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House of Representatives Standing Committee - Inquiry into Health Funding

Submission

March 2006

AMA QUEENSLAND

This is an AMA Queensland submission to the House of Representatives Inquiry into Health Funding.

This submission is supplementary to that of the Federal AMA. The AMA submission and testimony is supported wholly by AMA Queensland and is touched on throughout this submission; however, AMA Queensland will take the opportunity to introduce other health issues particular to the Queensland example – namely training at medical school and at the junior doctor level, the public and private interface, cost shifting, and task substitution.

Background

Queensland has suffered poor funding levels comparative to other jurisdictions for many years. In 2003-2004 the national average real recurrent expenditure on public hospitals was $964 per person. It ranged from almost $1,200 per person in the Northern Territory to under $800 per person in Queensland[i]. Similarly, the recurrent cost per casemix-adjusted separation for principal referral hospitals in 2002-03 was $3178 nationally. For those jurisdictions with data available to be published, the recurrent cost per casemix adjusted separation for principal referral hospitals was highest in NSW ($3363) and lowest in Queensland ($2977).[ii]

Data from the Australian Institute of Health and Welfare, and Productivity Commission consistently demonstrate this trend. The following examples and diagrams are taken from the *2006 Report on Government Services.*

Public hospital spending: Queensland has experienced the lowest real recurrent spending for a number of years, whether considered on a per person, or per weighted separation basis.

Figure 9.2 **Real recurrent expenditure per person, public hospitals (including psychiatric) (2002-03 dollars)**[a, b, c, d, e, f]

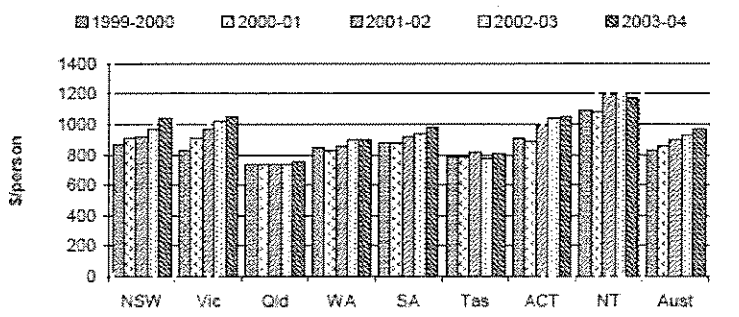
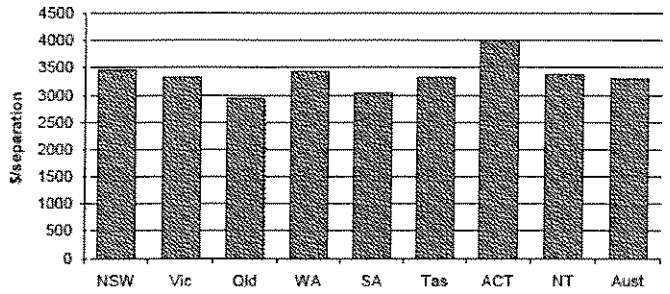
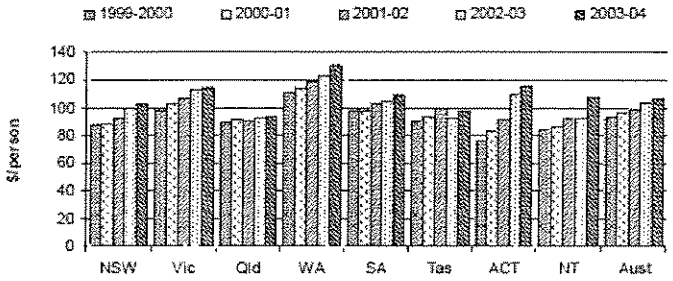


Figure 9.13 **Recurrent cost per casemix-adjusted separation, 2003-04**[a, b, c, d, e, f]



