



Save Our Hospital Incorporated

ABN 41 974 891 175

30 August 2010

The Director-General  
NSW Department of Health  
Locked Mail Bag 961  
North Sydney NSW 2059

Dear Professor Picone,

**Re: Health Reform in NSW – Proposed Southern NSW Local Health Network**

Our association welcomes the opportunity to make a submission in response to the *Discussion Paper on Implementing the Federal Government's 'A National Health and Hospitals Network for Australia's Future' in NSW*, which is available on your department's website.

Mindful that you and your department have been conducting information forums on National Health Reform at selected sites throughout NSW since 31 May 2010, but none in the south-east beyond Queanbeyan and Nowra, we and the local community on the far south coast are profoundly disappointed at being denied an opportunity to attend a similar forum which, earlier this month, you offered to arrange in response to my request, but which has not yet eventuated. I refer to your email of 02 August and my email of 03 August accepting your offer. It was hoped either you or your senior staff could explain these very important reforms to the community, in which they have a vital interest, as well as answer questions, in sufficient time to enable any group or individual to make an informed and meaningful submission regarding the *Discussion Paper* to your department by the 01 September 2010 deadline. We and the community rightly feel we have been ignored and marginalised.

As a not-for-profit, apolitical and community-based organisation, our association's primary objectives include securing superior health services in the Bega Valley Shire, and we are particularly concerned as to the impact the proposed Southern NSW Local Health Network (LHN) will have in this locality.

To illustrate the legitimacy of our association's objectives and strength of public sentiment and support, in 2009 a petition by 22,062 signatories requesting the restoration of services at Pambula District Hospital was presented to the NSW Parliament.

For the reasons stated in this submission, we believe the proposed Southern NSW LHN is neither appropriate for this locality, nor can it in any sense of word be described as *local* or compliant with the intent of the National Health and Hospitals Network (NHHN) Agreement.

## **NHHN Agreement**

A key aim of the NHHN Agreement is the creation of LHNs to decentralise public hospital management and increase *local* decision-making to better meet *local* needs. Localising planning, management and control of health service delivery is therefore at the heart of national health policy, and this was clearly the unambiguous intention of the Federal Government when the Prime Minister at the time, the Hon. Kevin Rudd MP, while delivering a keynote speech at the University of Queensland Centre for Clinical Research on 12 April last said, *inter alia*:

“The system that we currently have ..... often leaves key decisions in the hands of bureaucrats far too remote from the communities that health professionals serve. It is built around institutions and hospitals and not around the needs of patients....”

In relation to the new national LHN model, he continued:

“.....one that is funded nationally and run *locally* (my emphasis) .....Local Hospital Networks will deliver the services most appropriate to their communities. They will reflect local clinician knowledge and expertise. These clinicians, together with local nurses and allied health professionals, will have a core and expanded role in the local governing councils of local hospital networks. We want local needs to be reflected in the decisions taken .....They actually know how to better deliver health services within their communities.”

### **What is Local?**

We contend the word *local* means exactly that - *local*. For instance, the Macquarie Dictionary 5<sup>th</sup> Edition 2009 defines *local* as “4. Relates to a town or a small district ...” and *local government area* as “A city, town, shire, district, municipality or borough.”

The proposed Southern NSW LHN is nothing more than a regional network of health services and hospitals, covering a vast rural inland and coastal catchment of 44,545 km<sup>2</sup> which includes 10 local government areas, a population of about 196,269 and 16 hospitals/MPS/community health centres. To describe the proposed LHN as *local* is a misnomer; indeed, it is deceptively misleading.

### **Implications for the Governing Council**

There is a close correlation between the size of the proposed Southern NSW LHN catchment and the effectiveness of its Governing Council. Given the catchment’s spatial, geographic, demographic and variable climatic characteristics and cultural/economic diversity, efficient and effectual governance will be seriously challenged, if not rendered futile altogether.

