

## Submission to the Select Committee on Health 2015

This Standing Committee has been established to inquire into and report on health policy, administration and expenditure, with particular reference to various matters. This submission will address several of them.

### **About the author**

I speak from the perspective of a specialist Consultant Physician and Clinical Pathologist who worked in private consultant practice in Northern Sydney for 16 years between 1982 and 1998, then in consultant practice based at the Broken Hill Health Service from 1999 to the present.

Prior to moving to Broken Hill I was a member of the AMA (NSW) Executive for 6 years; Chairman of Council for 2 years. Since moving to Broken Hill I have served as the Chairman of the Greater Western Area Health Advisory Council from 2004 until 2010, Chairman of the Far West Local Health District Board. I am currently Chairman of the Board of NSW Health Pathology.

### **Issues raised**

- a The impact of reduced Commonwealth funding for hospital and other health services provided by state and territory governments, in particular, the impact on elective surgery and emergency department waiting times, hospital bed numbers, other hospital related care and cost shifting;**

The reduction in Commonwealth funding for hospitals started far before the election of the current Government.

Cost-shifting is due to the failure over the decades for Commonwealth and States to agree upon the proper apportionment of costs for hospitals and primary health care activities. Until consensus is reached, cost-shifting activities will continue, with ever-increasing complexity and resultant waste.

A larger proportion of primary care activities in the Far West Local Health District (LHD) are provided by the NSW public health system than in other NSW LHDs. This is a result of workforce issues, poor financial viability of private medical services and the vast areas the Far West LHD covers. As a result, much of the Far West LHD's budget is consumed by activities which would normally be underwritten by the Commonwealth through Medicare.

- b The impact of additional costs on access to affordable healthcare and the sustainability of Medicare;**

No comments.

- c The impact of reduced Commonwealth funding for health promotion, prevention and early intervention;**

Health promotion and preventive health care are low-cost investments which take a long time to show measurable outcomes. The health of a community depends very much on social factors such as education, employment, housing and entrenched health behaviours such as alcohol, tobacco and illicit drug use. It is very obvious that these drivers of health deteriorate the further a community is away from a Capital City.

The result is the well-documented rises in rates of metabolic diseases, heart and lung diseases and late diagnosis of cancer seen in rural and remote communities. Disinvestment in health promotion and preventive care is as short-sighted as neglecting the other social drivers of health.

- d The interaction between elements of the health system, including between aged care and health care;**

Even in the city of Broken Hill, which has a single hospital and a single Aged Care provider, interaction between hospital and Residential Aged Care Facilities (RACFs) is disjointed. Workforce issues result in lack of out-of-hours medical cover for RACFs here, so the nursing staff at the RACF are obliged to transfer many patients to our Emergency Department. This can be bewildering and painful for the patient. It seems cruel and unjust if the problem could have been sorted out in the RACF. Return to the RACF from the

hospital can be delayed by many days due to the lack of Registered Nurse cover after hours and on weekends.

Electronic medical records remain disintegrated between hospital, RACFs and general practices. The Personally Controlled Electronic Health Record (PCEHR) offers a solution to this lack of integration, but uptake of the PCEHR is as poor here as in other parts of the country. This author recommends changing enrolment onto the PCEHR to an 'opt-out' method. This would allow us to see how the PCEHR lives up to its promises.

## **e Improvements in the provision of health services, including Indigenous health and rural health;**

### **Workforce maldistribution**

Much on the subject of rural health has focused upon General Practitioner numbers. Workforce maldistribution is much worse with medical specialists. The 2012 *Senate Community Affairs Reference Committee inquiry into the factors affecting the supply of health services and medical professionals in rural areas* demonstrated that the number of specialists employed in Outer Regional areas such as Broken Hill was less than a fifth the number per head of population compared to major cities. For GPs the proportion was almost the same. (See Table 2.4, page 10 of this report).

The real workforce figures are probably worse than this. Most of our medical specialists maintain their homes in cities and fly in and out, either on a daily basis or for 1-2 week periods to staff the out-of-hours roster.

### **Cost of providing specialist services in Outer Regional areas**

The Australian Medical Association has shown how the gap between the Medicare Benefits Schedule fee (and therefore rebate) and the true cost of providing the service has failed to keep pace with all measures of inflation over the years. For example:

"Since 1985, annual indexation of the Medicare Benefits Schedule (MBS) has been below the market indices that have a direct impact on the cost of providing medical services – the labour price index and the consumer price index. This has resulted in a 40 per cent decline in the real value of Medicare fees, to which Medicare rebates are aligned." <https://ama.com.au/ausmed/gps-tight-spot-medicare-gap-widens> published 29 July 2013.

Like most regional centres our size or smaller, the only specialist consulting rooms are at the hospital. Members of the public expect no out-of-pocket charges when attending a public hospital. The gap between the Medicare benefit and the real cost of providing the service is thus borne by the hospital, with or without the help of Commonwealth-funded rural specialist outreach 'funding' programs.

These gaps in funding cripple our hospital's budget. The specialists who fly in and out for a day expect to earn at the same rate as they would in their home practice, including travel time. I will use the example of cardiology to illustrate this.