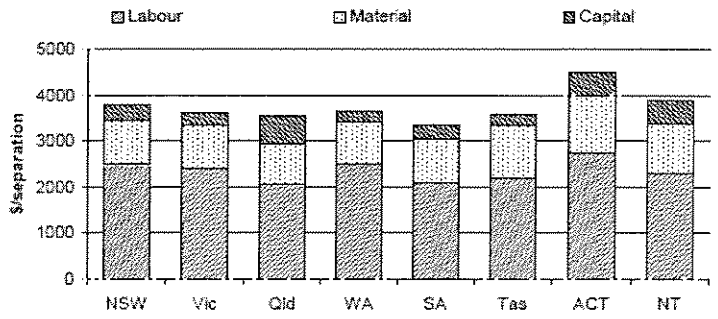
Mental Health: Queensland's mental health spending is below par, and has plateaued for several years, whilst the national trend has been to increase funding.

Figure 11.19 **Real recurrent expenditure at the discretion of State and Territory governments (2003-04 dollars)**[a, b, c, d, e]



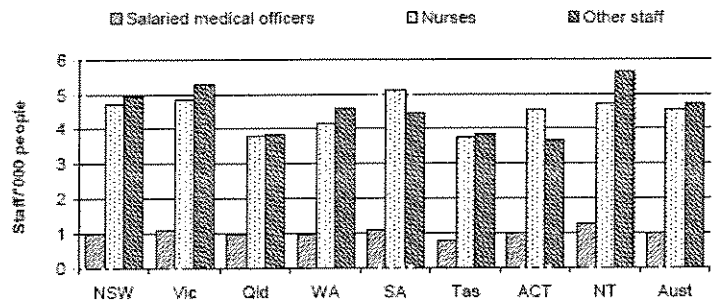
Staffing: Of this poor overall funding, Queensland spends a larger proportion on capital works than any state, and less on labour costs.

Figure 9.15 **Total cost per casemix-adjusted separation, public hospitals, 2003-04**[a, b, c]



Queensland has very low proportion of nurses and salaried doctors per head of population compared with other states:

Figure 9.9 **Average full time equivalent staff per 1000 people, public hospitals, 2003-04**[a, b, c, d, e, f, g]



The effects of these resource shortfalls are clear:

- Separations from public hospitals in Queensland have decreased consistently since 1999 – that is, service has obviously been rationed to cope with funding shortfalls;
- Queensland has one of the lowest relative stay indexes, on par only with Victoria, but does not enjoy the same access to step down facilities offered in Victoria; and, as a result
- Queensland consistently records a high-unplanned re-admission rates to its public hospitals. The current data collection shows it as equal highest in the nation with NSW, at 3.3 per 1000.

Federal AMA alluded strongly in their submission to real shortfalls in the areas of mental, indigenous, and aged care funding and service delivery. AMA Queensland echoes the belief that these are major areas that are disadvantaged by the division in State and Federal funding responsibilities. These areas have particular application in Queensland too.

Queensland has a high indigenous population and AMA Queensland takes a strong view that there must be more substantial and greater continuity of funding for successful community controlled health programs. Accountability is important, but when significant amount of time is wasted applying for funding through the grants process, there is little time left with which to distribute it effectively.

Aged Care and rehabilitation is of particular importance in Queensland, as we are a rapidly growing state, and we are attracting older, frailer citizens. There is a paucity of step down, sub acute, or community care in Queensland, and this puts significant pressure on the State's acute system, and results in inappropriate use of the aged care system. This is the one of the most important areas of health that the Federal Government has failed to deliver on, and both Governments have failed to work together to ensure appropriateness of care across the continuum. The lack of rehabilitation and step down resources is aggravated by other factors:

- Increasing longevity;
- Greater survival following trauma and surgery;

- Lagging workforce, facilities and services to meet these predictable changing patient demographics;
- Pressure to discharge early from acute care; and
- Less time for discharge planning;

As the health crisis and inquiries in Queensland over the last year have made abundantly clear, Queensland's health system is not failing because of a lack of funding alone. Culture and morale is at an all time low in Queensland. This issue and its effects received extensive discussion in the Bundaberg Hospital Commission of Inquiry and Queensland Public Hospitals Commission of Inquiry. The following issues, unless addressed, will continue to add to the erosion of culture and funding, and eventually standards, in what was once a vibrant health system.