We contend the proposed Southern NSW LHN Governing Council of 9 to 13 members will not adequately or fairly represent a constituency of close to 200,000 people over almost 45,000km<sup>2</sup> that is poorly served with public transport and that sits astride of the Great Dividing Range. Given these circumstances, it is really stretching the bounds of credulity to expect such a Governing Council to effectively connect with local clinicians and communities, or meet their needs, and deliver health services equitably or efficiently.

In fact, we are well aware of examples where the tyranny of distance meant that most of the communication and decision-making between parties in the old Southern Area Health Service had to take place by teleconference. This led to disjointed discussion where less than satisfactory outcomes occurred, compared with ‘face-to-face’ meetings.

The importance of the role local communities will have in determining the nature and extent of local health services was emphasised recently during a local media statement by the Federal Member for Eden-Monaro, Dr. Mike Kelly AM MP, in response to community agitation for the restoration of all services (including maternity) previously withdrawn from Pambula District Hospital by the Greater Southern Area Health Service. Dr. Kelly said, *inter alia*:

“My view is that the services provided at Pambula Hospital should reflect the needs of the community that it services. Under the federal government’s local hospital plan, communities will be empowered to make decisions over the services that best suit their needs through the local Clinical Councils that will be set up.....I definitely see an increased role for community participation in our health care services.”

While Dr. Kelly’s highly principled view of community inclusiveness in decision-making is to be applauded, for reasons explained earlier the size and composition of the proposed LHN for Southern NSW, if unchanged, will make the Governing Council’s mission impossible and will not achieve the much promised better health outcomes.

What is more, we apprehend the governance model proposed will become a centralised organisation, which is expected to be sited at or near Queanbeyan, some three or more hours drive from the southern part of the LHN. One could be forgiven for thinking that this will be a resurrected and refashioned Southern Area Health Service, which merged with the current Greater Southern Area Health Service in 2005.

The fact is that the former Southern Area Health Service was obliged to have in place an extensively devolved management structure just to deal with the size of the Area. There were Area Managers, Sector Managers, Division Managers, and of course Local Managers. Along with this were the various Area Clinical Groups like the Area Medical Staff Council, Area Radiology, Area Obstetric Committee and so on, all of which then had meetings (usually by teleconference after hours) with minutes to be taken and distributed. All of these levels of management and various meetings require a level of additional supportive infrastructure and reduce the availability of resources, which are better directed towards actual patient care.

It is simply not possible for any Governing Council to have local knowledge to effectively give a voice to local communities. Just like the former Southern Area Health Service, it will be necessary to create Local Health Advisory Groups to provide advice to the Governing Council. These local community structures will have no power and are just another layer in the bureaucracy.

Returning to the NHHN Agreement, we do not see the proposed Southern NSW LHN as compliant with that Agreement, a key aim of which - to reiterate - is to decentralise public hospital management and increase *local* decision-making to better meet *local* needs.

In the next section of this submission, an alternative and superior model of a LHN and Governing Council is recommended.

## Alternative Model

To ensure a more efficient, effective and equitable model of health service delivery and governance, we strongly recommend the boundaries of the proposed Southern NSW LHN be amended to provide for the creation of an alternative model for the NSW far south coast, to be called the NSW Far South Coast LHN, which will include five existing hospitals, namely, Batemans Bay, Bega, Bombala, Moruya and Pambula, and the proposed new hospital at Bega to replace the existing when it is built.

Significantly, in the Bega Valley Shire both Bega District Hospital and Pambula District Hospital are recent beneficiaries of major capital investments in health infrastructure. For example, Bega recently received a \$2 million upgrade with the establishment of a much needed 6-bed mental health ward. This enhancement will benefit patients in both the Bega Valley and Eurobodalla Shires by obviating the need to routinely transfer such patients to Goulburn. At Pambula, on 09 August the Minister for Rural and Regional Health, the Hon. Warren Snowdon MP, and the Federal Member for Eden-Monaro, Dr. Mike Kelly AM MP, announced that the Federal Government will invest \$300,000.00 to upgrade the hospital's air conditioning system, which will service its operating theatre, recovery and sterile stock storage areas, and a further \$35,000.00 to purchase a heart monitor and mechanical ventilator to provide assisted breathing for patients requiring emergency care. In particular, the air conditioning upgrade at Pambula will facilitate the start of a new ophthalmology service, with patients not having to travel to Canberra or Batemans Bay for ophthalmic treatment.

