	28.1%	40.1%	58.4%	28.6%	31.6%	57%	40.4%	62.1%	31.8%	72.3%	47%	
ED Separations *														
Ward In *	60	85	73	81	79	71	80	101	65	56	62	35	43	
Ward Out *	87	89	83	99	90	79	104	92	62	58	44	29	34	7
ED Presentations *	248	225	235	245	238	214	250	238	195	125	188	165	132	
Ambulance Details														
All Patients in ED	95	117	93	75	60	81	80	65	69	36	59	69	57	
Non-admitted Patients	41	41	38	34	14	32	46	20	19	9	21	24	24	
First Seen														
Triage Category														
Length of Stay														
Admitted Patients in ED	54	76	55	41	46	49	34	45	50	27	38	45	33	
Occupancy														
No. of ED acc. beds	337	492	455	450	423	400	395	395	329	280	266	230	216	
No. of occupied ED acc. beds	325	506	487	431	421	394	415	391	341	306	270	239	244	
	96.4%	102.8%	107%	95.8%	99.5%	98.5%	105.1%	99%	103.6%	109.3%	101.5%	103.9%	113%	
No. of patients in transit lounge	0	0	1	0	0	2	0	0	0	0	0	0	0	
	0%	0%	0%	0%	0%	14.3%	0%	0%	0%	0%	0%	0%	0%	
No. of surge / closed beds in use		16	45	1			26	6	19	27	7	12	29	


James Mallows (Nepean Blue Mc
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Individual styles
Westmead Hospital
Nepean Hospital
Blacktown Hospital
Mt Druitt Hospital Luxford Rd
Liverpool Hospital
Hawkesbury Hospital Emerg...
Concord Repatriation Genera...
Royal Prince Alfred Hospital
Royal North Shore Hospital
Hornsby Hospital, Palmersto...
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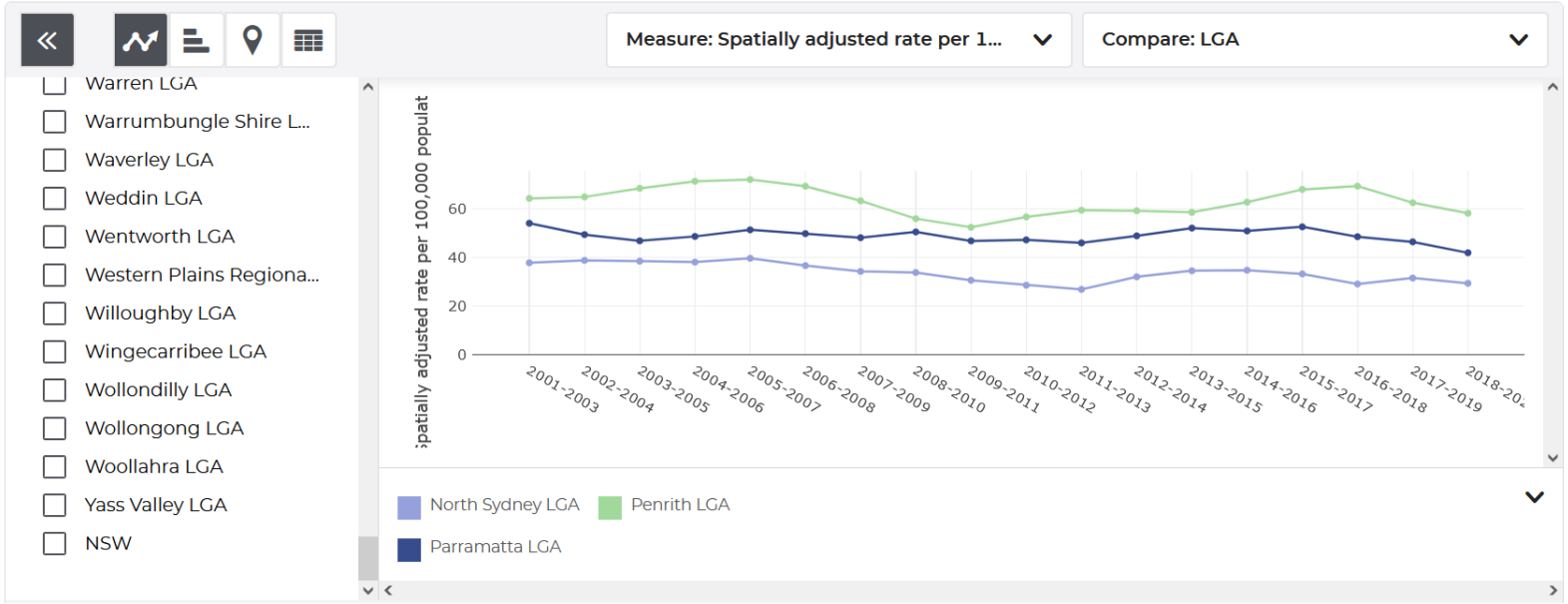
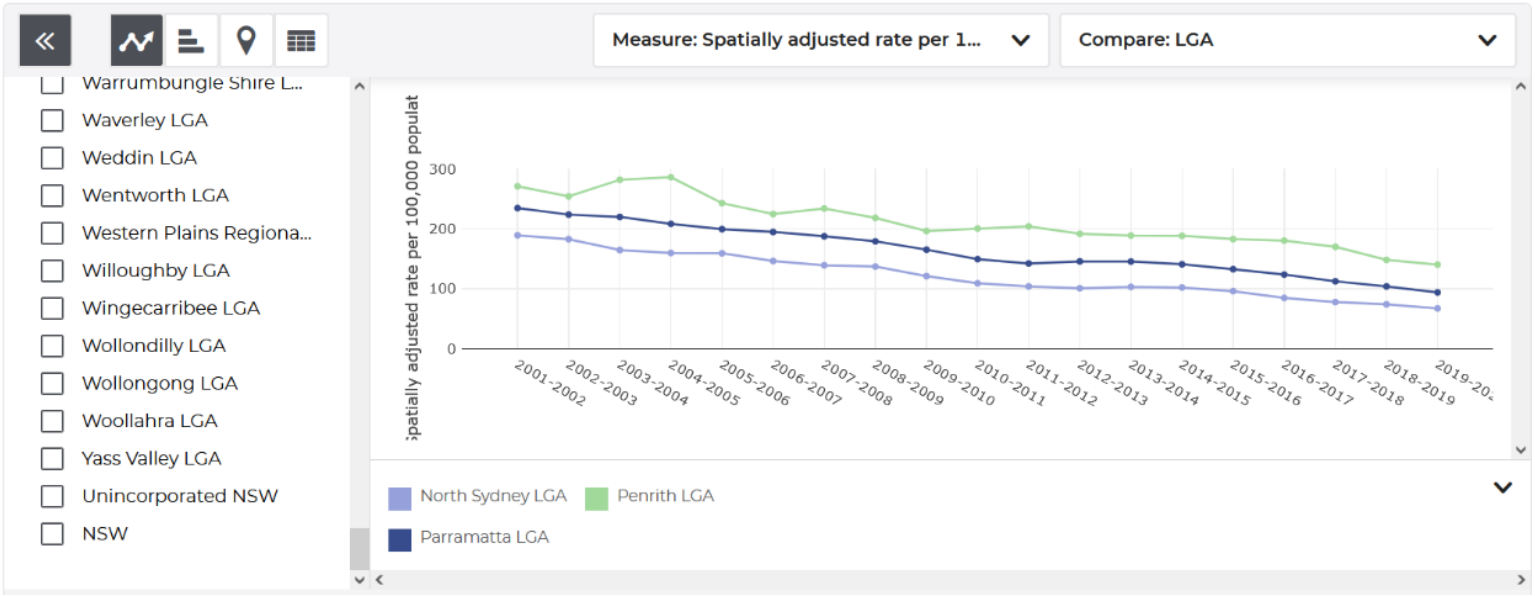
Chronic kidney disease deaths