Medical Training and Education

University Training

The focus on medical student numbers has ignored the real crisis, the here and now number one concern, which is attraction and retention of doctors to academic medicine.

Speaking specifically of the Queensland situation, as Queensland Health has addressed salary packages to attract doctors to staff specialist positions in its public hospitals, the salaries of those with similar professional qualifications and expertise who are employed either in a fulltime or fractional position in academic practice in our four medical schools are left far behind.

This crisis threatens the very existence of academic medicine. To appropriately train the next generation of doctors, to pursue quality research and evaluation it is essential to have staff of calibre, staff that have a background in a hospital based academic discipline. Unless this issue is addressed with urgency the staff teaching the next generation of doctors will be non-doctor professional educators and doctors with miniscule fractional appointments. Medical school key staff will become glorified organisers.

The universities are unlikely to accept the need to address the salary differential, as they would see it as having a flow on effect to their other departments.

Therefore, the Association recommends that:

- The Federal Government provide funding directly to the medical schools, outside the university funding process, to ensure parity with the hospital salaried positions of those with comparable qualifications and expertise. The Federal Government may seek to share the cost with the individual state governments. If this sharing is pursued then it would be essential the process would provide surety of funding to the medical schools e.g. the Federal Government provide the funds and then retain the State contribution from its distribution of other funds (GST revenue) to the states.
- As many medical academic appointments are drawn from clinicians at Queensland Health, they could be funded as per the equivalent enterprise bargaining agreement. The source of funds should be negotiated between Governments. This would ensure parity of academic and clinical remuneration, whilst at the same time strengthening the links between

the public hospital system and the universities, and thus the three important cornerstones of medicine: service delivery, research, and teaching.

Medical Students

Medical student numbers have received considerable attention by State and Federal Governments of late, most notably with the Queensland Government's push through the Council of Australian Governments (COAG) to significantly increase the medical student numbers over the next four years. The reality is that there have already been significant increases in the medical student number intakes in recent years. Although overdue, these increases appropriately reflect the number of graduates required. The problem is simply that medical students take quite some time to graduate, and as such a short-term medical workforce shortage remains.

Prior to 2000 Queensland had a single medical school, now there are four. Also prior to 2000, the medical student intake had not increased (to accommodate population growth, increasing specialisation, or demand) since the 1970s.

In 2004, the number of domestic graduates from Queensland Medical Schools was 225, or 5.79 per 100,000 population (compared with 6.34 per 100,000 population for all Australian Medical Schools). In 2005, 276, or 23 per cent more students graduated.

The intake to medical schools last year was 496, and this will increase to 554 by 2007 (based on current approvals). Assuming the usual two per cent attrition rate, this means 543 graduates will be graduating by 2011 or 12.65 per 100,000 population, compared with 10.65 per 100,000 for all Australian Medical Schools. This means 318 extra graduates over 2004 levels, or a 141 per cent increase.[iii]

The issues would not appear to be a lack of medical students, but rather the ability to train them to become solo doctors. Without academics and staff specialists in place, there can be no future doctors. The change in medical student numbers therefore, must happen in a controlled manner. The issue with regard to academic staff is critical. When you quadruple the number of medical schools it is obvious that there will follow a significant increase in demand for academic staff. Couple this with the situation of lack of parity in salaries with the staff specialists and the crisis needs urgent attention.

Medical students not only need teachers but also patient exposure. To continue to increase the numbers of medical students in at the bottom of the ladder, particularly by asking them to fund themselves, with no attention paid to their need for patient contact is a disaster waiting to happen. AMA Queensland has thus raised concerns that further expansion of medical student places at this point in time requires caution.

