



AMA

**SUBMISSION TO THE NATIONAL
HEALTH AND HOSPITALS
REFORM COMMISSION**

AUSTRALIAN MEDICAL ASSOCIATION

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EXECUTIVE SUMMARY

Australia has a mostly excellent health system but with room for improvement, especially in the areas of Indigenous, rural and mental health and public hospitals. Reform of the health financing and delivery systems has some potential to improve the overall effectiveness of health spending, provided such reform is based on a keen understanding of the strengths and weaknesses of the system and builds on the strengths. That said, the AMA notes reform alone could not meet the emerging challenges and that net additional resources (financial and workforce) are required in some areas.

This submission makes a number of recommendations, key items being:

- *The Commission's early work articulating design principles and key challenges is a good start. It will be made much more useful if the Commission now seeks to relate this aspirational framework to the reality of scarce resources. The further work of the Commission should include advice to the Government on priorities and, if principles and challenges are to be overlooked, that needs to be explicit.*
- *The Commission should have regard to the longer term fiscal framework and the significant likelihood of fiscal stress by the year 2020 which will make it very difficult for the public sector to continue financing nearly 70% of national health spending. The Commission should therefore consider what could be done to enhance and sustain the capacity of private health insurance and open the door to more innovative private sector health financing options.*
- *The precept "**First, do no harm**" should guide the Commission's reform agenda. Radical reform is not needed and, indeed, may do more harm than good. Likewise, fear of failure is a poor companion if it freezes change. We can learn from past mistakes, including excessive intervention that has not worked. The AMA calls for careful, incremental change that takes the patients and providers along for the ride as active participants in system redesign, not as silent spectators to a debacle. **Change must not compromise the quality and safety of patient care.***
- *General Practice plays a key role in the Australian health care system, providing primary and preventive care and acting as the "gatekeepers" to the tertiary healthcare system. There is scope to improve support for General Practice.*
- *Public hospitals need more resources (financial and human), and expanded hospital infrastructure, to enable the hospitals to operate at safe levels (not now the case). There is some scope for efficiency gains, especially in hospital administration, but the gap between available resources and current needs is too large to bridge that way.*
- *Considerable risks attach to accountability and performance benchmarks (APBs). Badly implemented APBs might be worse than none at all. The Commission must be completely satisfied that its recommended benchmarks align closely with best medical practice and "true" good health outcomes across the system (not just in the limited areas being measured). Financial penalties should not be attached to APBs until the indicators themselves are seen to perform.*



- *The AMA would like to see an improvement in the Commonwealth/State framework but has very low expectations given the immense inertia against system change reflecting the preference of governments at all levels to maintain a cost and blame shifting system so as to avoid accountability. Commonwealth/State dysfunction hides other dysfunctions in the way the system is run. It is time to take a step back and to examine the actual outcomes from the multiple tiers of bureaucracy, not only between Commonwealth and State but also the multiple tiers within State administrations. It may not be the fact that there is a Commonwealth and State divide that is a problem, but rather layers of administration and bureaucracy are the impediment. Reform of Commonwealth/State arrangements must not be used to deflect the responsibility of the Commonwealth to pull its weight in public hospital funding.*
- *The high quality of the health workforce has been a strength of the Australian system. In particular our medical practitioners are of a standard highly regarded around the world. Australia must now continue to provide the same standard of training to our increased number of medical graduates which have been established in response to the medical workforce shortages. The AMA advocates investment in training resources and infrastructure, the use of expanded clinical settings in the private sector (including General Practice) and warns against substitution of lesser-trained health professionals.*
- *Access to high quality medical services is central to improving health outcomes for Australians. The AMA advocates that MBS rebates for patients be properly indexed to avoid an ever-widening gap between aggregate fees charged and aggregate benefits paid, that MSAC processes be improved via an interim listing process and that MBS GP items be reviewed and simplified to enable patients to receive rebates appropriate to the high quality acute care, complex care and chronic disease management and preventive care from General Practice.*
- *AMA feels that the Commission must give high priority to steps to bridge the rural health divide and advocates rural hospital infrastructure that is rebuilt, properly funded and staffed, a substantial program of incentives to attract and retain doctors in rural areas, scholarship programs to attract young doctors to rural areas, further investment in outreach services and harmonisation and augmentation of patient assisted travel schemes.*
- *On Indigenous Health, what is needed is a very significant boost in the capacity of primary care services for Indigenous people (\$500 million per annum) including infrastructure, capital works and equipment, significant expansion of the medical and health workforce and sustainable improvements in the social correlates of health, including education, employment and community safety.*



