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Senator Scott Ryan
Chair
Senate Finance and Public Administration
- References Committee
Parliament House
CANBERRA ACT 2600

Dear Senator Ryan

Thank you for the opportunity to make a submission to the Committee's inquiry regarding the operation of the Council of Australian Governments' agreement on the National Health and Hospitals Network made on 20 April 2010.

The AMA's views on the agreement and its potential impact on Australia's health care system are attached.

As noted in our submission, the AMA commends the intention behind many elements of the agreement. However, there is still considerable detail to be developed about how many of the reforms and initiatives will be implemented, and this will impact on their success. The AMA also considers that many important health areas have largely been ignored.

Our submission highlights the many questions that remain to be answered and the complex issues that will need to be resolved before we can have confidence that there will be significant improvements in the system.

We would be pleased to provide further evidence before the Committee if requested.

Yours sincerely

Dr Andrew Pesce
President

26 May 2010

AMA SUBMISSION TO
THE SENATE FINANCE AND PUBLIC ADMINISTRATION
- REFERENCES COMMITTEE INQUIRY ON THE
COAG NATIONAL HEALTH AND HOSPITALS NETWORK AGREEMENT

Introduction

There is no doubt that Australia needs reform of its health care system. If Australia is to continue to achieve health outcomes and enjoy health care that is amongst the best in the world, structural changes need to occur to keep up with the growth in demand and costs. Continuing as we are is not an option.

Doctors have the ultimate clinical responsibility for patient care. They have a unique role in, and perspective on, the health care system. Their integral role in patient care provides them with knowledge and expertise to identify and advise on issues across the health care system.

As the body with the largest doctor membership in Australia, the AMA represents the most comprehensive view of the widest range of doctors.

The additional investment committed by the Australian Government is welcome in this climate of fiscal constraint. It recognises the importance that good health has in underpinning a robust economy. But even this investment may not be enough given the magnitude of what is required to keep up with demand and growth.

The AMA's understanding is that, after adjusting for the transfers of revenue and spending between jurisdictions, the underlying National Health and Hospitals Network (NHHN) funding will grow on average by about 5% per year in nominal terms over the forward estimates period. However, in recent years public hospital and medical benefit costs have grown by an average of 9% per year. It appears the Commonwealth Government's forward estimates make strong assumptions about large and early efficiency gains from the NHHN, the MBS Quality Framework program and from further PBS reforms.

The AMA's views on health reform and its priorities for action are articulated in its 2010-11 Federal Budget Submission and Priority Investment Plan (attached).

The AMA's main objectives in terms of health reform are clear and simple. We need:

- increased capacity in the system;

- an end to the blame game;
- devolution of responsibility, that is, a system that responds to input from local doctors so that it is more flexible and responsive to local needs; and
- less funding in the system spent on red tape and bureaucracy and more new funding allocated to patient care.

What we support (in principle)

There are many aspects of the COAG National Health and Hospitals Network Agreement (IGA) that we therefore support. In particular, the AMA commends the intention behind the following elements of the IGA, although whether they achieve the desired result will depend on how the reforms work in practice.

The Commonwealth Government is taking the greatest responsibility for growth.
The AMA would have preferred a single level of government to be responsible for all health funding, so that this responsibility would be unequivocal, however, the IGA has still shifted most of the risk for meeting growth in health care demand to the Commonwealth. This is appropriate given it has the greatest capacity to fund it under Australia's current taxation arrangements.

There is greater transparency and more direct funding to hospitals.
The IGA creates a direct and transparent mechanism for hospitals to receive funding, at least for hospital services that will be funded through activity based funding. Most funding will no longer pass through State governments in a way that will allow it to be 'reduced' before it actually reaches hospitals.

The Commonwealth and State governments share funding for capital, teaching/training and research in hospitals.
For the first time, the Commonwealth Government will now overtly share the funding, and risks, of capital, teaching/training and research in public hospitals. The separation of these elements from other funding means it is more likely it will be spent as intended. However, it does introduce complexity in trying to separately identify the costs of service delivery versus teaching/training and research inherent in many hospital activities.

Transparent national standards will strengthen accountability.
The AMA fully supports the development of national standards. These will not only improve patient care, but also ensure all levels of government can be held to account for funding and services provided.

There is a greater investment leading to increased capacity in hospitals.
The IGA has provided the basis for a significant increase in acute care funding, with additional support for elective surgery, emergency departments, capital works and subacute beds.

There is potential for better local governance.
The creation of Local Hospital Networks has the potential to move decision making closer to where health care is actually delivered. This may provide more capacity for direct doctor engagement in decision making.

The Commonwealth Government is taking full policy and funding responsibility for general practice and primary health care services and aged care services.
This approach will provide a better basis for the delivery of a broad range of patient services and will allow general practitioners greater opportunities to support patients in accessing the care they need.

There is additional investment in aged care.
The IGA has provided the basis for some additional investment in aged care, although given the level of funding on offer for new places it is unclear whether it will lead to an expansion of services in reality, or an improvement in quality.

There is a greater investment in the future health workforce.
The IGA has provided the basis for a significant increase in workforce capacity over the next ten years, although this will need to be matched by State governments providing sufficient undergraduate, pre-vocational and vocational clinical training positions in public hospitals.

However, at this stage, the AMA can only provide in-principle support for the IGA and the particular reforms identified above. There is still considerable detail to be developed about how many of the reforms and initiatives will be implemented (refer 'specific issues' section below). Their success will depend on this detail and how much flexibility there is in how they are implemented. We look forward to fully participating in this process.

Areas of concern

Systemic concerns

The AMA understands that reform of this nature always involve some compromise. For example, the AMA would have preferred that the Commonwealth Government become the single funder of hospitals, with the States governments continuing to operate them. Instead, under the IGA the States will maintain considerable control and influence on how services are delivered locally. States will decide on the range and quantum of services negotiated with, and delivered by, Local Hospital Networks and on their structure and governance. The Commonwealth will have no role in these matters. The potential disconnect between what hospitals are expected to do as opposed to what they are paid to do remains an area of concern.