by LGA



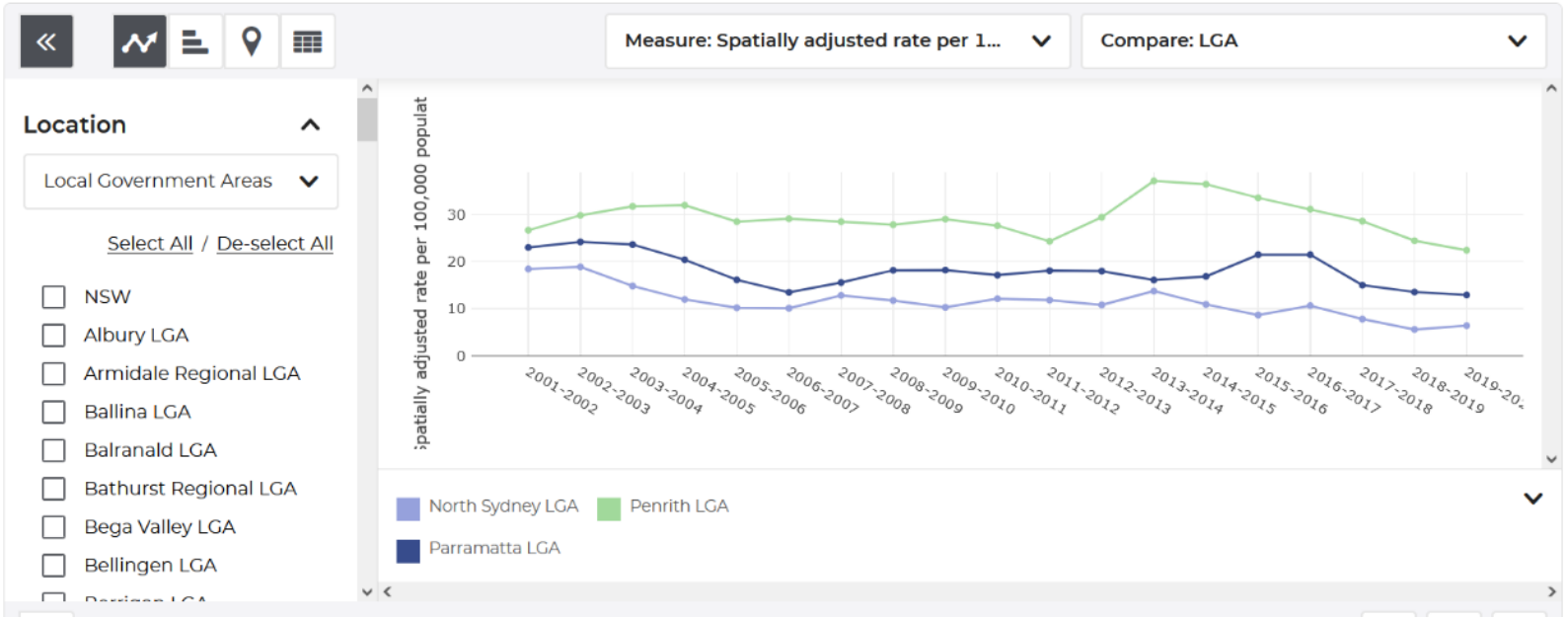
Cardiovascular disease deaths, total

by LGA



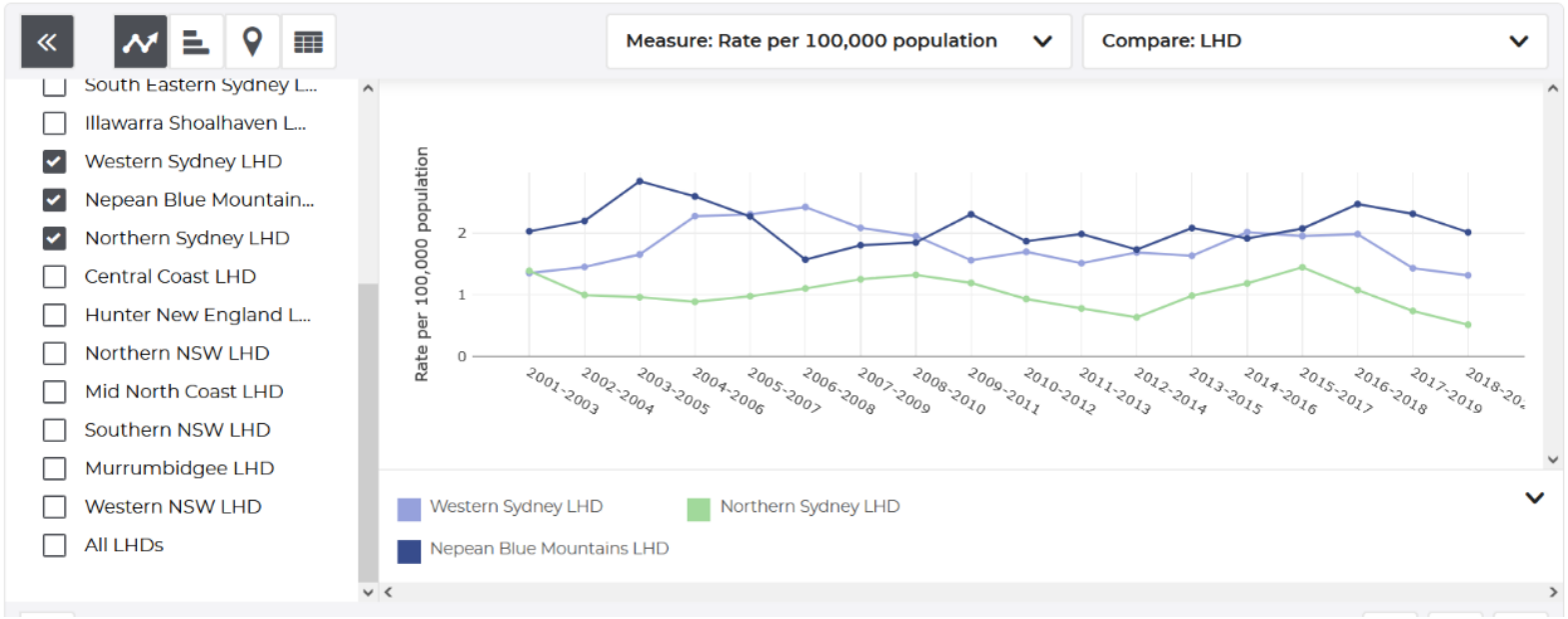
Chronic obstructive pulmonary disease deaths