1 INTRODUCTION

The Australian Medical Association (AMA) is pleased to have the opportunity to make this submission to the National Health and Hospitals Reform Commission (NHHRC).

On any comparison with similar first world countries, Australia has an excellent health system. Health outcomes compare very favourably and are delivered at a modest cost to the community. We would sum it up as outcomes well above average for only average cost. We are doing well but we acknowledge that there can be improvements.

Successful health reform relies on an understanding of the things that we do well, as well as an understanding of the areas where there is room for improvement. It would be very foolish not to understand the strengths of our system and to build on them. The areas of relative strength/high performance are:

- ❑ Our medical practitioners are **well trained** (hence highly regarded overseas), highly ethical and sharply focussed on trying to improve health outcomes for their patients;
- ❑ Our system benefits from the role of **General Practice** in providing primary and preventive care and as the “gatekeepers” to the tertiary healthcare system. This gatekeeper role actually maximises cost efficiency and efficient utilisation of health services (There is clear scope to improve support for General Practice);
- ❑ For the most part, Australia invests appropriately in **health infrastructure** and ensures that Australians have access to modern health technologies;
- ❑ Australia's **Pharmaceutical Benefits Scheme** is seen, both within Australia and overseas, as a very successful and effective financing mechanism for pharmaceuticals;
- ❑ Our **fee-for-service medical payments system** provides the right incentives for a highly productive medical workforce; there is direct accountability of doctor to patient for the service delivered;
- ❑ Our record in **health and medical research** is outstanding and, again, Australian medical researchers are highly regarded overseas;
- ❑ For the most part, Australia has successfully used a complementary mix of **public and private sector** health financing and health service provision; and
- ❑ With some exceptions (five mentioned below) Australians have good **access** to high quality health services.

There are, however, a number of areas where there is significant room for improvement:

- ❑ Australia has neglected **Indigenous health** for far too long and the outcomes that flow from this are a national disgrace. Only very recently has there been any political resolve to turn this around. Other first world countries with Indigenous populations have a much better record than Australia;
- ❑ Our record on **mental health** is barely any better. As with Indigenous health, there has been chronic under-funding and undersupply. The health outcomes achieved fall well short of the potential and well short of what Australians should be able to access;
- ❑ Despite more than a dozen years of effort and a passing parade of spending programs, we seem no closer to finding the solutions to the poor access to health services in **rural and regional** areas. Other countries with a similar geographic challenge appear to do little or no better;
- ❑ Our record of investing in the **health workforce** is very modest. The current health workforce shortages should have been foreseen and remedial action taken years



earlier; We currently expect to have double the number of medical graduates in 2012, a long awaited outcome to a tardy response to need.

- In recent years, the Commonwealth Government has dropped the ball on funding for **public hospitals**, while the State and Territory Governments record in the management of the hospitals is lacklustre. Public hospitals need to be able to respond to increased demand by an investment in increasing their capacity.

There is undoubtedly scope for Australia to lift its game and take the steps needed to give Australians a truly first class health system.

1.1 Responding to the terms of reference

This AMA submission has been written against the backdrop of NHHRC's terms of reference and seeks to offer views relevant to the Commission's task. There are sections of this report where it might be argued that we have stepped outside the terms of reference. If so, we have very good reasons for doing so. The health system may be treated for funding purposes as though it were a set of independent silos, but that is not its nature. Health resources are scarce and competition for those scarce resources can be fierce, the more so given the increasing international mobility of skilled health professionals. Decisions taken in one area of the health system inevitably have an impact on the skills and health infrastructure available in other areas.