The IGA provides for new performance reporting and monitoring to ensure that States are accountable. However, it is yet to be seen whether this will provide sufficient leverage in the short term or sufficient political clout in the long term, given that performance monitoring of the health system is difficult to do fairly and accurately, without introducing perverse incentives that compromise patient care. The IGA focuses on States' performance rather than hospitals' performance.

The AMA is concerned that the funding structure agreed to in the IGA will not end the blame game, but instead merely provide different opportunities to undermine and 'game' the system.

While the IGA expands the Commonwealth's role in primary health care, it also did not result in a single funder for these services. The detail about which level of government will be responsible for many parts of primary health care service delivery, is still to be considered in future COAG meetings. There is no guarantee that the Commonwealth's intention to become solely responsible for primary health funding will be successfully negotiated, as illustrated by Victoria's retention of its home and community care programs under this IGA.

The AMA is also concerned that the IGA does not accurately reflect the most important health care issues. While it is true that there needs to be a staged approach to implement health reform, it is questionable whether the areas agreed as 'first stage' are a higher priority than those that are relegated to a future response. For example, the AMA considers that a comprehensive national response to mental health, aged care and Indigenous health are 'first stage' priorities that have not been adequately addressed.

The new reforms appear to introduce considerable new bureaucracy. It is not clear yet how much of the new funding will be needed to support implementation of the reforms rather that the reforms themselves, or whether the additional bureaucracy will add real value. For example, the recent Federal Budget included $91.8 million to establish and run the Independent Hospital Pricing Authority and $163.4 million to rollout activity based funding. Establishing and running Medicare Locals and after hours primary care will cost $416.8 million over five years but it isn't clear how much of this will actually involve delivering health care services.

Specific concerns

The following are areas where the AMA is keen to see further detail and explanation about how initiatives will work in practice.

Hospital bed investment

The AMA has advocated strongly for a comprehensive and coordinated strategy to increase bed capacity in public hospitals. The capacity of the system is the fundamental foundation of any health reform. It is not possible to meet performance targets and improve access without increasing capacity.

The AMA considers there should be a maximum 85% bed occupancy in public hospitals in order to meet emergency department and elective surgery demand, and for hospitals to operate at internationally accepted, safe bed occupancy levels. There is strong evidence that patient safety and quality of care are compromised when hospitals consistently run at higher average occupancy rates. Our current estimates are that, nationally, an additional 3870 new beds are needed to meet this.

The Commonwealth Government has committed to considerable new investment in hospitals, including in subacute beds, and provided incentives to State governments and hospitals to increase capacity, but there is no detail explaining how this will be achieved.

The AMA is concerned that, despite this additional investment, there is no guarantee that it will result in new acute beds. The AMA's Priority Investment Plan calls for a 'Bedwatch' scheme, an ongoing monitoring system that would transparently report on the number of new and existing beds that are available in public hospitals. Performance monitoring must include monitoring of bed capacity as per our Bedwatch scheme.

The AMA would like to understand:

- how decisions will be made about where investments will occur, in which hospitals and for what particular purpose?
- how will decisions be made about what proportion of new subacute beds will be allocated for mental health, geriatric, rehabilitation or palliative care?
- how will States be accountable for using new funding to improve hospital capacity within agreed timeframes, beyond the targets proposed for elective surgery and emergency waiting times?

Activity based funding for hospital services

The IGA includes the development of a national 'efficient' price by an independent hospital pricing authority. The AMA acknowledges that activity based funding of hospital services helps make funding transparent by demonstrating to both administrators and doctors exactly how money is spent. It provides rich and detailed data for improving both efficiency and quality, and it provides a clear basis for establishing new and additional services. Activity based funding will also clearly show any impact on public hospital costs from drops in private health insurance rates.

Commonwealth and State contributions to activity based funding will be paid to Local Hospital Networks through specially established funding authorities, which is intended to ensure the money is used only for hospital funding.

However, the AMA has ongoing questions about how activity based funding will be introduced, particularly since the Productivity Commission reports of December 2009 and May this year highlight the paucity of data available on which to base an efficient price:

- how will a national price deal with genuine interjurisdictional differences in service delivery and cost?
- how will loadings be developed to account for differences in hospitals and patient cohorts?
- what kind of transitional arrangements will be put in place to ensure hospitals that do not currently operate under casemix are able to adjust without risk to patient care?
- how will the pricing authority ensure that States do not end up paying significantly more than 40% in order to cover the real costs of providing hospital care?
- what mechanism will be established to ensure practising doctors inform the development of the efficient price and loadings, and provide ongoing feedback so they can be adjusted over time?

Other hospital funding: block funding, teaching, research and capital

The AMA welcomes the decision to continue funding some hospitals, such as rural or small hospitals, through block funding. However, we note that Commonwealth contributions for hospital block funding will not go through the new fully accountable funding authorities but instead be paid directly to State governments. This raises questions about how transparent and 'protected' this Commonwealth funding contribution will be.

The AMA also welcomes the clear separation of funding for capital purposes, teaching and research, as well as the Commonwealth's commitment to fund 60% of these costs. However, as noted earlier, it does introduce complexity in separately identifying the costs of service delivery versus teaching/training and research inherent in many hospital activities. For example, in implementing the IGA, it is essential that the Commonwealth's 60% contribution to the recurrent costs of training in public hospitals be properly costed.

We are keen to know:

- how will block funding, capital investments, teaching and research funding levels be decided and funds distributed?
- what role will the Commonwealth play in making these decisions?
- what mechanisms will be established to ensure Local Hospital Networks and local practising doctors inform the decisions?
- what mechanisms will be established to ensure that the funding provided for particular purposes is used for those purposes?
- how will training in hospitals be accurately costed?
- will the advice of doctors be sought on in-hospital training costs?