Particular mention should be made of the move to increase full fee paying places. If Australia has need of a 15 per cent increase in doctors every year then appropriate funding of student places needs consideration. Families whose children are offered a full fee paying place may go through significant hardship to provide that opportunity. When these students have graduated they will quite

reasonably look to positions in which they can repay the debt incurred. These positions are unlikely to be in the public sector, and in any case, the full fee paying graduates will feel less loyalty to 'give back to the system'. It is important to state that in the current situation, students who are offered full fee paying places would have achieved the necessary academic score on a par with students with HECS funded places. Also of note is that because of the Federal Government requirement for 25 per cent of HECS students to undertake 50 per cent of their clinical years in rural clinical positions, full fee paying students are unable to choose to spend a year of their training in the rural clinical schools. These situations are not equitable on a number of fronts.

Junior Doctor Training

It is unfortunate that Queensland has arrived in the situation where there has been a lack of graduates for many years. However, it is also because of this very situation that medical student numbers cannot be drastically increased overnight. It doesn't matter how many new medical students places are created, the graduates will not be available or able to practice until they have completed their postgraduate hospital based training.

There is grave concern in Queensland as to the availability of sufficient intern positions for graduates from the four medical schools beyond 2010 when all schools will be graduating students. If all Queensland graduates seek intern positions in Queensland (which the vast majority do) it would produce a need for approximately 560 intern positions. Currently there are less than 320 intern positions in Queensland and it is considered the maximum under the current situation would be 386. There are specific requirements for supervision and training of interns legislatively and to ensure competent, safe doctors. It is not possible to just 'create' positions. This is another reason why AMA Queensland has cautioned against further increase in medical student places over the short term in Queensland.

Training of doctors in postgraduate positions requires:

1. Funding of those positions;
2. Adequate specialists to provide the training;
3. Sufficient exposure to patients; and
4. Sufficient acquisition of procedural skills.

Failure with regard to these responsibilities often lies within the province of the state governments. State governments fail to fund the registrar training positions. The culture of Queensland Health has alienated many specialists (although it must be acknowledged the Queensland Government has addressed the issue with regard to remuneration of salaried specialist staff). Inadequate bed numbers means patient exposure is limited and also results in cancellation of theatre lists with resultant lack of opportunity for doctors in training to acquire procedural skills. In these circumstances, a specialist college cannot accredit a specialist training post within a public hospital.

It has been stated that governments will not increase the training positions for procedural specialities while training positions in less popular specialities remain unfilled. Governments should be honest in this matter if indeed this is the decision they have reached. Instead, specialist colleges are forced to waste

valuable resources and time responding to government appointed bodies on the grounds that the colleges are anticompetitive. There is significant hypocrisy in state governments choosing to inadequately fund public health care, in turn limiting patient access and training opportunities, and then laying the blame at the feet of the medical profession.

The tension between service provision and teaching in our public hospitals is an ongoing matter of concern. AMA Queensland is aware that a senior bureaucrat in Queensland Health advised funding for a state-wide training facility would be dependent on operative throughput for a specific surgical department in one of our major tertiary hospitals. This in itself is totally wrong but the situation was made even more absurd in that the hospital concerned had cancellation of routine operating lists in the same and subsequent weeks. There were surgeons, anaesthetists, nursing and other staff available but all were idle because the hospital had no beds for the patients. This is all totally deplorable.

The understanding that there is a training responsibility as well as a requirement for service provision has only been acknowledged very recently by Queensland Health and it is does not seem to have permeated some of the 'upper echelons' let alone moved down to the 'coalface'.

Task substitution

In response to the limited supply of medical practitioners, and lobbying on behalf of several professional interest groups and academics, stakeholders have proposed to expand the role of the non-medical workforce (that is nurses, allied health providers and other unregulated staff) into medical areas.