The pivotal role of Pambula District Hospital in the provision of health services in the Bega Valley Shire was underscored recently by an announcement on 20 August at Pambula by the NSW State Opposition Shadow Minister for Health, Mrs Jillian Skinner MP. Mrs Skinner announced that if the State Opposition were elected to Government next year, a new maternity service model embracing both Bega and Pambula hospitals would be implemented, including reinstatement of full maternity services at Pambula that were withdrawn by the Greater Southern Area Health Service in 2008.

Greater synergies, economies of scale and more meaningful local community engagement can be achieved, for example, by combining contiguous local government areas on the far south coast. The local government areas in question are the coastal shires of Bega Valley and Eurobodalla and south-west hinterland of Bombala. In reality, the communities in these closely and geographically linked areas form a 'natural community'.

The Bega Valley Shire is, geographically, the largest local government area on the NSW coast. The shire spans 6,280 km<sup>2</sup> and includes a permanent population of 33,481. By contrast, the Eurobodalla Shire covers a smaller area of 3,422 km<sup>2</sup>, but has a larger permanent population of 37,442. Bombala Shire has a larger area than Eurobodalla at 3,944 km<sup>2</sup>, but its permanent population is significantly smaller at 2,601.

Starting at the NSW-VIC border and extending 268 km north by road to Batemans Bay, the coastal Shires of Bega Valley and Eurobodalla have not only close geographical links, but common cultural and economic interests, and are much sought after retirement locations experiencing continued growth ('sea-change' phenomenon). For instance, population growth in the southern part of the Bega Valley Shire in particular is expected to reach 28,000 by the year 2030 according to the report on *Hospital and Health Care at Pambula* by Dr. Bill Coote and Emeritus Professor Wolfgang

*Kasper (May 2010)*. This report is not prescriptive, but a compelling and authoritative review of existing health services in the southern part of the Bega Valley Shire and makes suggestions to promote intelligent and informed debate. A copy of this report is attached.

Besides rural production and commercial fishing, tourism is a major source of income to both shires, with their population more than doubling at peak holiday season. For instance, visitors to the Bega Valley Shire reach about 500,000 annually, with the overwhelming majority visiting the coastal corridor. We understand the visitor numbers to Eurobodalla's coastal corridor for the same period would be greater.

While not coastal, Bombala is much closer and more accessible to the coast than any other inland town on the Monaro. In particular, it has a historically close relationship with the far south coast based on economic, cultural and recreational factors as well as retirement considerations, especially the towns of Eden, Merimbula and Pambula and, to a lesser extent, Bega and continues to do so. Indeed, a Merimbula-based GP obstetrician regularly visits patients in the Bombala Shire.

In our recommended model we also envisage inclusion of the cross-border small coastal towns and popular holiday centres of Mallacoota and Genoa, which are among the few most isolated towns in VIC. They have a combined population of ca. 1400 permanent residents, but which increases considerably during holiday periods. Indeed, with the influx of visitors during Easter and Christmas/New Year the population soars to ca. 8,000.

Given that area's isolation, residents and visitors avail themselves of the nearest shopping and banking facilities at Eden and health services at Pambula Hospital. The nearest VIC public hospital is at Orbost, some 144 km distant from Mallacoota over mountainous terrain. As stated earlier in this submission, there is a close correlation between the size of a LHN catchment and the effectiveness of its Governing Council.

Our association rejects the proposed methods of selection of the Governing Council, which are both unrepresentative of local needs and undemocratic and will do nothing to increase community participation in our local health care services, contrary to the objective of the NHHN Agreement.

The model proposed in the *Discussion Paper* is for a chairperson to be appointed by the Minister accepting the recommendation of NSW Health. The chair then appoints a selection committee, which in turn nominates members of the Governing Council, for approval by the Minister.