The AMA is developing criteria that could inform funding requirements for teaching and research, and performance measures to ensure this funding achieves its goals and that there is sufficient funding allocated to cover all of the costs associated with these activities. We would be pleased to share our work with the Commonwealth and State governments.

Four hour national access target for emergency departments

The AMA considers that performance targets for emergency care can be useful in driving improvements in whole-of-hospital service delivery. This is because delays in emergency departments are almost always due to capacity constraints elsewhere in the system. So, for example, setting targets in an emergency department can result in smarter discharge planning in the rest of the hospital to free up beds in a timely way.

However, any efficiencies driven by these targets can only provide a one-off capacity gain. It cannot substitute for ongoing bed capacity in our hospitals. There are also potential risks if a focus on meeting targets over-rides appropriate patient care.

The AMA seeks assurances that any system of targets is well managed and designed following significant consultation with the medical profession at all levels of the

health system. Implementation should be incremental and flexible in order to draw on evidence of any negative impact as it arises.

The AMA is keen to know:

- what process will be undertaken to develop targets and definitions?
- how will targets be defined so that they recognise situations where longer periods in emergency departments are in the best interests of the patient?
- will peer-reviewed evidence from Western Australia, where targets are already in place, and New Zealand, where a six hour targets have been introduced, be considered in implementation?
- will implementation of targets be flexible enough to be modified to take into account new evidence as it comes to light?
- will the Commonwealth and State governments ensure that there are no penalties applied to hospitals or individual doctors who are not able to meet targets?

Doctor engagement in decision making

The Commonwealth Government has indicated that the establishment of Local Hospital Networks (LHNs) will provide the mechanism for local practising doctors to be meaningfully engaged in decision making at the local level. The Commonwealth has stated that LHN governing councils will include local health, management and finance professionals, with an appropriate mix of skills, expertise and backgrounds and that LHNs will work with local clinicians to incorporate their expertise and views into the day-to-day operations of hospitals.

However, the AMA is uncertain what this really means in practice. The description of the role of local doctors in LHNs is different in the IGA compared to the most recent description in the Commonwealth's National Health and Hospitals Network publication released on Budget night. The IGA specifies that LHN governing councils will include members with clinical expertise but this would be 'external to the LHN wherever practical'. The AMA opposes a model that does not allow direct representation of local practising doctors.

The AMA seeks clarity about:

- whether local doctors will be members of governing councils?
- how governing council members will be selected?
- if local doctors are not on governing councils, how will their views be seriously considered?

Local Hospital Network service agreements with State governments

Under the IGA, State governments will be responsible for negotiating service level agreements with each LHN. Service agreements will include the number and broad mix of services to be provided, the quality and service standards to apply, the teaching and research functions to be undertaken, and the level of funding provided through activity based and block funding. It appears the Commonwealth will play no role in

the actual delivery of public hospital services apart from contributing to the development of national standards and performance reports.

The AMA considers that these service agreements will be a key factor in the success or otherwise of much of the health reform initiatives contained in the IGA. For example, if funding is insufficient due to unrealistic prices or poorly estimated service volumes, no matter how efficient the hospital and the potential number of services it could provide, performance targets will not be met and/or quality standards may suffer.

The AMA questions how the Commonwealth will ensure that States set realistic, transparent and achievable hospital-level targets and standards for LHNs and provide sufficient funding to achieve them. In particular:

- who will actually be involved in negotiations?
- will local doctors have meaningful input?
- will sufficient contingency funding be available to allow a sufficient number of public hospital services to meet unforeseen, short-term demand that is out of hospitals' control?
- how will the need to stay within budgets be balanced with the need to meet elective surgery and emergency care targets?
- what measures will be taken to prevent perverse behaviour, given that targets and reward payments have previously led to gaming and data manipulation as reported by the Auditor-General in Victoria?

Diabetes management

The AMA supports additional funding to better manage people with diabetes and prevent unnecessary hospital admissions. However, the Commonwealth's diabetes management plan was announced without consultation with doctors. As a result, there are many elements of the plan that may not work as intended.

The AMA opposes the move away from a fee-for-service model to a model that introduces fund-holding, fund capping and patient enrolment. This because it: removes patient choice; limits access to services; compromises the independence of doctors' clinical decision making (financial considerations versus clinical need); creates perverse incentives that may diminish access to, and the quality of care; and adds to the red-tape burden on GPs. There is no evidence that supports the change from the current proven model to a new approach and there are possible negative consequences for patients and doctors.

The AMA also questions the Commonwealth Government's focus on only diabetes, rather than all patients with chronic and complex conditions. We have developed an alternative approach that would provide well-coordinated multidisciplinary care to all patients with chronic and complex conditions, not just those with diabetes. This would reduce the number of avoidable hospital admissions and generate long term savings for the health system.

The AMA plan is more holistic and ensures that patients do not lose their entitlement to a Medicare rebate and that patients have more choice and greater control over decisions about their health care.

The following questions should be addressed before the Commonwealth Government's plan is implemented:

- why isn't the Government taking a comprehensive approach, as proposed in the AMA plan?
- what is the evidence-base for replacing patients' entitlement to Medicare with a fund-holding model?
- what arrangements will be in place to deal with situations where appropriate care for very sick patients exceeds the annual allowance provided?
- will patients be able to 'opt-out' of a fund holding arrangement if they wish and move back to a Medicare fee-for-service arrangement, and if so, how would this be dealt with?
- will patients be able to specify which doctor they wish to treat them, rather than which practice?
- will patients be able to move from one doctor to another, or one practice to another, and if so, how will the funding follow them?
- what monitoring and evaluation mechanisms will be put in place to track patient care and outcomes and ensure that very sick patients aren't excluded because of their potential high costs or that artificial or inappropriate restrictions are placed on the number or extent of services they receive to the detriment of health outcomes?