The hospital's contract with Adelaide Cardiology (a corporate group owned and operated by GenesisCare) cost the Health Service more than twice as much as it was able to re-coup from Medicare rebates when I served on the Far West LHD Board. The Rural Specialist Outreach Assistance Program and its successor the Rural Health Outreach Fund came nowhere near making up the shortfall. This is a cost which had to be borne by the health service if adequate specialist cardiology services were to be maintained. Given the indexation of the contract fees, not matched by proper indexation of Medicare rebates, this situation will have worsened each year since then.

Many of our other specialists are in fact itinerant workforce, retained through 'locum' agencies. These short-term visitors cost at least \$2,000 per day (for confirmation, see

[www.medrecruit.com](http://www.medrecruit.com)), plus travel, accommodation and use of a hospital car for their entire stay, on top of which go the agency's fees. To convert these short-term appointments to permanent appointments, the specialist not only expects the same pay and conditions, but the agency also expects to be paid a lump-sum recruitment fee.

If Australians living in rural and remote areas are to be provided with equitable health care, these costs must be acknowledged and covered. As the issue is a nation-wide one, the Commonwealth is responsible for the solution.

### **Improvements in Pathology Services**

NSW Health Pathology has recently introduced a managed Point of Care Testing (PoCT) system for all public hospitals in NSW lacking a pathology laboratory which is staffed around-the clock. This is the largest managed PoCT enterprise in the world. The result is that laboratory information needed urgently for patient care is available in a timely, accurate and affordable way. This author recommends its adoption throughout rural and regional Australia.

The Commonwealth should resist pressure from General Practitioners to have PoCT funded in their own practices. NSW Health Pathology and Pathology Queensland have confirmed that the following are essential if PoCT is to be reliable and cost-effective:

- The instruments should be regularly calibrated and quality-controlled;
- The instruments should be linked into the laboratory information system, to ensure that a permanent record of the result is maintained and available, and
- The instruments must be used by properly-trained operators subject to regular re-accreditation.

**f The better integration and coordination of Medicare services, including access to general practice, specialist medical practitioners, pharmaceuticals, optometry, diagnostic, dental and allied health services;**  
See above comments concerning the PCEHR.

**g Health workforce planning;**

See above comments concerning medical specialists. Funding for regional centres must be properly weighted to take these factors into account. We cannot force medical specialists to work in rural and remote areas, but we can certainly prevent them from doing so if the hospitals cannot afford them.

Fixing this inequity in funding for the small number of regional health services which require specialist services on the ground will not cost a lot, but will vastly improve the viability of the local hospitals.

**h Any related matters.**

Community-based screening for abdominal aortic aneurysm

In 2002, the hospital's Death & Complications meetings noted that there was a steady number of cases of local men dying as a result of abdominal aortic aneurysm (AAA). This is unsurprising. AAA is a degenerative condition of the great vessel running through the back of the abdomen, resulting in a weakening of the wall in this vessel. It is known to occur in 4.9% of men over the age of 65 years who have ever smoked. If this weakened vessel wall develops a leak, the person has just hours to get to a hospital equipped with a vascular surgical operating suite so that it can be repaired; even then survival rates are low. If it ruptures, the patient almost always dies.

Broken Hill is 500Km from the nearest vascular surgical facility. Nobody with either a leaking or a ruptured AAA is likely to survive. Community screening Had already been shown to be able to pick up silent AAAs. The British MASS study had demonstrated that, even using the old open technique for repair, screening for silent AAAs saves lives. In Australia several community-based screening studies had been reported but unrefined screening is not underwritten by Medicare rebates. A Solution Group was set up after this issue had been taken to a community Round Table meeting. Within 4 years, the Triple A Initiative had raised sufficient funds to commence community-based AAA screening.

The first screening round, undertaken in 2007, was coordinated through the Broken Hill University Department of Rural Health. Analysis was funded by a grant from the NSW Institute for Rural Health Research. The results were reported in the Australian Journal of Rural Health as follows:

“A total of 516 men without a previous diagnosis of AAA were screened, an estimated response rate of 60%. Of these, 463 (89.7%) had a normal aortic diameter, 28 (5.4%) ectatic and 25 (4.9%) a small, moderate or significant aneurysm. Two men with AAA were recommended for surgery.”

Since then, community-based AAA screening programs have been introduced in the USA, UK and Sweden. Community-based screening was recommended for Australia in 2009, but has yet to be implemented. Most diagnosed AAAs are now repaired by the minimally-invasive technique of endovascular aneurysm repair.

Last year the Triple A Initiative agreed to offer another round of AAA screening to men who have turned 65 years of age since 2007. The Commonwealth Dept of Human Services agreed to mail out invitations using the Electoral Role. The Far West Medicare Local coordinated appointments for those men who telephoned in to accept the invitations.

Over 450 men have arranged to attend for screening. In the last two weekends of May, 190 of these were screened, revealing two significant aneurysms and 24 dilated aortas. The remainder of those who booked in will be screened within two months.

This means that Broken Hill is probably the only community in Australia to have offered AAA screening to all men who turned 65 years of age during the last 17 years. This was totally funded by the Broken Hill-based Triple A Initiative.