The AMA believes that NHHRC should have a longer term focus. While it has been given specific advisory tasks in relation to the next AHCA's, decisions taken now will have a significant bearing on the capacity of the health system to meet the needs and expectations of the Australian people in years to come.

1.2 Structure of this report

Part 2 addresses the design principles which have been articulated by NHHRC.

Part 3 examines the longer term context for the Commission's work.

Part 4 discusses the need for policy balance.

Part 5 addresses the role of General Practice.

Part 6 addresses resourcing for public hospitals.

Part 7 examines workforce issues.

Part 8 articulates the AMA's concerns with Accountability and Performance Benchmarks (APBs).

Part 9 deals with Commonwealth/State issues.

Part 10 deals with medical Medicare and its role in the wider health financing system.

Part 11 looks at issues in rural health.

Part 12 looks at the challenge of indigenous health.

Part 13 summarises the AMA's recommendations to the NHHRC.



In this submission, “the health system” should be taken to mean both the health delivery system and the health financing system. Where our comments relate to one or the other, we have sought to make this explicit.



2 NHHRC'S DESIGN PRINCIPLES

The AMA commends the Commission for articulating design principles very early in the process. There is some overlap, for example, between **(6) Value for money** and **(14) Responsible spending on health**. However, in our view this does not diminish the value of the work. Rather, it speaks of the thoroughness.

The AMA does not have any major concerns with the individual design principles. The Commission has done a good job of capturing values that we believe are held by the great majority of Australians. In their daily work, health professionals give expression to these principles to the extent that they can. However, deep frustration arises in the many situations where health professionals feel that the system is working against their efforts to achieve the best possible health outcomes and that they are denied the resources (health infrastructure and human resources) that are consistent with good health outcomes.

To a degree, the principles are already expressed in many parts of the Australian health system as it is, but only to a degree. In some cases, the principles have been quite blatantly “*more honour'd in the breach than the observance*”¹. As we observed in Part 1, **Indigenous health** has been long neglected in Australia. Governments at all levels and of all persuasions and the wider Australian community more generally share the responsibility for this neglect. The AMA welcomes without reservation the emergence of some political resolve to deal with this national disgrace.

If the Australian health system satisfied these design principles, Part 1 of this submission would not have been listing areas where the system has performed badly and the Commission itself may never have been created.

2.1 Reality check

While we might all dream of a utopia where the health system generates excellent outcomes for all, that is not the reality we engage. As medical practitioners, our goal is to achieve the best health and clinical outcomes for patients. However, we recognise that resources are scarce when health funding competes with other wants and needs. This is just as true for individuals and households as it is for governments. Within the health sector, also, there is vigorous competition for funds, staff, facilities, research moneys and claims on priorities in the formulation of health policy.

The adjudication between the wants and needs of patients with very different problems and very different prognoses is the work done by medical practitioners on a daily basis. Medical practitioners take into account the cost effective use of resources in patient management for best clinical outcome with every patient encounter.

It is extraordinarily difficult and, more so for health policy makers who do not understand the clinical needs and priorities of the patient. In any case, health resource allocation is not exclusive to a handful of bureaucrats sitting in Canberra and other capital cities. There is another player, the consumer. In any year, some hundreds of millions of decisions by twenty one million Australians—decisions as to which health services they seek to access and decisions around their own out-of-pocket spending—have a very material impact.

There is little prospect that we will ever achieve the high aims implicit in the design principles the Commission has articulated. They give expression to our aspirations, the things we can agree that we will aim for.

¹ Shakespeare, *Hamlet*, 1603.



2.2 Necessary, but not sufficient

The articulation of the design principles is necessary, but not sufficient. The acid comes when we try to reconcile scarce and rationed resources with the ever-growing health wants and needs of the population. To increase the resources is actually an important side of the equation which will help deliver the solutions and aspirations.