Medicare Locals

The new primary health care organisations, or Medicare Locals, have the potential to benefit patient care by improving patients' access to better coordinated, allied health care. The Commonwealth Government has stated that Medicare Locals will complement and support the work of GPs, with GPs remaining responsible for the overall management of a patient's care.

The AMA believes that for Medicare Locals to work, they will require strong GP engagement, need to preserve and support the role of GPs, and focus on areas of unmet need. GP engagement would ensure that patient care is not fragmented. Medicare Locals must not interfere in the doctor-patient relationship and patients must maintain choice of GP or other medical practitioners.

The AMA notes the Commonwealth Government's assurances about these issues, however, there are still unanswered questions:

- how will Medicare Locals be structured and what will be their governance?
- what mechanisms will be put in place to ensure effective and ongoing coordination with general practitioners, Divisions of General Practice, Local Hospital Networks and aged care services?
- how and when will decisions be made about Medicare Locals' area of geographic area of responsibility?

- will there be coordination between the planning of Medicare Local boundaries and Local Hospital Networks boundaries being planned by State governments?
- If Medicare Locals hold funds for patient care from allied health and other providers, how will this be integrated with the GP provided care, so that they do not interfere with the management of the patient or restrict their choice?
- will Medicare Locals be evaluated to examine their impact on patient care, how effective they are at improving coordinated care without duplicating existing effort, and whether they have reduced or increased red tape?

Aged care

The AMA welcomes the Commonwealth Government's commitment to be fully responsible for aged care and its increased investment in many aspects of the aged care sector. However, further investment is needed to ensure aged care is sustainable, and that it is geared up to meet Australia's future needs.

The interest free loans offered to build new beds need to be supported by proper ongoing funding to ensure that these new beds will actually be built, opened and maintained over the longer term. The AMA is concerned that without expanded ongoing investment, new aged care beds may not eventuate, and therefore not free up beds in public hospitals.

The AMA also notes the redirection of funding in the recent Federal Budget from high care residential care to long stay older patients in public hospitals and high level community based care which suggests there may be no net increase in high level aged care places.

The incentives for GP services in the aged care sector, while attempting to address a clear deficiency in current arrangements, are unlikely to be sufficient to make a real difference. In its Priority Investment Plan, the AMA recommended much more extensive reform to make a real difference, in which:

- aged care providers are funded to develop service agreements with local doctors to provide medical care to residents on an ongoing basis; and
- Medicare rebates for these services are increased to better reflect the complexity and time of providing medical care to residents, most of whom have multiple and complex health care needs.

Considerably more could be done to create more flexibility in how medical care for aged care residents is provided, to improve sustainable access to multidisciplinary medical and other health care, and to reduce red tape.

Regarding the Commonwealth Government's aged care plan, the AMA would like to know:

- is there a contingency plan if the zero interest loans do not lead to the expected number of beds?
- will the impact of funding additional GP services be evaluated?

- what is the net increase in high level aged care places resulting from the movement of funding from residential located care to hospital and community located care?
- will the impact of moving funding from one aged care area to another be monitored?

Mental health

There is significant unmet need in the mental health system across the service spectrum, from prevention and early intervention, to sub-acute and acute care and specialist follow-up in both community and hospital settings.

The IGA focus on early intervention and prevention is important, but more needs to be done. And this focus should be in addition to, not instead of, funding to address the significant deficits in community-based service provision and acute mental health care. The IGA commits to further work in 2011 but this allows these problems to become further entrenched.

The AMA considers there are significant funding gaps and planning uncertainties in mental health, with the following questions of particular importance:

- when and how will governments provide adequate:
    - support for child and adolescent mental health?
    - support for specialist psychiatric support services in the community?
    - provision of accommodation and post-acute transitional care back into the community?
    - acute care in hospital settings?
- what proportion of the 1300 recently announced subacute care beds/services will be allocated for mental health care, as opposed to geriatric, palliative and rehabilitative care?
- what role will Local Hospital Networks play in providing mental health services and how will these services be integrated with other primary and acute care services through Medicare Locals?

Medical workforce training

The Commonwealth Government commitment to fund additional student and training places will go some way to ensuring that future medical graduates will be able to access prevocational or vocational training positions.

The AMA is less confident that State governments will match the Commonwealth's commitment by boosting the number of training positions in public hospitals. Unless States lift their overall contribution, it is likely that a shortage of quality training positions will occur or that the overall quality of the training in public hospitals will diminish.

In implementing the IGA, it is essential that States be held to account for delivering the required number of high quality training places.

The AMA recommends that the Commonwealth's contribution to training should be tied to clearly identified targets that States must meet. Health Workforce Australia could provide advice on targets that could then be monitored through the Medical Training Review Panel that publishes data in an annual report to Federal Parliament.

The AMA therefore seeks clarity on:

- how will State governments deliver on IGA commitments in practice?
- how will State governments be held to account for delivering on sufficient, quality medical training positions in public hospitals?
- how will new training places be monitored and reported?

Areas not adequately addressed or ignored

The IGA and the recent Federal Budget represent a considerable additional investment in health. Many priority areas identified by the AMA have received attention.

However, the AMA believes many important health areas have still not been adequately addressed or have largely been ignored.

General *hospital bed capacity* and *chronic disease management* are two key areas identified in the AMA's Priority Investment Plan and our concerns in these areas are articulated above.

In addition, the following areas have been under-funded or ignored.

Indigenous health

The health gap is too wide between Indigenous people and other Australians. Provision of primary care to Indigenous Australians must be significantly improved through expanding the workforce for Indigenous health and building health-related capacities in Indigenous communities.

Dental health care

The most disadvantaged people in our community are those that are most likely to miss out on essential dental care. Poor dental health has proven links to poor health outcomes, particularly for people with chronic disease. Lack of investment in dental health is a glaring omission in the IGA and the Federal Budget.