There seems a tendency in government to see solutions proposed by academics to have some 'purity of intent'. In fact these academics often have their own agendas and some produce solutions that do not stand up to practical assessment. For example, Paul Gross (a health economist) has recommended to a Federal Government department that provision of prophylactic antibiotics to all patients prior to surgery could lower infection rates. An extra payment to hospitals if they followed such protocols was recommended.[iv] In an age where there is significant concern with regard to antibiotic resistant organisms with overuse of antibiotics, and risk of allergic reaction, it confirms a view that decisions regarding the provision of quality medical care requires well-trained medical practitioners.

In Queensland, the State Government made clear its intention to alter the workforce in the Queensland Health submission to the Bundaberg Hospital Commission of Inquiry dated June 2005, *Enhanced Clinical Roles*[v], which recommended that workforce problems could be ameliorated by using:

- Nurses to prescribe medications and other treatments/therapies including colonoscopies, forensic examinations and anesthetics;
- Optometrists and orthoptists in eye clinics to deal with complex issues such as glaucoma;
- Physiotherapists in the areas of Accident and Emergency and Orthopaedic Outpatient Clinics where they could administer immediate treatment, manage patients with musculoskeletal traumatic injuries and discharge home with advice.

- Occupational therapists and podiatrists in orthopaedic roles, including surgical roles; and using,
- Pharmacists to manage chronic medical conditions, provide education and advice on health problems, and prescribe drugs.

To varying degrees these ideas originated or have been supported by bodies such as the Productivity Commission in its recent *Health Workforce Report* and the research project that preceded it.

There are immense ramifications for these types of proposals. It is important that decisions made with regard to this matter are based on sound, properly evaluated, practical outcomes in the Australian environment, and do not represent 'change for the sake of change' to appear as though something is being done even though it will not produce the desired outcomes. Maintaining the standard of patient care must be the paramount concern.

Nonetheless, the Association appreciates the need to adopt a modest approach to service delivery in times of workforce crisis. AMA Queensland does not deny that there are tasks which can be conducted by other professionals, and that in many instances this may add to productivity. There is some upskilling and delegation of higher duties that could be done within multi-skilled teams to better streamline care delivery and use each type of provider to their best ability, but it does not involve substituting allied health professionals and nurses for doctors.

The least desirable outcome of this pursuit for patients and the Association is to have an array of autonomously prescribing, diagnosing, and treating health practitioners of varying qualifications and training that have no collaboration, consultation, standard of care, or accountability between them. This is the 'task substitution' model. Non-medical practitioners display evidence of not knowing when to refer onwards to more specialised care. The 'task substitution' agenda regularly fails to address the equally serious shortage of nurses and other allied professionals. It also sets to exacerbate the lost emphasis of training and education within the health system. If there is no end point (read, the medical practitioner) to coordinate patient care and delegate and supervise duties appropriately, there is no structure to guarantee adequate accredited training places or exposure of junior doctors in various skills and disciplines, nor to up-skill the other professions that intend to take on expanded roles.

AMA Queensland supports a medical-led, team approach to patient care: the supervised collaborative approach is the minimum standard in care. This is the 'task delegation' model, in which ultimate responsibility lies with the medical practitioner. This model acknowledges that medical practitioners have a wider scope of medical knowledge to apply in the physical, social, and pharmaceutical context of patient care and promotes that parties should work with mutually agreed guidelines and policies that define the shared responsibilities of care. Task delegation also ensures one point of coordination for care of one patient, or 'continuity of care'. Close cooperation between different care providers and recognition of each other's competence and limitations is essential to ensure good quality care.

Physicians Assistants

There is a current move to introduce physician assistant programs. Whether or not it is appropriate to consider this form of health worker in Australia may be a matter of discussion. However, at this current time it would be inappropriate to introduce such a course because of the impact it would have on junior doctor training. As discussed previously, there are concerns as to the adequacy of our current system to train the doubled number of medical student graduates, let alone to up-skill non-medical practitioners in medical skills.

It has been suggested by some academics that these physician assistants would be of use in rural areas. This is not a view it seems shared by the Rural Doctors Association of Australia. In any case, the experience in the USA shows these practitioners have no more desire to work in rural areas than other practitioners.