The fifteen design principles do not appear to us to be all of equal importance. As much as Governments might like to duck for cover when they have to make compromises that might end up pleasing nobody, those compromises implicitly give expression to the choices that are made between competing objectives. Those choices have many dimensions. They might be choices between diseases, say between cancer and diabetes. They might be choices between modes of delivery of health care, at the broad level between institutional or community services with many more sub-choices below that. At another, more subliminal level, those choices might be between access and equity on the one hand and sustainable budget outlays on the other.

The AMA considers that the Commission should now go further in relation to the design principles. What is the “pecking order”? When it is not possible to satisfy all simultaneously, which principles will be preferred over others?

The Commission has articulated twelve challenges. These challenges effectively state the Commissions’ view as to the intersect between the design principles and the areas where health system performance now falls short.

In a similar vein, we are not going to be able to hit all these twelve bases simultaneously because the resources for that will not be available. It cannot be denied that if the principles articulated are of significant importance then it will mean that increased resourcing must be contributed in order to achieve them. Otherwise, there is a need to articulate priorities to indicate where the trade-offs and the discounting should occur.

Trade offs are not acceptable if the consequence is the compromise of patient care.

3 UNDERSTANDING THE LONGER TERM CONTEXT

The AMA contends that the Commission's work needs to be undertaken with a very keen understanding of the longer term fiscal context.

In recent years, Australian governments have experienced extraordinary revenue growth, reflecting the resources boom, the extended period of strength in domestic demand and the wonders of income tax bracket creep.

An investment in health at a time of wealth is an investment in the future of Australia.

3.1 Commonwealth government revenue bonanza

The Commonwealth government has experienced a revenue bonanza way beyond its wildest dreams. One set of figures illustrates starkly the extent of this bonanza:

- In the 2003-04 Budget, Commonwealth government revenue was forecast to grow in the budget and forward estimates years by 4.2% per annum on average;
- The actual growth experienced over that four-year period was 7.4% per annum on average which equates to an extra \$82b with nearly \$30b extra in 2006-07 alone.

Despite successive cuts in income tax, the Commonwealth has had ample room to spend expansively and still produce Budget surpluses in eleven of the twelve years to 2008-09. When a revenue bonanza is experienced, the windfall is not always spent carefully or spent well. The Commonwealth found ample money to fund family tax benefits and the baby bonus (payments of a "churning" nature). It also found more money for General Practice in 2004. However, it dropped the ball on funding for public hospitals with an adverse impact that is now quite painfully apparent.

The current resources boom is making an important contribution to the government's revenue bonanza. The 2008-09 budget papers note that:

"The terms of trade are expected to rise by a strong 16 per cent in 2008-09, from levels that are already the highest in more than 50 years. Australian coal contracts have recently been settled for US dollar price increases in the range from 125 to 240 per cent, while iron ore contract prices are expected to increase by at least 65 per cent in US dollar terms. In contrast, falls in base metal prices are expected, with the slowdown in global growth adding more uncertainty to this outlook. Rural prices and import prices are also expected to support the terms of trade."²

And that:

"Over the 2008 calendar year, the terms of trade are forecast to rise by over 20 per cent which, if realised, would be the largest increase in a generation."

Resources booms come and go. In the midst of them, governments typically become over-confident. The 2007 Intergenerational report painted a less threatening picture than the 2002 report, yet not much has changed. Federal fiscal challenges are looming within the timeframe for the Commission's work so it cannot turn a blind eye to them.

However the environment is such that careful investment now will help to tide health over more difficult times.

² 2008-09 Budget paper number 1, Statement Number 2, page 2.5.



3.2 State governments also enjoying strong revenue

State and Territory governments have also enjoyed strong revenue growth:

- GST is collected by the Commonwealth government but all spent by the States and Territories. On a cash basis, GST collections were \$23.6b in the initial year (2000-01). The Budget estimate for 2008-09 is almost double that at \$45.4b. That represents average growth of nearly 9% per annum, in stark contrast to average earnings which have grown by some 4% per annum in the same period; and
- State and Territory governments have also “cleaned up” with their various taxes on property given the rises in house and land values.
- State Governments can also afford to invest in their public hospitals and in community services.