Rural and remote rescue package

Rural communities need more doctors, particularly with obstetrics, surgical, anaesthetic and emergency skills. There is insufficient emphasis/support in announcements to date to properly address this problem. The AMA's Rural Rescue Package, which calls for a two tier incentive package, including rural isolation payments and rural procedural and emergency/on-call loadings, would bolster the rural workforce and ensure that patients in rural communities have access to the doctors the need.

Conclusion

The IGA negotiated and signed on 20 April represents a fundamental recasting of funding arrangements and a consolidation of State government responsibility for public hospital service delivery, accountability, planning, reporting and monitoring. On the other hand, the Commonwealth Government has increased its responsibility only in the area of funding and national-level accountability without the power or control of public hospital service delivery that would allow it to fix parts of the hospital system that aren't working well.

There appears to be only a weak connection between the Commonwealth Government's contribution to funding and the agreed planning and purchasing of services under the IGA (where State governments undertake the planning and purchasing of hospital services and Medicare Locals undertake the planning and purchasing of primary care services).

The Commonwealth Government has no commensurate responsibility for ensuring bed capacity or service delivery or infrastructure organisation. While it is taking on more funding responsibility, it will have little say on the development of these input measures and will rely on broad level performance targets to ensure it expectations are met.

As a result, it is unlikely that the new arrangements will see any end to the 'blame game'. The AMA expects that without the Commonwealth Government taking real responsibility for public hospitals, this will continue.

The primary result of the IGA is an overall increase in funding, although the real magnitude is unclear given the mix of spending and savings measures within the Federal Budget.

Even within this framework of additional funding, there continues to be uncertainty about how this funding will be used and the impact it will have. For example, where funding has been announced to create beds, it is still unclear how this will be guaranteed and demonstrated to have happened.

This submission highlights the many questions that need to be answered and the complex issues that will need to be carefully resolved before we can have any confidence that there will be significant improvements in the system.

26 May 2010

Federal Budget Submission 2010 - 11

On 16 September 2009, the AMA released its Priority Investment Plan for Australia's Health System (the Plan). As AMA President, I personally handed the Plan - the AMA's response to all of the health reform reports that have been prepared for the Government – to Prime Minister Rudd on the day of the release.

The Plan sets out the initiatives that the AMA believes require immediate implementation to improve productivity in the health system, place a greater focus on people and their health needs, and improve the quality and safety of health care. To be successful, the Plan will require upfront incentives, infrastructure, capacity building, and ongoing funding.

The AMA has re-endorsed the Plan for formal submission to the Government as the AMA's 2010-11 Budget Submission.

The Plan includes a range of high priority initiatives focussing on key areas of the health system. A full copy of the Plan is attached. However, in summary, it calls for the following:

Indigenous Australians are dying too young, the health gap is too wide, and poverty is endemic in the Indigenous population

The capacity to provide primary health care to Indigenous communities in rural, remote and urban areas must be significantly improved through expanding the workforce for Indigenous health, and building the health-related capacity of Indigenous communities.

When people get sick or injured, they want to see a doctor, usually a GP

The Government must strengthen the role of general practice. The AMA recommends a range of support and training for general practice including infrastructure support to allow existing general practices to evolve and develop into GP Primary Care Centres with GPs leading teams of co-located health professionals.

Our public hospitals are being starved of proper resources – there are insufficient beds, too many people are waiting too long on elective surgery waiting lists and, as a result, too many people are becoming more expensive and risky emergency cases.

The AMA wants a maximum 85 per cent bed occupancy in public hospitals. More hospital beds are needed and the AMA proposes a national stocktake of public

hospital beds and sub-acute beds. The AMA recommends an ongoing monitoring system called Bed Watch to transparently report on the number of existing and new beds in public hospitals and reductions in emergency department access block over time.

Future generations of Australians must have access to highly trained doctors in the right numbers to serve the health needs of all Australian communities.

As a nation, we should not support any substitution and shifting of health care and medical work that compromises the safety and quality of health care. To ensure we have enough doctors to provide our medical care, there is an urgent need to expand the number of pre-vocational and specialist medical training places and training infrastructure in our health system so that we have a training position for every medical school graduate.

Give immediate attention to the forgotten people in the system.

The AMA makes recommendations to improve health services for people requiring sub-acute care, medical services in rural and remote Australia, and care and support for people with serious disabilities through a long term care scheme. The AMA also calls for more medical services for people with mental illness - continued investment in mental health services is essential given the increasing demand and inadequate infrastructure, co-ordination and services currently available.

Taking advantage of the e-Health revolution.

The AMA fully supports the roll-out of e-Health initiatives in order to integrate systems, reduce fragmentation, streamline service delivery, reduce duplication, and improve quality and safety.

Ending the 'Blame Game'.

It is time to end the 'blame game' between the Commonwealth and the States over the funding of our public hospitals. Looking ahead, the AMA believes there should be a single public funder for public hospitals that has total responsibility for fully funding the public hospital system. While the AMA does not support a Commonwealth takeover of the operation of the public hospital system, the AMA model of a single public funder of public hospitals with State-based local governance arrangements would provide transparency and would negate overt cost shifting.

Additional items

In addition to the critical initiatives set out in the Plan, there are a number of further budget priorities that the AMA has written to the Government about since the release of the Plan.

These are things that we believe should also be included in the forthcoming Budget.

GP Practice Nurses

The AMA has recently written to the Government to reiterate previous calls to extend support for GP practice nurses, a model of collaborative care within general practice that is fully supported by the general practice community and has been a major success story in improving access to care through general practice.
In practical terms, this would require the Government to extend practice nurse subsidies under the Practice Incentives Program to all geographic locations and to expand MBS coverage to reflect and support the full range of work undertaken by practice nurses for and on behalf of GPs.

Preventative Health Response

The AMA asks that the Government provides an urgent and robust response to the National Preventative Health Strategy, including funding in the next Federal Budget to ensure real action is taken to comprehensively tackle the burden of chronic disease currently caused by obesity, tobacco, and excessive consumption of alcohol.