by LGA



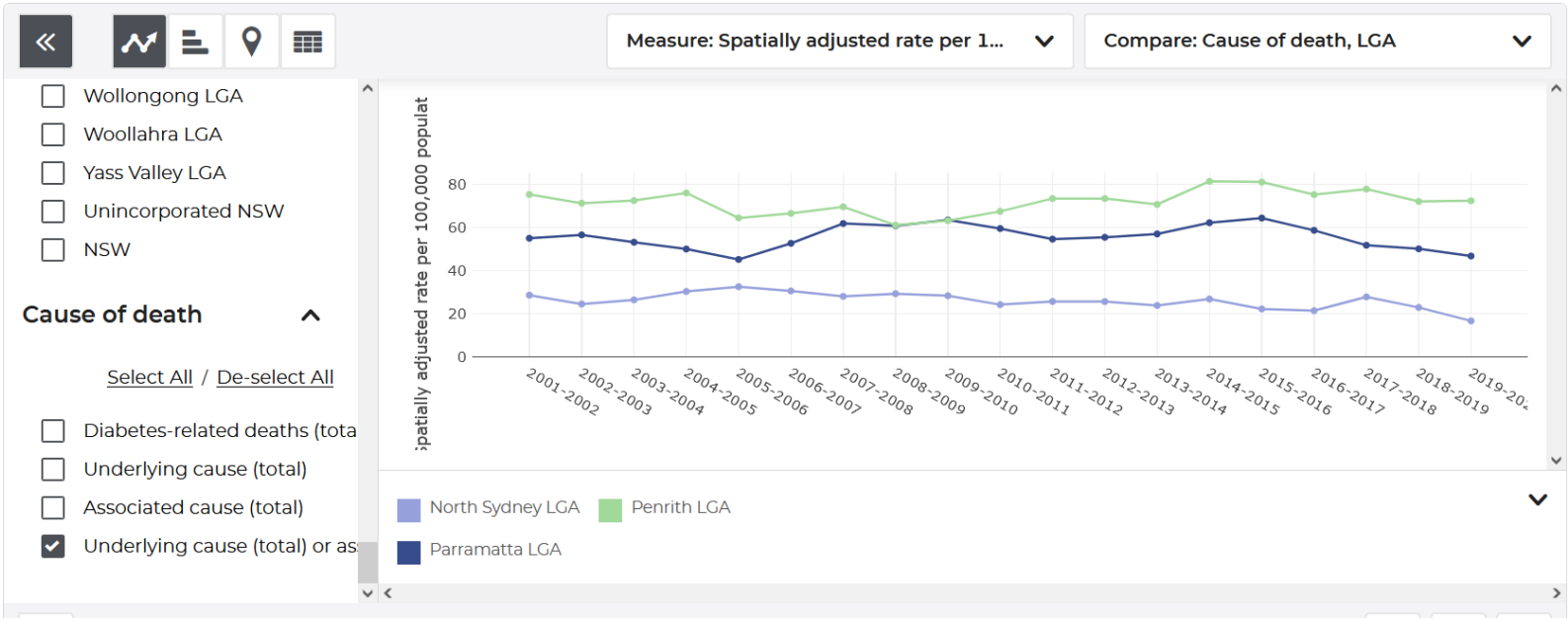
Asthma deaths

by LHD



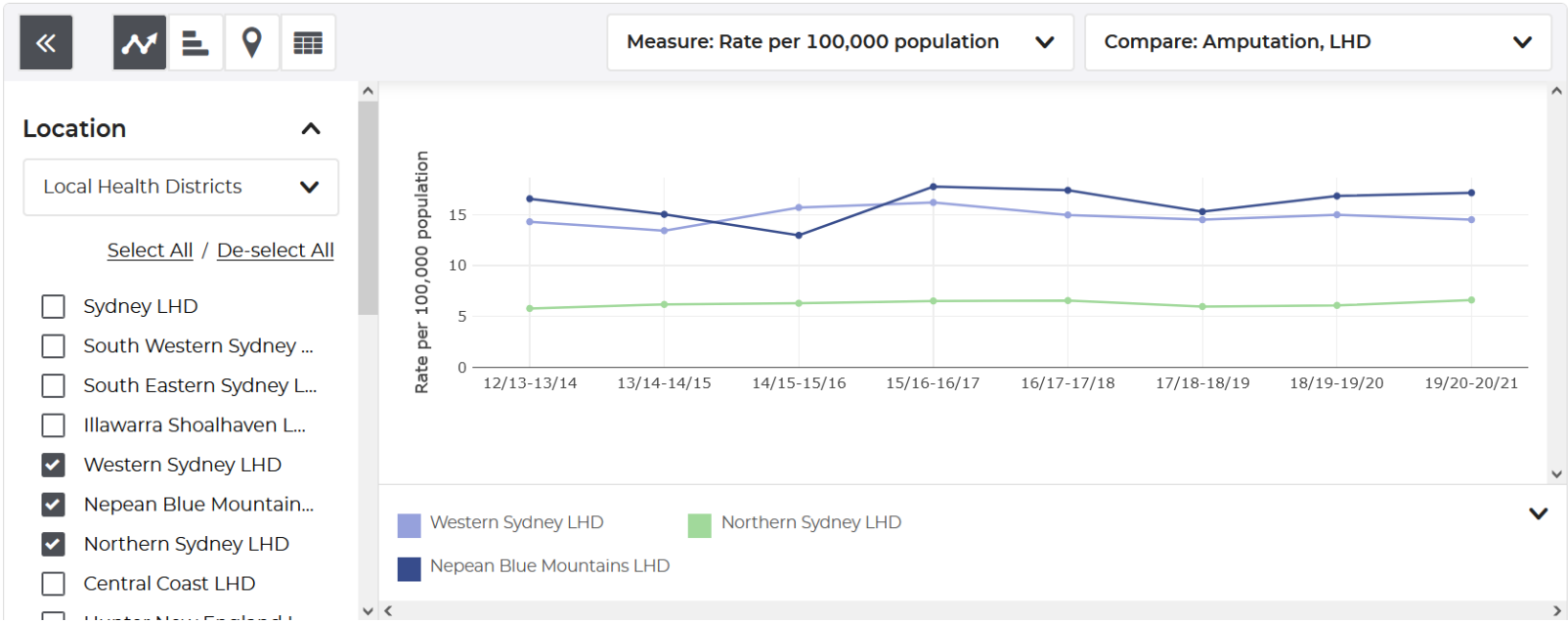
Diabetes-related deaths