3.3 Risk of myopia

Governments are hostages to the electoral cycle and have short memories to boot. The terms of reference for the Commission illustrate the conundrum. The Commission does have leave to explore the longer term issues but its first and pressing task is to provide advice pertinent to the next set of AHCA's.

3.4 Intergenerational issues and fiscal pressures

The demographic context is articulated in the two intergenerational reports and in other highly reputable research. The key features are the long term decline in the birth rate, the long term rise in the proportion of the population who are big health consumers (those aged 65 and over) with a marked acceleration from now until 2020 and a working ages population (those aged 15 to 64) that is stagnating and may start falling in absolute terms within 40 years. These trends have implications for health spending (although new health technologies will likely continue as the larger influence on demand). The demographic trends resolve as a sharp rise in total crude dependency, now about 2 people of working age for each person outside the envelope (aged under 15 or 65 and over), but heading for 1:1.

The Australian health financing system has long relied on intergenerational tax transfers. The demographic trends suggest that we won't be able to continue increasing those transfers. We may have to reduce them instead to maintain intergenerational equity, to balance fairly the interests of younger taxpayers against the 65 and over group.

Health prevention lifts the capacity of the health system to generate good health outcomes, but will likely do little to relieve fiscal stress (and may even worsen it in the short term). Health, medical and pharma research does produce significant gains to the system. Again, this does little to reduce fiscal stress and (may even worsen it in the short term given that new technologies lift demand). The prime outcome is seen instead in quality gain, expressed in the trend improvements in health status.

The AMA expects that fiscal stress will make it impossible, politically, for Australian governments to continue contributing around 70% of an ever-rising national health bill.

Governments have a responsibility to ensure that health funding delivers quality services and accessibility to patients. In order to achieve this contributions from the private sector are required and affordable patient investment is desirable.



3.5 Recommendation

The AMA urges the Commission to give very careful consideration to reforms that will equip the private health financing system to carry a progressively larger share of the health financing burden over time. This will also have a finite limit and should be achieved by incremental change. The Commonwealth government should move sooner rather than later to enhance and sustain the capacity of private health insurance and to open the door to more innovative private health financing options.

The governments recent change to the income thresholds for the Medicare Levy Surcharge have an opposite effect to the one that is needed and desired. It will encourage drop out from private health insurance and increased burden on the public sector and public purse.

The Commission will now have to take into account this change in the demand in the public hospital system when considering the AHCA's.



4 PRIMUM NON NOCERE

This chapter focuses on the need to use a strong basis of evidence in progressing any health system reform and pursuing reforms incrementally to ensure that the quality and safety of our health system are not compromised in the process. It outlines strategies to address the following health and health care challenges identified by the NHHRC:

- 8. Promoting improved safety and quality of health care*
- 9. Improving distribution and equitable access to services*

“Success is the ability to go from one failure to another with no loss of enthusiasm.”
Sir Winston Churchill

“First, do no harm” (*primum non nocere*) is one of the principal precepts all medical students are taught in medical school. A physician always considers the possible harm that any intervention might do.

The AMA would implore that government hold to this same principle when looking at health reform.

4.1 The same framework for health system reform

The AMA believes that health system reform should rest on the same precepts of doing no harm and using a strong basis of evidence.

In Part 1, we argued that the Australian health system is a good system over all with some particular failings. It is not a system with terminal signs. Rather, it is a system with particular failings requiring particular remedial action.

In the past, both in Australia and overseas, health system reforms—more often reforms of the health financing system — have done considerable harm. Changes to the health financing system can have unanticipated and adverse consequences for health delivery. Badly judged reforms damage institutions, wreck morale among doctors and kill patients.

However to not carefully consider changes is as bad an outcome as a rash, ill-considered reform process. There is no system that is incapable of being improved. We often learn more from our failures than from our successes. The safety of the health system today rests importantly on the ability to learn from past misadventures.

Changes are necessary. But they should be pursued with great care so as to ensure that they contribute to system improvement and do no harm in areas where we have considerable strengths.