Medicare Easyclaim

To provide convenience for patients and create further administrative efficiencies for the Government, the AMA continues to call for ongoing financial support to assist medical practices cover the administrative costs associated with lodging on-line Medicare claims.

Support for Temporary Resident International Medical Graduates

The AMA calls on the Government to establish a process in 2010 to explore alternatives to the current 10 year moratorium on Medicare provider numbers for temporary resident international medical graduates and, in the interim, to amend its policy in the next Federal Budget to give these international medical graduates and their families access to Medicare and public education. International medical graduates make a valuable contribution to the medical workforce, particularly in rural and remote Australia, because of the long-term shortage of GPs and specialists in these areas, and the AMA believes that they should be treated with dignity and fairness while they are working in Australia.

Medical Training

The AMA has recently written to the Minister for Health and Ageing urging her to provide specific extra support for pre-vocational and specialist medical training through the new Health Workforce Australia agency in the form of:

- dedicated teaching and training time for senior clinicians;
- development of more innovative training for interns;
- professional development programs to enhance the teaching capacity of junior doctors; and
- pre-vocational training positions in community settings.

The AMA Priority Investment Plan and these additional items provide the Government with practical initiatives to deliver, not only on its 2007 election promise to 'fix the hospitals', but to fix the health system.

This comprehensive AMA 2010-11 Federal Budget Submission is all about affordable, achievable solutions that will give the Australian people better access to quality health care for the long term.

The AMA stands ready to work with the Government on the implementation of these measures.

Dr Andrew Pesce
AMA Federal President
January 2010

Priority Investment Plan

for Australia's Health System

RE-ENDORSED FOR SUBMISSION AS AMA FEDERAL BUDGET SUBMISSION
2010-11
January 2010

Priority Investment Plan for Australia's Health System

This is an AMA investment plan for the health of all Australians. It is for immediate implementation. The time for talk is over.

We need this plan to improve productivity in the health system, place a greater focus on people and their health needs, and improve the quality and safety of health care.

To be successful, this plan will require upfront incentives, infrastructure, capacity building, and ongoing funding.

This investment is needed because a healthy community is a productive community.

An effective health system reflects a compassionate society that has its priorities right.

We all know that good health care comes at a cost. Responsible governments and communities invest in health. The returns on the investment are huge. Good health care allows people to contribute productively to society.

To assist the Government define its health reform agenda, the AMA has selected priority areas for *immediate* significant investment in health.

Looking ahead, the AMA sees the need for action to end the 'blame game' between governments over the funding of our public hospitals.

We believe there should be a single public funder for public hospitals that has total responsibility for fully funding the public hospital system.

The AMA does not support a takeover of the public hospital system. We support local governance arrangements.

The AMA's *Priority Investment Plan for Australia's Health System* is detailed in the following pages.

1. Indigenous Australians are dying too young, the health gap is too wide, and poverty is endemic in the Indigenous population

As a nation, we must do all that we can to help close the gap in Indigenous health because this is both a symptom of, and a contributor to, the cycle of poverty in Indigenous communities.

The capacity to provide primary health care to Indigenous communities in rural, remote and urban areas must be significantly improved through expanding the workforce for Indigenous health, and building the capacity of Aboriginal Community Controlled Services.

Under the AMA plan, this will require the following practical and immediate measures:

- Additional grants of $440 million a year over five years to Aboriginal primary care services (with $500 million a year sustained thereafter) for enhanced infrastructure and services, and to allow Aboriginal Medical Services to:
    - Offer mentoring and training opportunities in Indigenous health in Indigenous communities to Indigenous and non-Indigenous medical students and vocational trainees; and
    - Offer salary and conditions for doctors wishing to work in Aboriginal Medical Services that are comparable to those of State salaried doctors;
- New funding of $100 million over six years for development of Indigenous specific medical training to deliver 430 medical practitioners to work in Aboriginal health settings; and
- New funding of $100 million over ten years in grants to community groups or NGOs for health-related capacity building in Indigenous communities, because capacity building requires generational change and must be supported for sufficient time to make a real difference.

These measures must be implemented as part of a long term national strategic plan for closing the gap in Indigenous health, which is developed in genuine partnership with Indigenous people and their representative organisations.

2. When people get sick or injured, they want to see a doctor, usually a GP

The NHHRC's focus on providing access to multidisciplinary primary care services has significant merit.

General practice can lead the way in the development of such services, but lacks the necessary infrastructure to do so.

For prevention advice, sickness, injury, or chronic disease management, people want to be able to see a doctor, usually a GP.

With over 7000 general practices across the country, the Commonwealth could significantly enhance patient access to general practice and allied health services through a broad infrastructure support program targeting existing general practices.

This would allow existing general practices around Australia to evolve and develop into *GP Primary Care Centres*, similar to the Comprehensive Primary Health Care Centres (CPHCC) envisaged by the NHHRC, or to provide specific additional services tailored to local needs and to train our future GP workforce.

Better infrastructure could support more community-based training, support more on-site collaborative care, support more virtual consolidation and coordination with other services, support more practice nurse services and the integration of nurse practitioner services on site, and support more person-specific preventive health care through primary care services in the community.

Strengthening the role of general practice requires more than bricks and mortar.

The management of patient care could be improved significantly if patients were given better access to relevant technologies such as MRI and point of care testing.

The general practice workforce must also be strengthened through the provision of additional prevocational and vocational GP training places, support for medical students and other health professional training in general practice, and improved funding arrangements to support the delivery of multidisciplinary care.