Task substitution relies on the premise that salary differentials will provide a cost saving, however it is often shown that the lower productivity of non-medical practitioners (including Nurse Practitioners) offsets any reduction in costs. In the Physician Assistant example, it can be seen that their salaries have increased at a rate greater than the CPI every year since their inception. It seems that neither issues of access nor affordability are therefore adequately addressed.

National Accreditation and Assessment of Competency

Although AMA Queensland has supported a national registration system for medical practitioners, the issue of national regulation of all health professions under one body, as suggested by the Productivity Commission seems in practical terms unworkable.

There is a concept of neatness and efficiency in having a single registration of medical practitioners, but the same does not apply for a single standards body for all health practitioners. If the proposal for a single regulatory body is then interpreted as producing an overarching body while the current individual organisations such as the Australian Medical Council (AMC) and various specialist colleges still undertake the work in reality (at least to commence with), then this would be seen as merely another government layer of unnecessary bureaucracy with the associated waste of time and finance as well as further useless 'red tape'.

The effect of centralised regulation of all health providers may erode the ability of the colleges and AMC to use their specialised and localised knowledge in their area of expertise. Diversity in this sense is important. The standards and regulation required for physiotherapists should not be determined by the same body focusing on nurses, just as dermatologists cannot decide the matters of importance for orthopaedic surgeons.

Assessment of competency requires availability of good quality data and overseas experience advises an appropriately funded and structured remediation process is essential before embarking on this process.

The Public/Private Mix

Queensland, in contrast to some of the other states, has a distinct and well developed private hospital system. Because Queensland had free public hospitals for many decades prior to the first incarnations of Medibank and Medicare, and furthermore because of a (now apparently reversed) decision in Queensland Health to discourage private (intermediate) patients within the public hospitals, our major private hospitals have facilities comparable to that of the tertiary public hospitals.

There are possibly great efficiency gains to be made from greater cooperation between the two sectors, but there are also particular issues that must be addressed.

Training students in the private sector

Training of both medical students and junior doctors in the private sector has been raised as a solution to deal with the impending increase in medical student graduates and their subsequent training as junior doctors.

There are issues with regard to patient understanding of privately funded care and their consent to being used for teaching purposes within the private system. Public education is needed if training were to proceed in this context.

There is also a matter of indemnity for junior doctors and those responsible for them. Currently the State is unwilling to fund indemnity for training in the private sector.

In Queensland, as most private in-patients are in private hospitals, it is important to consider the practicalities of using these facilities for teaching purposes. In private hospitals there is no structure of resident and registrar positions. Teaching would need to be done by the private specialists in the course of their normal duties. Just as when medical students are taught in General Practice, there is a cost in time and throughput that accompanies this model. Is there an intention to fund this teaching or is it expected the private practitioners will provide this without remuneration? Doctors have a commitment to training those who follow them, but there are financial imperatives to maintaining private practice and the quantity of teaching that can be provided as a professional responsibility is constrained by the practicalities of financial viability.

There is an example of some success of the public/private interface in the training of pathology registrars. These registrars are funded by the Federal Government in private practice organisations and rotated through both the public and private sector. However, in a pathology practice there is no direct patient contact and the individual doctor patient relationship that occurs with most areas of private practice is not evident.

Outsourcing patients to the private sector

There have been moves in Queensland to 'outsource' public patients to the private sector. This has occurred at least once in Queensland as a result of an election promise to curtail burgeoning waiting lists.

There are many concerns with this model but the most significant relate to the eventual destruction of an appropriately funded public system to give quality patient care to those who are unable to fund their own care; as well as providing an appropriate teaching environment to future generations of doctors. There is a very real incentive for the private sector to 'cherry pick' profitable services it would like to perform for the public patients (for a fee from Government). The services likely left in the public sector will be complex and costly, exacerbating the efficiency problems already experienced in public hospitals.