4.2 Elsewhere in this submission

Elsewhere in this submission, we address particular areas of the health system where great care is needed to make sure that reform produces good results:

- Part 6 stresses that the public hospitals need more resources (financial and human). This does not exclude the possibility of efficiency gains through systematic changes in the way the public hospitals are run. The point is that those system changes will not, in themselves, be enough. If the resources available to the public hospital system are not augmented, we will continue to see sub-optimal health outcomes and the reforms will be judged a failure even if they have gained some ground.



- Part 7 addresses workforce issues. High quality education of medical practitioners has been one of the key strengths of the Australian health system. Australia is now at very considerable risk of wasting that advantage by not doing enough to augment the training infrastructure at this critical time of generational change in the medical workforce. Workforce substitution has been advocated in some quarters as the solution to a shortage of doctors. The AMA sees that as a high risk, backwards step that trades off health outcomes and may ultimately generate more cost.
- Part 8 addresses the considerable risks attaching to accountability and performance benchmarks (APBs). Badly implemented APBs might be worse than none at all. The medical profession is much more likely to support APBs if they are done well and if they are shown to align, in a material way, with best medical practice and good health outcomes.
- Part 9 addresses Commonwealth/State issues. The AMA is frank in saying that it has low expectations of the benefits that will come from reforms in this area. Australia's federal system of government has implications for many areas of the economy. The health and education sectors tend to regard themselves as major casualties of the federal system. There is immense inertia against system change, and there is concomitant risk that political consensus will be possible only around very limited and poor quality reforms.
- Part 10 addresses medical Medicare. This is a core item in the Australian health financing matrix. It has both strengths and weaknesses. There are particular issues which, if not addressed, have the potential to exacerbate community discontent and sap public confidence in Medicare.

The remainder of this section poses further questions and challenges for the Commission as it seeks to advise the Commonwealth government and COAG on the future directions for health system reform.

4.3 When the intervention is the problem

Some interventions in the health system create problems. In the interests of public safety, there is a high degree of regulation. This regulation is not uniformly successful. When it fails (as it does from time to time), it is most common to see regulators calling for stronger powers to intervene in the system.

A high degree of regulation imposes considerable costs on the system. This can reduce the capacity of the system to respond to patient need.

There is a good deal of regulation that is supported by the medical profession. It is well understood among health practitioners that public health measures (safe water, proper sanitation, food safety, immunisation) make a very large contribution to the health status of the people.

The AMA stands for the 99.9 per cent of medical practitioners who act ethically in the interest of the patient. It supports sanctions against those who do not do the right thing through institutions such as medical boards and the PSR. The Australian people should expect that medical practitioners and all governments would work together without reserve to engender the highest ethical and professional standards possible.

Stronger powers of intervention are not necessarily the answer to every problem. Sanctions have their place in the scheme of things but they will never serve as substitutes for high quality education and positive incentives for proper conduct.



The AMA urges the Commission, in the course of its review of the health system, to give further consideration to areas where regulation and financial interventions are ineffective and are not cost effective. Where the intervention itself is the problem, reform is certainly needed. The reform process should consider whether the answer lies in more or less regulation and whether the framework strikes the right balance between positive and negative incentives. It is a mistake to take excellent work for granted while punishing wrongdoing. The best form of insurance against health system failure is a highly skilled, highly ethical and well-motivated health workforce.

4.4 “Big bang” reform is high risk

Advocates of “big bang” reform invariably start with the proposition that the system is broken. That is patent nonsense. The Australian health system is not broken just because particular elements are in need of repair.

“Big bang” reform carries considerable risk. Potential gains are much harder to articulate. Those who advocate “big bang” reform are typically driven by ideology. Part 3 argues that the growing pressures on governments from rising health spending will force a rethinking of the respective roles for public health insurance, private health insurance and individual financial responsibility. The AMA contends that the adjustments that will be needed in the years ahead will be less likely to damage the fabric of the health system if they are pursued incrementally.

People need time to adjust to new systems. Successful reform is more likely if governments engage communities openly and honestly and if the reform process is a two-way street, with governments listening carefully to the view of patients and providers.