Underlying cause (total) or associated cause (total) by LGA



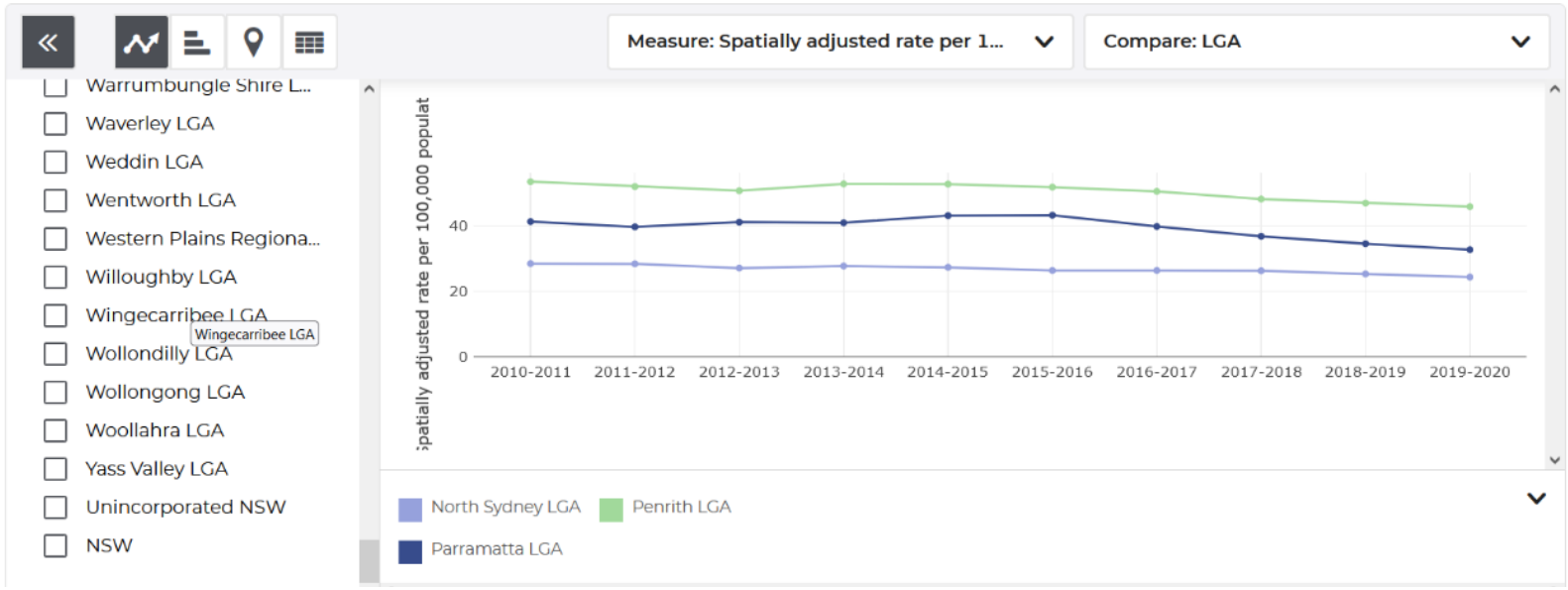
Amputations due to diabetes

Total by LHD



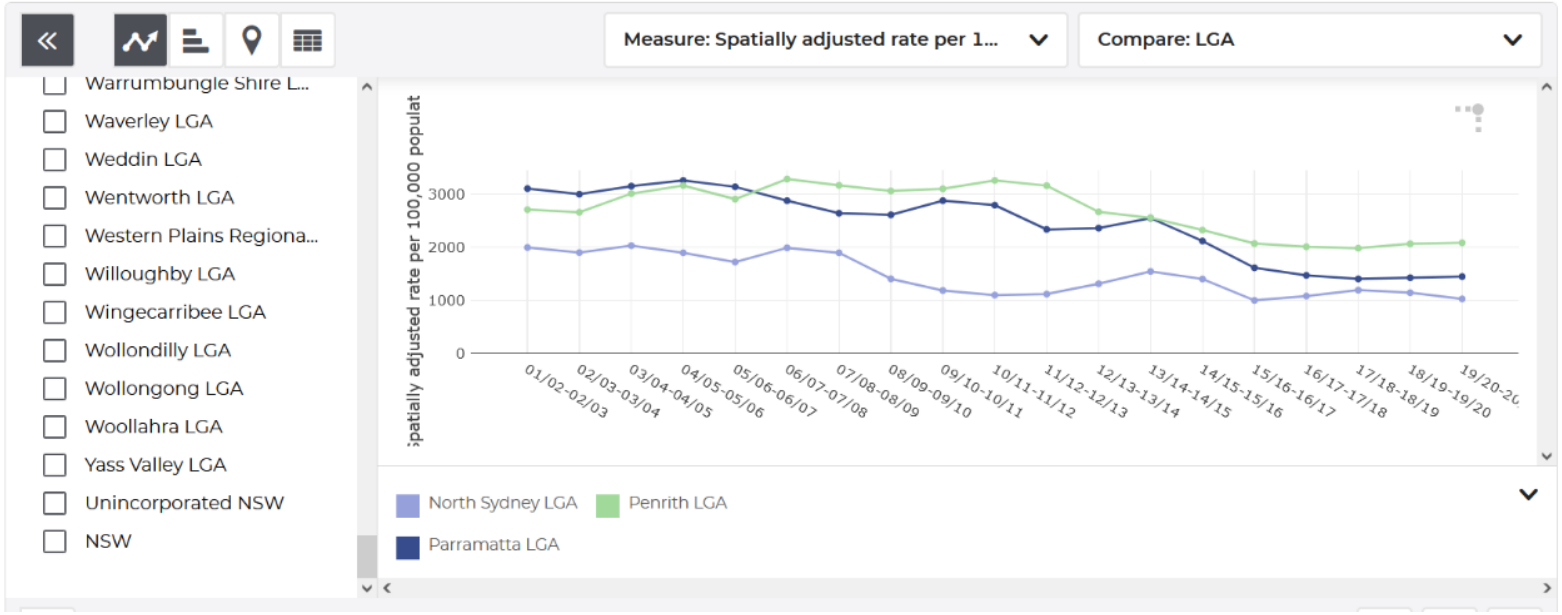