The AMA plan requires:

- General practice infrastructure grants totalling $830 million over three years in order to kick-start the facilities required to teach and train and provide comprehensive multidisciplinary care through general practice;
- 820 prevocational general practice training placements a year by 2012;
- 1500 first year GP vocational training positions a year by 2015;
- Immediate doubling of existing teaching grants to fund increased opportunities for medical students and other health care providers to access multidisciplinary clinical training in general practice;
- Improved MBS arrangements to support a broader range of work to be undertaken by GP practice nurses and allied health workers for and on behalf of GPs;
- 1300 more GP practice nurse/allied health worker grants by 2011-12;
- Review and simplification of MBS GP items to enable patients to receive rebates appropriate to, and reflective of, the high quality acute care, complex care, chronic disease management, and preventive care provided in general practice;

- Implementation of GP referred MRI and point of care testing based on best practice clinical guidelines; and

- $67 million a year to provide medical services in Residential Aged Care Facilities, as per the NHHRC recommendation.

3. Our public hospitals are being starved of proper resources and there are not enough beds

We need to ensure a maximum 85 per cent bed occupancy in public hospitals.

We are aware that the Commonwealth has provided additional funding to the States for public hospitals.

We are aware also that the Prime Minister has indicated that this could be used to establish 3,750 new beds in 2009-10, growing to 7,800 additional beds by 2012-13.

The AMA's plan to increase bed capacity in public hospitals could ensure that we achieve this essential outcome.

Currently there is no evidence that there is a comprehensive and coordinated strategy to open and staff the required beds.

There have been some ad hoc announcements of new beds but no comprehensive strategy where the Commonwealth holds each State or Territory accountable.

There is no evidence that the States aren't closing beds as quickly as the Prime Minister announces ad hoc funding for new ones out of the additional Commonwealth funding.

The AMA plan for our public hospitals involves:

- Undertaking a stocktake of the actual number of beds needed in each hospital to ensure no more than 85 per cent average occupancy;

- Undertaking a stocktake of the number of sub-acute beds needed to take pressure off acute hospitals in each area;

- Obtaining formal intergovernmental agreement on the timeframe for their establishment and formal agreement of the evidence that will be provided to demonstrate that the States have also provided the additional required funding in each institution's recurrent budget;

- Implementing a robust accountability system so that the Commonwealth can be assured unequivocally that the funding it is providing under the new National Healthcare Agreements is used to establish these new beds within agreed timeframes - say, within the next 18 months; and

- Implementing an ongoing monitoring system – ***Bed Watch*** – that would transparently report on the number of new and existing beds that are available in public hospitals. ***Bed Watch*** would also monitor other important factors related to hospital occupancy such as access block in emergency departments, with a view to achieving a target of 10% or less patients who wait more than 8 hours in emergency departments before reaching an inpatient bed or being transferred to another hospital for admission.

On hospital funding, it is not possible for a sustainable public hospital service to be provided everywhere in Australia based on the cheapest cost in Australia. Therefore, we don't support the NHHRC's proposal for activity-based funding based on the 'efficient cost of care'.

Instead, we support funding for the '**effective cost of care**'. This will require significantly *more* funding for public hospitals across Australia.

The critical characteristics of an 'effectiveness payment' are:

- It allows local flexibility and decision-making. An effective payment arrangement for public hospitals *must* incorporate sufficient loadings, adjustments and flexibility to reflect the variable geographic and other circumstances of individual hospitals;
- It recognises different cost pressures in different geographic locations/settings;
- It does not compromise or limit the clinical decisions that doctors make for their patients;
- It does not introduce incentives for perverse behaviour and gaming through reward payments but, rather, allows services to be delivered safely and to a high quality;
- It ensures that teaching and research activity can be maintained;
- It supports the training of the future health workforce;
- It allows 85 per cent maximum occupancy to be maintained; and
- It ensures that sufficient funding is provided for capital.

4. Future generations of Australians must have access to highly trained doctors in the right numbers to serve the health needs of all Australian communities

As a nation, we should not support substitution and shifting of health care and medical work.

There is a significant mismatch between the number of pre-vocational and vocational training places and the training infrastructure available and the number of medical school graduates expected to graduate from medical schools around Australia.

To address this problem and to ensure that we have sufficient doctors in the future, there is an urgent need to expand the number of medical training places and training infrastructure in our health system so that we have a training position for every medical school graduate.

The Government should actively and genuinely work with the medical profession to determine how many of each medical discipline or craft group is required and what we are going to do to get them.

We want doctors back into the planning process for this vital function.

It can only be achieved through improved workforce planning - with doctors closely involved and advising - to ensure governments match demand for workforce with prevocational and vocational training positions.

We also need rigorous ongoing analysis and debate about:

- How many different health professionals across all disciplines are required and by when;

- What we mean by collaborative care, and what the risks are to the system of supporting expanded independent practice;

- How we can re-engineer the system to allow health professionals to spend more time in the clinical care of patients and less time on administration and paperwork (the NHHRC's recommended additional reporting and accountability requirements would result in more, not less, time spent on administration); and

- The equitable distribution of the medical workforce, with the right skill mix.

Under the AMA plan, this would require:

- By 2013, 3400 intern places guaranteed with processes under which States are accountable to the Commonwealth for delivering on this, and an annual process of monitoring by the Commonwealth to ensure that these places are provided;

- Commensurate increases in prevocational training places to meet the increasing number of junior doctors that complete their intern year;

- To restore the balance of service delivery and medical workforce training in our public hospital system and to support a sustainable and well-trained medical workforce, junior doctors must have better access to protected teaching time, while senior clinicians should be guaranteed at least 30 per cent of their ordinary working time to devote to clinical support activities such as teaching and training;

- Progressively increasing the number of first year vocational training places to 2,000 by 2015, over and above the GP training places outlined above, across both public and private settings;

- The Health Workforce Agency (HWA) – in close collaboration with the medical profession through the AMA – to undertake comprehensive and robust medical workforce modelling of supply and demand requirements for the next 10 years to determine the detailed number of vocational training places required in each discipline. Following this process, there should be a Commonwealth-State Ministers summit to lock in the commitment from governments as required to deliver on these additional vocational training places; and

- The Medical Training Review Panel to report annually on the availability of clinical training places for students at medical school, for doctors in training at prevocational and vocational levels, and to assess progress against the above targets established by the HWA. This should be accompanied by a Biennial Review of Clinical Training Places to identify training bottlenecks or shortages and to provide relevant policy advice to Government.

