Submission to the COVID-19 Response Inquiry

About Q-bital Healthcare Solutions

Q-bital Healthcare Solutions is a clinical Healthcare Spaces provider, operating a range of mobile and modular clinical facilities, including day surgery facilities, laminar flow operating theatres, decontamination and sterilisation facilities, outpatient clinics, and visiting hospitals to remote regions.

With nearly 25 years of experience as a trusted partner to the NHS and private healthcare providers in the UK, Q-bital facilities can perform the majority of surgical procedures undertaken in a major acute hospital. To date more than 300,000 surgical procedures have been undertaken in Q-bital facilities globally.

In 2023 Q-bital established an Australian manufacturing premises where a fleet of Australian-made, mobile, modular, mixed-modality healthcare spaces can be designed, built, and maintained to Australia's unique compliance and certification standards. This means that Q-bital facilities can be established anywhere in Australia within 10-14 days and are specifically tailored to meet the bespoke needs of any health setting. With existing infrastructure projects in Victoria and Queensland, Q-bital is cementing a crucial role in supporting Australia's health system to meet hospitals maintain targets, improve patient flow and address backlogs.

Q-bital has written two white papers that specifically outline the impact of COIVD-19 on delays and backlogs, and recommendations to address them. In 2021 in collaboration with Bowel Cancer Australia, Q-bital released *The impending bowel cancer crisis: Ensuring bowel cancer doesn't become the forgotten 'C' in the long shadow of COVID-19,* identifying that planning for post-COVID-19 colonoscopy catch-up and ongoing capacity is urgently required.

Similarly, in 2022 Q-bital subsequently released *COVID-19 and the elective surgery backlog: Australia needs a response that cuts it,* identifying that if measures were not taken to address the impact of COVID-19 on elective surgery, half a million Australians could be waiting for treatment in 2023.

Through these case studies, this submission seeks to respond to the following aspects of the COVID-19 Inquiry's Terms of Reference:

1. Key health response measures (for example across COVID-19 vaccinations and treatments, key medical supplies such as personal protective equipment, quarantine facilities, and public health messaging).
2. Broader health supports for people impacted by COVID-19 and/or lockdowns (for example mental health and suicide prevention supports, and access to screening and other preventive health measures).
3. Mechanisms to better target future responses to the needs of particular populations (including across genders, age groups, socio-economic status, geographic location, people with disability, First Nations peoples and communities and people from culturally and linguistically diverse communities).

Colonoscopies and Bowel Cancer Surgeries

During COVID-19, health systems attempted to curb the spread of the virus by suspending services in a number of areas, including screenings, diagnostic procedures, outpatient specialist appointments and elective surgeries.

Many patients also changed their health-seeking behaviour and deferred health appointments, delaying diagnoses and treatment further.

[redacted]

Backlogs in many areas existed before the pandemic and were severely exacerbated by the interruption of services. Logjams at any point in a health system –

even momentary pauses – cascade through the treatment pathway, accumulate over time, and bleed into other areas of service. Health conditions go undiagnosed, untreated and can worsen, requiring additional and more advanced treatment later on.

Prior to the pandemic, it was anticipated that 1.11 million colonoscopies would be performed each year in Australia by 2021, or 90,000 each month. In reality, with the declaration of a global pandemic in March 2020, the number of colonoscopies and sigmoidoscopy procedures performed more than halved immediately, from 56,048 that month to 25,454 in April.[1] Comparing the total national number of services provided from January to September 2020 to the same period in 2019, there were 78,048 fewer procedures.[2] Across Australia, reports in the media confirmed instances of some patients waiting up to nearly three years for this routine but vital procedure.[3,4,5]

Inevitably, disruption to screening and diagnoses results in increased number of later diagnosed or undiagnosed cancers. Referrals to oncology centres also plummeted, with a 40 per cent reduction reported in August 2020 as compared with previous years.[6] Data released in December 2021 by the Victorian Cancer Registry showed a large increase in undiagnosed bowel cancers during the pandemic. For example, in Victoria there was a 17 per cent decrease in bowel cancer detections in the first nine months of 2020.[7]

Studies have long established that delays in screening, diagnostic, and surveillance colonoscopies increase the risk for bowel cancer progression and mortality. Just a four-week delay of cancer treatment is associated with increased mortality.[8]

The number of operations for bowel cancer fell from 1,056 to 883 from March to May 2020. A fall of over 16 per cent. Some recovery of service numbers was observed in June with 938 services, but this was still 11 per cent lower than for March.[9]

This is reflective of what the Cancer Registry referred to as a "break in the chain" for cancer diagnosis.[10] The reduction in surgeries is a direct result of both lockdown measures postponing non-urgent surgeries, but also the smaller number of bowel cancer detections and subsequent referral for surgery. When this happens, and normal services resume, huge demand is placed on operating theatres and other treatment pathways (radiation therapy centres, for example).[11]

Elective Surgeries – the Visible and "Hidden" Waitlists

The example of delayed bowel cancer surgery is just one example of ongoing surgery delays that can be seen through the inordinate growth of backlogs in elective surgeries.