Overweight and obesity attributable deaths

by LGA



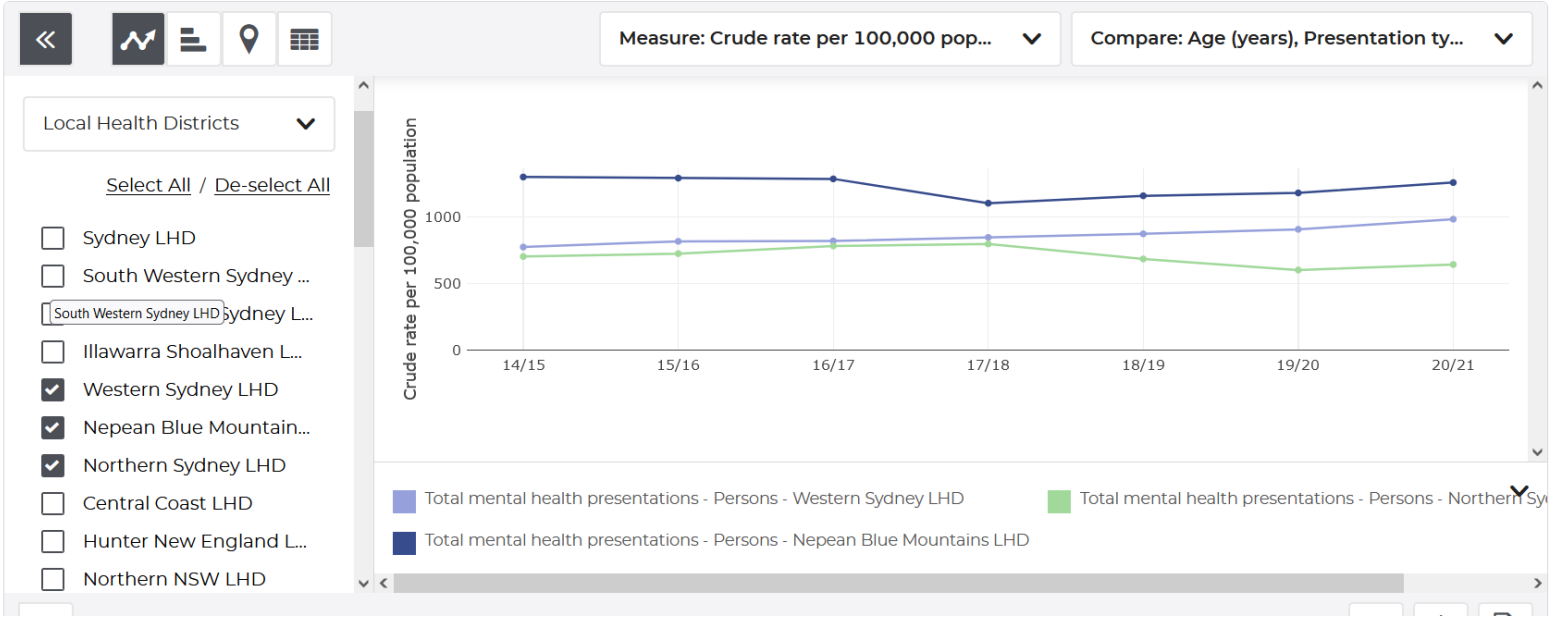
Dementia hospitalisations (aged 65 years and over)