In our opinion this is a top-down, bureaucratically controlled structure which will produce the same negative results as the current thoroughly discredited Area Health Services and their ineffective 'advisory bodies,' which have produced reductions in our local health services and worse health outcomes for our rural/regional patients.

We strongly recommend an alternative process of selection of the LHN Governing Council, whereby each individual hospital community nominates and elects a local *pro bono* community hospital board.

In consultation with the chair of the Governing Council, each local board will nominate one clinical and one community member to represent its interests on the Governing Council.

For the five local hospitals in our recommended LHN model, we propose that the Governing Council comprise 14 members, to include the chair, five clinical and five community members, and three Shire councillors. Shire representation would be based on each of the three Shires nominating one councillor. The Governing Council could be established at either Moruya or Bega, but meet at any venue in the LHN as it chooses.

This selection process would permit local boards and local councillors to bring local health service needs directly to the Governing Council. Equally, it would empower local communities to communicate local health needs more effectively and to receive direct local feedback on the operation of the Governing Council.

In summary, the NSW Far South Coast LHN model we recommend includes an area of 13,646 km<sup>2</sup>, with a permanent population of 73,524 and five hospitals. Extending the catchment to include the cross-border coastal communities of Mallacoota and Genoa, the total permanent population rises to ca. 74,924. However, as noted earlier, during peak holiday periods the population of coastal communities in particular increases exponentially, creating significant demands on an already, severely strained local health service, but these conditions are expected to improve when the proposed new hospital in Bega is constructed and all services at Pambula District Hospital are returned.

## **Conclusion**

The NHHN Agreement indicates, *inter alia*, that LHNs may be developed based on unique geographical circumstances, a specific functional focus, or on the basis of logical network linkages or patient catchments. The Agreement also makes abundantly clear that a flexible approach will need to be taken in applying LHN criteria in regional and rural areas with a focus on developing LHN boundaries that best meet the needs of these communities.

We believe that, taking a flexible approach, our recommended model adequately addresses and satisfies the criteria, especially the unique geographical circumstances, patient catchments and long-standing cultural and economic relationships among three closely-linked contiguous local government areas forming a 'natural community,' in addition to the cross-border relationship with Mallacoota and Genoa. What is more, the coastal corridor is a recognised growth area.

The fact that our model does not include a tertiary level hospital should not be fatal to our submission, because there is no compelling rational argument why a tertiary level hospital, like The Canberra Hospital, could not be part of more than one LHN, especially in rural environments surrounding the ACT.

Economies of scale are achievable to ensure administrative overheads are kept to an absolute minimum, so that front-line services are not adversely impacted. However, the 4% of budget threshold stipulated in the *Discussion Paper* is questionable. Although accurate statistics are not made public, a number of informed sources estimate administrative costs in the NSW Health system range between 20 and 40% of budget, which indicates the 4% threshold for LHNs is not at all realistic.

The most effective means of reducing administrative costs is through local management and local community boards, comprising appropriately skilled and experienced individuals drawn from the

community and engaged *pro bono*. Indeed, we believe that in a rural environment or locality such as ours, a locally constituted board for each hospital as described in this submission would be viable and answerable to the Governing Council. Importantly, this arrangement would ensure the Governing Council has a more meaningful and productive relationship with local clinicians and communities in the LHN. In the example of Pambula District Hospital, other cost savings would be achieved by sourcing catering and linen locally, instead of from Wollongong. Further savings could include instrument autoclaving, hospital waste disposal and instrument maintenance.

Patients in rural and regional Australia have the worst health outcomes when compared to patients in capital cities or major regional centres such as Albury-Wodonga, Newcastle or Wollongong. Indeed, the plight of communities in rural and regional areas was highlighted on 23 August 2010 during a press conference by the Prime Minister, the Hon. Julia Gillard MP.

Finally, our recommended model ensures a truly localised LHN that will best meet the needs of communities in this catchment.

Yours sincerely,



Geoff Dove  
**President**

Annexure: 1. *Hospital and Health Care at Pambula by Dr. Bill Coote and Emeritus Professor Wolfgang Kasper (May 2010)*



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