In terms of collaborative care arrangements, these should be carefully implemented, working with the medical profession, to develop rigorous arrangements which ensure that there is no fragmentation or duplication of care, and that patients get appropriate access to services by other health professionals.

5. Give immediate attention to the forgotten people in the system

Sub-acute

We need an immediate increase in restorative services and sub-acute beds for rehabilitation and convalescence, as identified by the NHHRC, so that there are appropriate services for people who leave hospital but need further care. We support the NHHRC's recommendation to provide an additional $1.5 billion in capital funding plus an additional $460 million a year for operating costs to expand sub-acute services by five per cent annually until 2012-13, which will increase the number of beds by 1,560 to 8,800.

Mental health

While the NHHRC identifies a number of important initiatives to improve care for people with a mental illness through expanded early intervention for young people, more sub-acute care, better links between acute care and community care, including through rapid response teams working from acute care settings in the community, the report is silent on the continuing unmet need for acute care, often required on an inpatient basis for patients with mental illness.

There are many patients requiring acute inpatient care during initial diagnosis, stabilisation of their condition, or while they are under clinical supervision during a change in their medication to avoid a relapse in their condition.

The Government needs to undertake an analysis of the number of new psychiatric inpatient beds required in the public hospital system as part of the AMA's proposed stocktake on public hospital bed capacity.

The additional psychiatric acute care beds identified in the stocktake should be formally agreed with State and Territory Governments, with the establishment and funding of these beds monitored through the proposed ***Bed Watch*** monitoring arrangements for public hospital beds.

There also needs to be an expanded integration of the role for psychiatrists in the provision of community-based care for people with mental illness.

This should include targeted funding for psychiatric nurses and psychologists to be able to work under the supervision of private psychiatrists, linked closely to the current referral system from GPs to private psychiatrists.

Long term care scheme

In addition to our national aged care program, which provides support for older Australians who need care, we support a national disability insurance scheme - which is 'no fault' and comprehensive in the care and support it provides - to cover the cost of long term care for people with serious disabilities.

Rural and remote

The Government should support the Rural Rescue Package developed by the AMA with the Rural Doctors Association of Australia. Implementation of the Rural Rescue Package, costed at $375 million a year, would bolster the rural workforce and ensure that patients in rural communities have improved access to doctors.

The Package encourages more doctors to work in rural and regional Australia and recognises essential obstetrics, surgical, anaesthetic and emergency skills.

This funding would provide a two-tier incentive package, including further enhancements to rural isolation payments and rural procedural and emergency/on-call loading. The on-call loading in particular reflects the vital role that rural doctors have in providing emergency care for their patients when they need it, no matter what time of the day or week it is.

6. Taking advantage of the e-Health revolution

The AMA fully supports the roll-out of e-Health initiatives in order to integrate systems, reduce fragmentation, streamline service delivery, reduce duplication, and improve quality and safety.

The roll-out should start with e-prescribing and medically-controlled sharing of essential patient health information between health care providers through electronic records.

Priority needs now to go to funding and rolling out the infrastructure for e-Health - especially electronic health records - given that investment to date has mainly focussed on development of standards and technical specifications.

The AMA believes that a vital part of the e-Health revolution is to have remote communities 'wired' for e-Health service delivery such as telehealth and Internet consultations and advice, as recommended by the NHHRC.

7. Ending the 'Blame Game'

It is time to end the 'blame game' between the Commonwealth and the States over the funding of our public hospitals.

The AMA believes there should be a single public funder for public hospitals that has total responsibility for fully funding the public hospital system.

While the AMA does not support a takeover of the operation of the public hospital system, the AMA model of a single public funder of public hospitals with local governance arrangements would provide transparency and would negate overt cost shifting.

It would also help to eliminate waste and inefficiency in the system.

Under the AMA model, there would be a single public funder for public hospital services, primary care and aged care, ensuring that the overall adequacy of funding in any one particular area could not be used as an excuse for poor patient access in other related areas of the health system.

This would be in conjunction with the continuation of existing fee for service MBS and PBS arrangements covering the cost of medical services and pharmaceutical costs for patients.

Funding for public hospitals from the single public funder would need to cover the effective cost of care (as outlined under point 3 in this plan) and include additional, dedicated funding for research and development, training and education of the health profession, and capital funding for public hospital infrastructure. This will require significantly *more* funding for public hospitals across Australia.

The AMA model for a single public funder with local governance would involve:

- The development of national targets and performance indicators through agreement with both the Commonwealth and State and Territory Governments;
- Service planning by State and Territory Governments, with clinician involvement, to take account of local needs;
- Allocation of funding by State and Territory Governments in accordance with the service planning;

- Purchasing and service provision at the local level with local clinician involvement in service level resource allocation;
- Monitoring of performance at the national level by both the Commonwealth and State and Territory Governments; and
- An independent audit process to make transparent and monitor over time the amount of public funding provided for clinical services, as opposed to hospital and health department administration, and the performance of the public hospital system against agreed national targets.

Conclusion

The Government is currently consulting with the health sector and the community on a broad reform agenda based on the recommendations of three reports – the National Health and Hospitals Reform Commission, the National Preventative Health Taskforce, and the Draft National Primary Health Care Strategy.

Following this consultation process, the Government will select the recommendations it wishes to adopt as policy.

The AMA has examined the three major reports and their recommendations.

We have identified the elements of the health system in most urgent need of reform and packaged them in our *Priority Investment Plan for Australia's Health System*.

We are offering the Government real solutions to real problems.

Our plan is simple, it is immediate, it is affordable, it is practical, and it is common sense.

The AMA is keen to work with the Government on the health reform agenda outlined in this plan.