by LGA



Mental Health related Emergency Department visits

All ages for Total mental health presentations and Persons by LHD

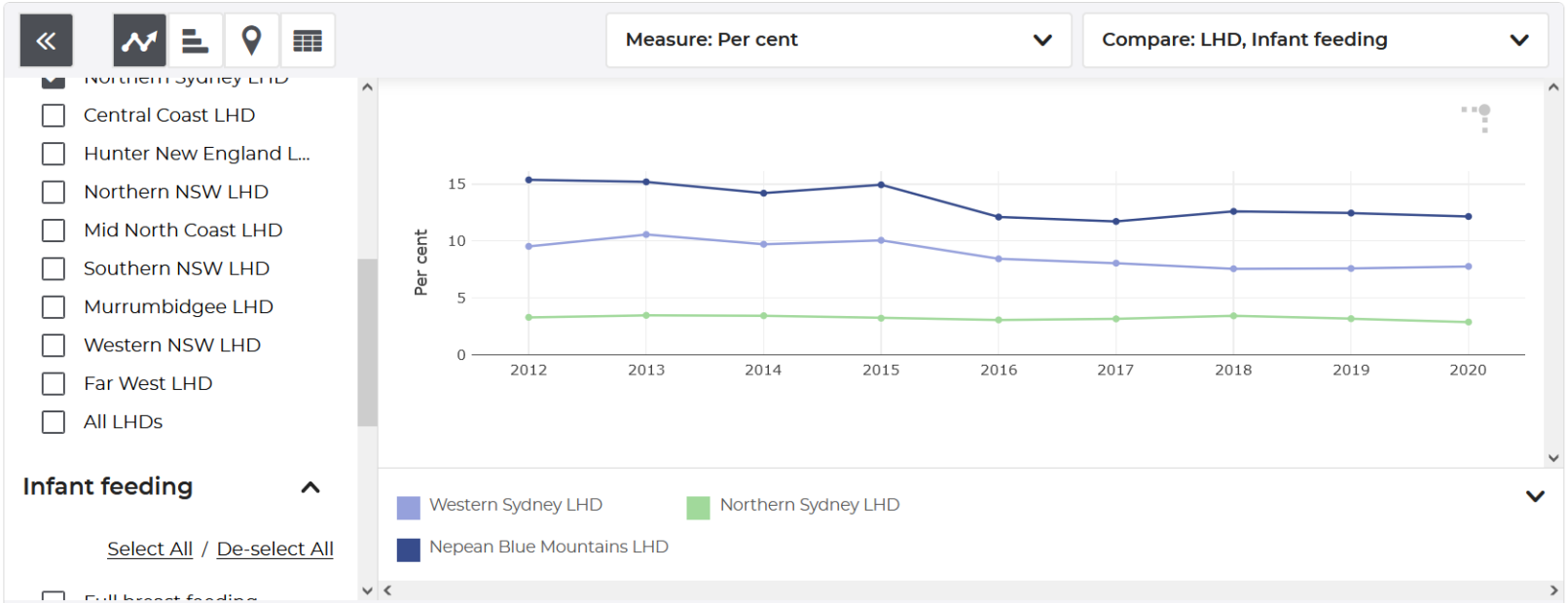


Baby discharge status

by Baby discharge status and Mother's Aboriginality

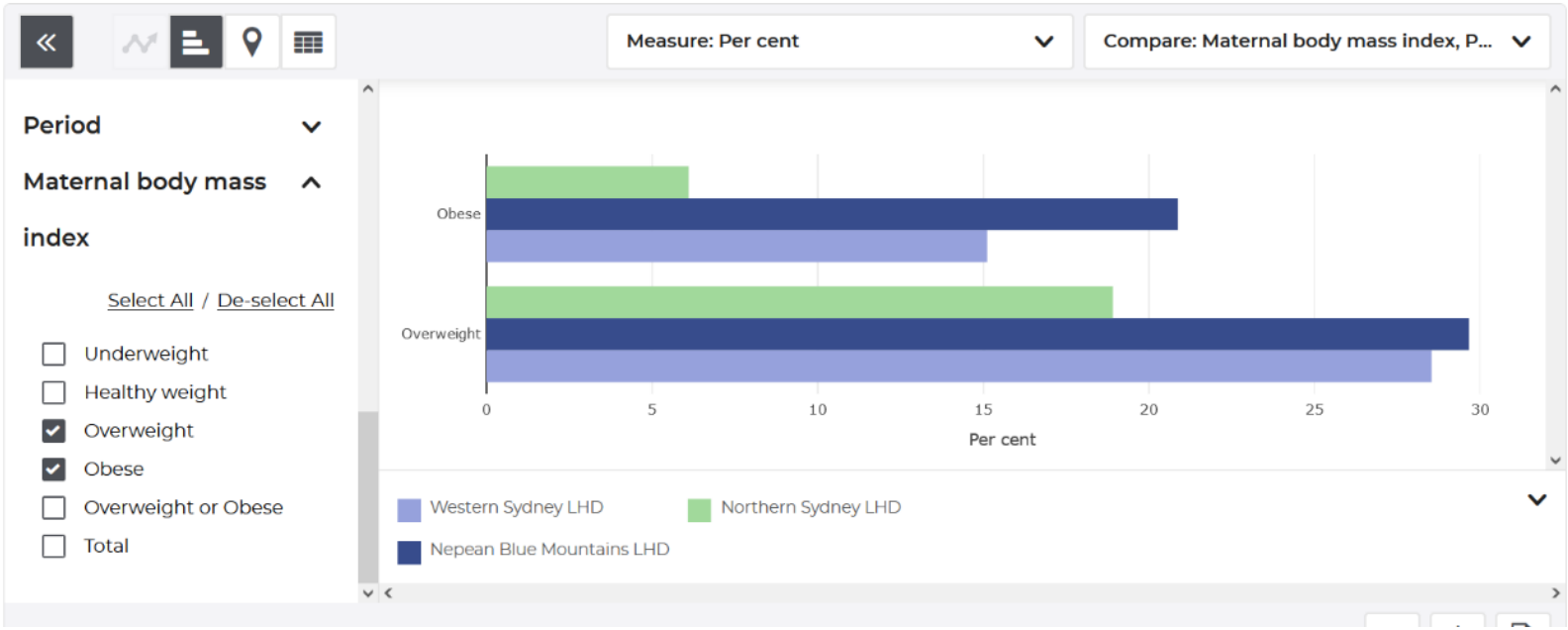
Infant feeding at discharge

Infant formula only by LHD



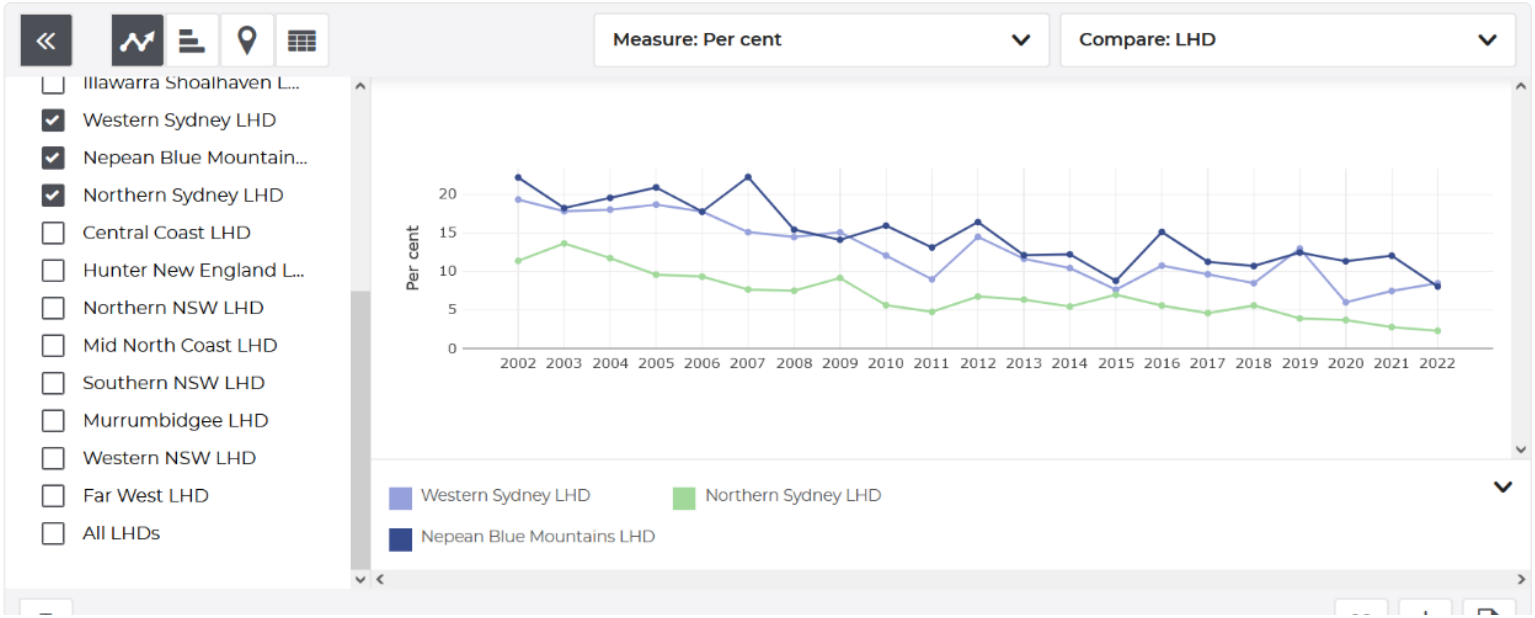
Maternal overweight and obesity

by Maternal body mass index for 2020 by LHD



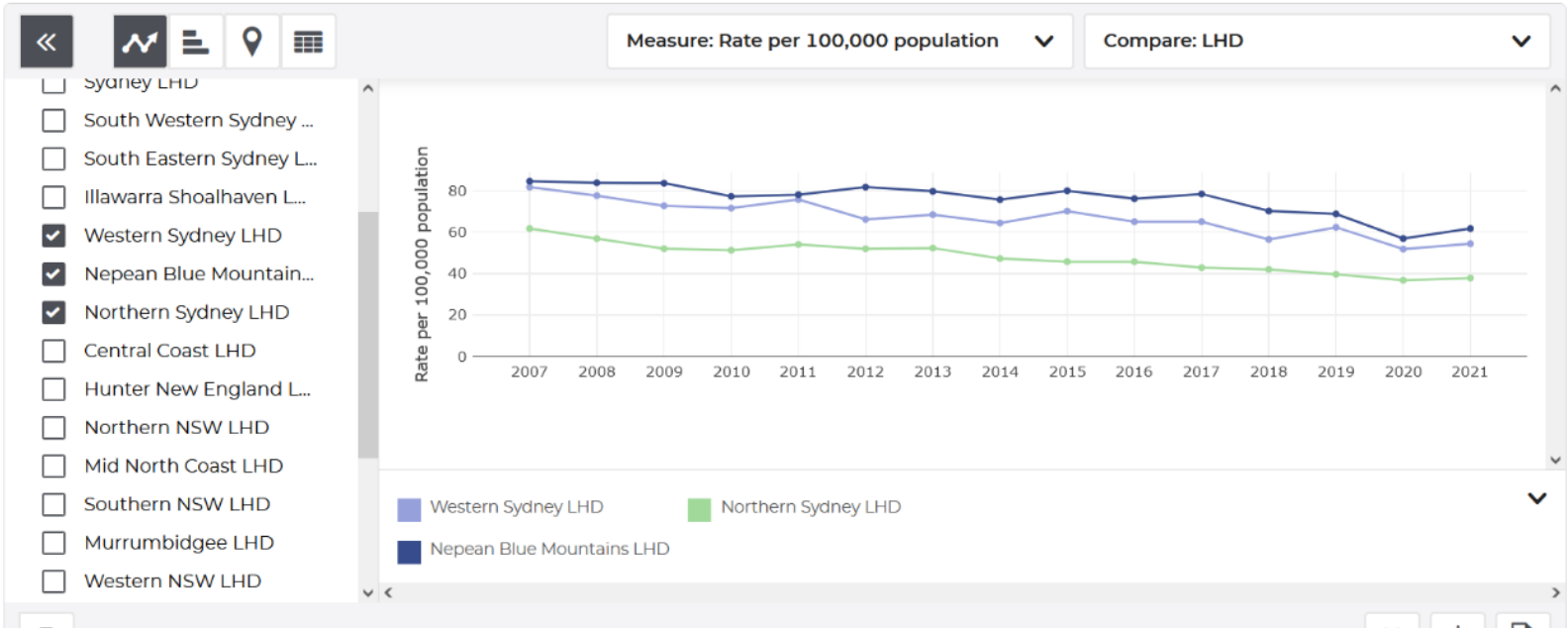
Daily smoking in adults

by LHD



Smoking attributable deaths

by LHD



A/Prof James Mallows

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'Not what emergency care is about': Major funding shake-up for NSW hospitals

'Incentivised price gouging': The private companies making millions off doctor shortages

NSW government promises crackdown on 'unsustainable' cost of temporary doctors

A record number of patients wait in our EDs. Can NSW's hospital crisis be solved?

There has been a lot of talk about staffing, temporary and locum doctors, price gouging by locum companies, and the resultant blowouts of the health budget. Unfortunately, much of this has been caused by years, if not decades, of hospital funding models that pay no attention to any kind of equitable funding, and therefore staffing, across the health system.

There are not enough doctors to staff all the hospitals in the state. However there is gross inequity in hospital staffing, with many hospitals being fully staffed but other hospitals having significant numbers of vacancies. To keep services operating, hospitals are doing everything they can to maintain staffing, and part of this includes paying locum rates, often at short notice for critical vacancies. There are a number of reasons why we have ended up at this point.

Doctors are like anyone else. They want to live close to where they work. In medical school, they gravitate toward the hospital they are training at. Often, they pick a hospital close to where they are living in the first place. The newly graduated intern then aims to work at the hospital they trained at. As their career progresses, they stay at that home hospital as much is possible in whichever specialty they finally choose as a career path. For this reason, after spending years training and then working at the same hospital, they would invariably live close to where they worked.