4.5 Learn from the mistakes of the past

Australia does not have to repeat the mistakes of the past, whether Australia’s own mistakes or mistakes made overseas. Following are some mistakes we do not need to make:

- At a time when the private health financing system needs to be strengthened for the heavier-duty role it will have to assume in the future, we do not need to make the mistake of forcing private health insurance into a spiral of decline—by one cut after another—and in the process damaging the community rating that underpins the entire system. The recent budget change to the Medicare Levy Income surcharge threshold is a mistake which will encourage private health insurance drop out.
- We can learn a great deal from the adverse outcomes, health administration wastage and community disquiet with US-style managed care. Managed care, or managed spending, is the antithesis of the people and family centred system articulated as the Commission’s first design principle. It structures the system around the financial needs of the insurers. Government decisions that lower the privately insured pool in Australia will have direct impact on private health insurance premiums. Insurers will have to raise premiums; this may make them unaffordable to an increasing number of the population. Further fall out means further premium increases and insurers will attempt to contain prices and costs by implementing managed care in Australia. The US health system is not the best system in the world, merely the most expensive, the most burdened by bureaucratic wastage and the most litigious. The Australian health system arguably produces better health outcomes for most (Indigenous peoples being a stark exception), is more equitable and makes more efficient use of health workforce and health infrastructure. We do not need to copy US mistakes.



- At a time when GPs are in short supply, we do not need to copy the UK mistake of trying to make GPs the budget holders (in effect, health care administrators and agents to impose rationing on behalf of the government). GPs have a critically important role in the Australian health care system. They are the gatekeepers to the system. The skill with which they carry out that role has an important bearing on the overall cost effectiveness of the system. They carry the biggest burden of acute care, preventive health care and chronic disease management. They carry the biggest burden of mental health care. The creation of budget or fund holders serves merely to distance politicians from their decisions to impose excessive rationing of access to health care. Fund holding means that the doctors must ration the care and there are perverse incentives introduced into the clinical relationship between doctor and patient. It is the antithesis to making governments accountable for their actions. Australia will get best results by better equipping GPs for their role as the first line in preventive health care, the gatekeepers to the tertiary health care system and advocates for their patients.

4.6 Recommendations

The AMA recommends to the Commission that:

- All its reform proposals are evidence-based and carefully assessed for any potential harm as well as for possible benefit;
- The risk of harm should inform, rather than impede, the process of developing options for the future. It will enable development of better policy. The emphasis should be on careful, incremental change. Medical practitioner led reforms will make the patient the priority and deliver the best outcomes. Patients and providers must be active participants in system redesign, not silent spectators to a debacle.



5 THE ROLE OF GENERAL PRACTICE

This chapter focuses on the importance of further expanding GP-led primary care to ensure that patients receive properly coordinated and high quality holistic primary care under the guidance of the supervising and coordinating medical practitioner. It outlines strategies to address the following health and health care challenges identified by the NHHRC:

- 2. Investing in prevention*
- 3. Ensuring a healthy start*
- 4. Redesigning care for those with chronic and complex conditions*
- 5. Recognising the health needs of the whole person*
- 7. Caring for and respecting the needs of people at the end of their life*
- 8. Promoting improved safety and quality of health care*
- 9. Improving distribution and equitable access to services*
- 11. Improving and connecting information to support high quality care*

5.1 Current situation

Australia has a strong primary health care system, built around the role of the GP. 80% of Australians visit a GP at least once each year and evidence shows that Australians spend more time with their GP than in most comparable countries.

In 2006–07 GPs delivered around 103 million services through Medicare at an average of 5 GP services per person. This equates to approximately 280,000 services per day, every day of the year at an average cost to the public purse of around \$40 per service. Given the high quality health care outcomes GPs deliver, in any language, this represents excellent value for taxpayer dollars.

GPs also provided an estimated additional 6.6 million services that were paid for by other funders (such as workers compensation, state Government) or not charged for at all.

GP numbers in Australia, per head of population, are comparable to similar nations. Like many other countries Australia is going through a period of workforce shortage. GP shortages are not uniform although it is fair to say that outer metropolitan, regional, rural and remote areas are most likely to encounter GP shortages.