Elective surgeries – including those deemed non-urgent – should not be confused with "not needed". Elective surgery is any surgery that can be delayed for at least 24 hours, but that is considered medically necessary. In this way, as Royal Australian College of Surgeons (RACS) stated in February last year, "Elective surgery is not an optional procedure that a patient or doctor elects to have – it is essential surgery. It is surgery to address often life-threatening conditions and conditions that prevent patients from living a normal life because of severe pain or dysfunction."[12]

The annual growth of elective surgery admissions between 2014-15 and 2018-19 was 2.1 per cent. However, in 2021-22 admissions declined 17.4 per cent on the previous year, and 17.8 per cent since the last reporting period before COVID-19 2018-19.[13]

By applying the annual growth rate of admissions prior to COVID-19 to these years, it can be calculated that the estimated surgery backlog was 306,281 patients; a backlog of five months. In January 2023 the AMA confirmed this figure.[14] It can therefore be estimated that by the end of the 2022-23 reporting period, this will grow to 507,764, or eight months, "if hospitals do not expand their capacity to address this backlog".[15]

The percentage of patients waiting over a year for their surgery had tripled since 2018-19.[16] Among the three most common categories of elective surgery in 2021-22, compared to the previous year nearly 14,000, 13,500 and 12,500 fewer patients were admitted from elective surgery waiting lists to receive ophthalmological, orthopaedic, and general surgery, respectively.[17]

AIHW figures show that 30 per cent of patients requiring a knee replacement waited more than a year in 2021-2022, 20 per cent for hip replacements and 10 per cent for cataract extractions.[18] These are enormous increases compared to 2018-19, where just 6 per cent, 8 per cent and 2 per cent of patients had to wait more than a year.[19] Paediatric surgeries have also been affected. Compared to 2020-21, the number of paediatric surgeries fell by 774, some 8.6 per cent, from the previous year.[20]

Furthermore, these worrying statistics only detail the delays faced by people *on* the waitlist. When the pandemic struck in 2019-20, and GP, screening, and diagnostic procedures were suspended, outpatient services also fell by almost 1 million, to 38,152,773. As normal services resumed during 2020-2021 and services attempted to catch up, they increased to 46,846,617. This was an increase of 8,693,844, or nearly 23 per cent.[21]

The "hidden waitlist" - the period between GP appointment and referral to a specialist - has also therefore increased exponentially. With millions of procedures, consultations and diagnostic services completed in outpatient settings every year, patients often wait months or years for specialist appointments even before they go on the elective surgery waitlist.

The Impact on Elective Surgeries in Regional and Metropolitan Health Services

A well-publicised phenomenon arising from the pandemic was the increased migration of large numbers of people from urban centres to regional areas. In the 12 months to June 2021, the combined capital cities population declined for the first time on record. In this same period, inner regional, outer regional, and remote Australia experienced population growths of 64,000, 8,000 and 1,100 respectively.[22]

Capital to region migration remained well above pre-COVID-19 levels long after the easing of public health measures. In September 2022 quarterly migration flows over the previous 12 months averaged a level 15.1 per cent higher than during the two years prior to the pandemic.[23]

This pattern of movement places further pressure on regional centres and hospitals, some of which already have the least capacity and most stretched resources, further exacerbating the backlogs. By analysing the AIHW elective surgery statistics for 2021-2022, regional areas disproportionately featured in those failing to deliver elective surgeries on time.

In 2018-19 one fifth of Local Health Networks (LHNs) with a higher-than-average total number of late elective surgeries served regional patients, by 2021-22 this had risen to one third. In the same time period, regional LHNs experienced a 117 per cent rise in the number of late urgent elective surgeries, a 105 per cent rise for semi-urgent elective surgeries, and a 150 per cent rise for non-urgent elective surgeries. In total, the number of elective surgeries delivered late rose 134 per cent in non-metropolitan LHNs. Comparatively, LHNs in cities experienced an 88 per cent rise in the total number of elective surgeries delivered after the clinically recommended time.[24]

Recommendations

The AMA has stated that "significant investment will be required to restore the capacity of public hospitals and provide access to all those who require it within the clinically recommended timeframes… establishing enough capacity to meet the population demand while factoring in repeat waves of COVID-19 infections into the future."[25] Q-bital endorses this position and considers that the following is necessary to improve response measures in the event of future pandemics:

1. Funding commitments from governments (both upfront and long term) to deliver immediate increased capacity in the health system to reduce backlogs, including in pandemic response and planning.
2. Continuous reviews of waitlists and backlogs as part of future pandemic planning, in order to identify bottlenecks, where alternative care pathways may be appropriate, and which of these can be initiated as part of a pandemic response.
3. Consideration of the use of mobile facilities to provide increased capacity in any health setting, including regional or remote areas, that require temporary or permanent increases in healthcare capacity as part of pandemic response and planning.

References

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