There is a well-documented shortage of doctors in New South Wales. The cause of this is multifactorial. Hospitals have expanded to meet increasing workloads. The "tsunami" of medical graduates 10 years ago led to hospitals expanding to cope with the extra interns. However, once the tsunami dissipated, intern numbers dropped but hospitals stayed the same size. Covid put a stop to the steady stream of overseas trained graduates employed in the health system, notably UK graduates. University places in medical school have not kept up with the forecast demand. New South Wales has the lowest base salaries for medical officers in the country, causing an exodus of doctors leaving to get more money elsewhere and reducing the number of doctors who see New

South Wales as a destination for their medical career. Other countries are paying large amounts of money to attract their citizens back to work for them, leading to an exodus of internationally trained graduates and overseas medical students. Doctor shortages are not just state or nationwide.

The population centre of Sydney is very close to Westmead Hospital. If you draw a line north-south through Westmead Hospital, this line will largely divide the Sydney population in two, with half residing east of Westmead Hospital and half residing to the west. There are 15 hospitals to the east of this line, and 8 hospitals to the west serving the same population. This imbalance has led to severe geographical inequities with regards to medical staffing and resources. Having previously been in charge emergency department recruitment for 10 years, we have a phrase at Nepean Hospital: “vacancies travel west”. When doctors move from west to east to find their preferred location of employment, the vacancies therefore move from east to west. Whether it be junior medical officers working in hospitals, community GPs, or medical and surgical specialists, the western parts of Sydney are severely shortchanged compared to their eastern counterparts.

And to support my colleagues in the far west of the state beyond the Blue Mountains, the situation is similar if not worse. I worked for a number of years for CareFlight, supporting the helicopter retrieval base at Orange. Working there, I learnt the term the “sandstone curtain”, which referred to the Blue Mountains and the fact that hospitals in the far west were seemingly hidden from sight. Hospitals routinely rely on locum staffing, either as a formal semipermanent relationship, for example surgeons, obstetricians and anaesthetists flying in to support a regular service, or to staff critical shifts at short notice. There are health services that would otherwise close if they did not have a doctor. Economic theory mandates that with increased demand comes increased cost.

For example, whenever there is talk of poor Emergency Department performance, long waiting times, ambulance ramping and overcrowding, the 3 hospitals mentioned in the same breath are Westmead, Blacktown and Nepean hospitals. These 3 hospitals are routinely at the bottom of any Emergency Department performance reports and KPIs. Although the 3 hospitals will have different potential causes for this, the ultimate root cause is a lack of resources and staffing.

It is well known in emergency medicine literature that the cause of ED overcrowding, ambulance ramping and access block is a lack of inpatient ward bed capacity. There are not enough beds on the wards, admitted patients wait in the ED for prolonged periods before getting to the ward, the ED becomes overcrowded, and the massive inefficiencies caused by a sheer lack of physical space to see new patients causes predictable blowouts in waiting times and potentially quality of care.

Is it then any wonder that the performance of Westmead, Blacktown and Nepean hospitals is poor compared to other hospitals in the Sydney metropolitan area. Nepean Hospital currently has a

significant number of vacancies in all specialties and at all levels. There are no permanent staff available to fill these vacancies.

Every doctor in the state has a full-time permanent job if they want one. However, doctors often choose not to have a full-time permanent job. They may be part-time because of family commitments, training commitments, or maybe because they are having a gap year to avoid burnout, an increasingly common phenomenon especially amongst junior doctors about to commence training or at the end of their training and not surprising considering their 7 to 8 year medical degree.

Doctors are also not working excessive overtime. Having graduated in the mid-90s, there have been times in my career that I have routinely worked 60 to 80 hour weeks. I have worked 24 hour shifts, which would often turn into 32 hour shifts because you would still work a day shift the next day. Although there are junior doctors working these kind of rosters currently, it is fortunately almost a thing of the past. Working less hours means the doctors are healthier and happier, and patients are better looked after.

However overtime was always seen as a way of buffing one's income. Working a mid-week 16 hour shift would give you 8 hours of overtime including 6 hours of double time. Working an extra shift on the weekend would also give you double time. Increasingly, overtime is restricted, firstly because of doctor and patient safety, secondly because of health budget pressures, and thirdly simply because hospitals have enough staff and overtime is not required to cover inpatient rosters.

Locum shifts offer the opportunity for junior doctors and trainees to earn money that they are not able to earn at their home hospital. Second jobs are almost becoming the norm, and this is no different for junior doctors. They can work a 40 hour week at their home hospital and pick up a locum shift on the weekend to generate extra income that is otherwise not available. Some doctors working part-time pick up extra locum shifts when their life allows, as it is more cost and time effective to work part-time in a salaried position and pick up locum shifts to fill the income shortfall.

Junior doctors are not necessarily holding out for higher rates. They are making a decision based on the financial reward of doing a locum shift versus the personal cost of doing this shift, which usually includes a long drive often out of hours, and the opportunity cost of missing out on a day off. You may not do a shift for $80 per hour, but when the price goes up to $120 per hour, it is tempting to make a different decision. This is an economic reality.

Locum agencies are simply the middlemen. Just as real estate agent numbers bloom during a property boom due to increasing commissions, so to have locum agencies bloomed in times of a

health system staffing crisis and the need for hospitals to rely increasingly on locum staff. 15% is not an onerous commission for locum agencies. In fact 15% is probably a realistic commission for any employment agency, whether it be medical or otherwise. A number of carers agencies working through the NDIS charge similar commissions.

The fundamental reason why locums have become a solution to the staffing crisis is the fact that there are hospitals that are much better staffed, with no vacancies, with doctors working minimal or no overtime, versus hospitals with inadequate staffing, with large vacancy numbers and doctors working significant amounts of overtime. In this setting, health policy and funding models have largely led to the locum model of staffing being the solution to staffing problems in these hospitals.

What is required is a recalibration of staffing levels of various hospitals, with the ultimate aim of equalising doctor numbers. This will ultimately lead to equitable staffing, equitable rosters, equitable patient care, equitable achievements of standard hospital KPIs such as emergency department performance and elective surgical waiting lists, and equitable financial performance. Focusing on a symptom of the disease, such as the proliferation of locum work and locum agencies and the cost blowouts this has generated, will only lead to poor health policy and funding models.