Furthermore, it is inevitable that human nature being what it is, many who could well afford to fund their own health care will 'make the system work for them' to have their care prioritised privately while in fact they are public patients, while those who need the public system will be left languishing with the public hospital system in tatters. There has been a good example of the negative results of this sort of process in the 'voucher system' used by the Blair government in the UK.

Other options for reform

There are examples of bringing elements of the private sector into the public sector that may result in efficiencies, without eroding the teaching and service delivery capacity of the public sector.

Queensland has the most decentralised population of all the Australian states. As such we require a health system that is adaptive to this, as the health system is not as decentralised. This is particularly so for the public sector. In many areas, because of the difficulties with recruitment and retention the procedural skills simply do not exist within some public hospitals, which may well be staffed by relatively recently graduates who are only there for the short term. However, there are several regional centres that can or should be able to provide, to some degree, sophisticated care to public patients, but the only senior doctors available may be in private practice.

Therefore, AMA Queensland recommends fee for service arrangements for private doctors to perform work in public hospitals as VMOs may be more efficient use of dollars than hourly rates for doctors who consult in, and are on call for, rural and regional public hospitals. There are cogent arguments for fee for service arrangements in that they provide for greater efficiencies in service delivery.

Cost shifting

There is a growing concern about the degree of cost shifting that occurs between jurisdictions as a result of the dual public funding model in health. There is no doubt that the blurred responsibilities for acute, primary, and tertiary health funding contribute to State and Federal blame shifting in certain areas of health, and that this public lack of accountability and financial responsibility is detrimental to the continuum of patient care.

The Federal Government has justified withholding money from the States under the Australian Health Care Agreements (AHCA) to account for the level of cost

shifting that occurs between the public hospital and Medicare Benefit Schedule (MBS).

AMA Queensland's major concern in this regard is that it is the medical practitioner who is held responsible for what is often an effort on the part of the State Government to ensure Commonwealth funding for public hospital patients. It appears at times the Federal Government 'turns a blind eye' to these activities, however doctors wish clarity in the legal ramifications.

Some examples of cost shifting include:

- Public patients are sent to have pathology and radiology undertaken either in private practice clinics at the public hospitals or sent to GPs to have the request ordered privately by the GP. When GPs refer patients to the public outpatient department (as unlike most States, these still exist in Queensland) a letter comes back requesting they send a named referral to one of the salaried staff specialists working in the Private Practice Clinic. This then enables the item to be billed under the MBS;
- AMA Queensland is aware of a patient, when referred for a procedure to be done publicly was asked by a hospital bureaucrat if they had private health insurance, as they could then have their procedure done as a private patient by one of the salaried specialists without any out of pocket expenses. They did not have private insurance, but asked what would be the hospital cost (the medical cost would be bulk billed). A figure was supplied, and the patient then opted to pay the hospital cost themselves. It seems an interesting way to 'queue jump' for a fee. Unfortunately if one needed the procedure and could not afford the fee, then one would have to 'wait in line'. This is clearly not ethical or the intent of the universal health care system; and
- In one of the major teaching hospitals it has been reported that almost all public patients referred for endoscopy and colonoscopy have the procedure performed as private bulk-billed patients by the staff specialists. The hospital charges no facility fee. Apart from concerns about cost shifting there is grave concern as to the loss of opportunity for teaching of registrars.

Governments have a responsibility to clarify the Government responsibilities in these types of issues. AMA Queensland currently has requested a written ruling from Medicare Australia so that members can be appropriately advised as to their obligations, rights and responsibilities under their provider number and the AHCA.

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[i] Report on Government Services (2006), Productivity Commission, www.pc.gov.au
[ii] National Hospital Cost Data Collection (2004), Cost Report Round 7
[iii] Committee of Deans of Australian Medical Schools, www.cdams.org.au
[iv] Report makes experts queasy (2006), *Australian Financial Review*, 13 January 2006, p16
[v] Queensland Health (2005), *Issues Paper for Bundaberg Hospital Commission of Inquiry: Enhanced Clinical Roles*, http://www.health.qld.gov.au/inquiry/submissions/enhancedroles.pdf