There is little doubt that GP shortages have been engineered by successive Government policy decisions. Governments have placed artificially low caps on GP training numbers and have not given general practice the support it needs. The red tape burden on general practice has grown while patient rebates fall further behind the cost of delivering GP services every year. It invariably takes a crisis for the Government to sit up and take notice.

Despite this, general practice has shown itself to be remarkably resilient and as being able to adapt to the times. GPs have embraced team based care arrangements and are moving away from solo to multi-doctor practices. The majority of practices are now accredited and the take up of IT in general practice has been strong.

GPs are tackling key issues such as mental health and chronic disease. In providing these services, GPs already provide their patients with access to allied health services. In addition many GP practices employ Practice Nurses who provide care to patients under the direct supervision of the GP. These nurses are involved in a variety of activities such as wound management, immunization and pap smears for which rebates are available on a for and on



behalf of basis. GPs utilize their practice nurses for many more services which increase patient access to General Practice care, and the AMA has been calling for and extension of the “for and behalf of “ rebate for patients for these services.

General practice is doing its best to keep up with the times, and with more support, there is no doubt it could do even better. We need to build on these achievements.

5.2 The benefits to the health system of the GP

The strength of general practice continues to relate to its gatekeeper role. Patients appreciate the first-contact and coordinating role of their GP. There is evidence of improved patient centred care, improved efficiency and quality of care, and cost effectiveness in comparison to other health sectors.

GPs have the comprehensive training to treat the patient holistically, not just as an ailment or disease. Only doctors can take a history, examine and put together the whole person when making a diagnosis, initiating investigation and management and treatment.

GPs determine what services a patient needs based on a proper clinical assessment. Unnecessary tests, inappropriate referrals etc are avoided and patients will be able to get access to treatment in clinically appropriate timeframes.

A system that does not support this traditional role of the GP will start to erode its function, and more fragmented and expensive sites of care will emerge as a result. This is not good public policy.

5.3 How can we improve the system?

The Commonwealth Government has announced its intention to develop a National Primary Care Strategy. At the same time, the Government will also conduct a review of GP items in the Medicare Benefits Schedule. There is no doubt that these reviews will cut across the work of the Commission.

AMA policies are consistent with many aspects of the stated aims of the primary care strategy. The AMA is firmly committed to:

- ❑ Better rewarding prevention.
- ❑ Promoting evidence-based management of chronic disease.
- ❑ Supporting patients with chronic disease to manage their condition.
- ❑ Supporting GP led multidisciplinary care teams, which allows enhanced access to other health professionals including practice nurses and allied health professionals like physiotherapists and dieticians.

The proposed primary care strategy must not undermine patient access to a GP. The role of GPs in diagnosis and coordinating patient care is fundamental to quality health care. GPs have embraced team based care arrangements and work to ensure that patients get the right care at the right time.

The current structure for MBS GP consultation items is excessively complex. The number of GP consultation items has grown enormously. In the early 1990s, there were 46 GP consultation items. By November 2005, there were four times as many. Even so, the vast majority of GP consultation items billed were the stock standard in-surgery consultation items (items 3, 23, 36 & 44).



There is a complex interaction with other funding streams including — the practice incentives program and the service incentives program. The growing complexity, in part, appears to be driven more by the desire of bureaucrats to collect statistics than any particular imperative for quality patient outcomes.

GP management plan items, team care arrangements, health assessments, and case conferencing items make the MBS a nightmare to navigate. Strict conditions are often tied to many of these items as well. When you add inadequate patient rebate levels to this mix, it is simply a recipe for GPs to say it is all too hard.

The current Medicare Benefits Schedule is complex, and needs to be modernized to meet changing patient needs. Patients need a rebate system that supports them when they see a doctor for acute care, and also for more chronic or complex problems, and for preventative medicine. GP are needing to spend more time with their patients

Studies show that patients who have access to longer consultations with their GPs use other areas of the health system less often - saving the health system and the community money.

We need a modern Medicare Benefits Schedule that supports the patient's access to the clinically effective and cost effective high-quality care that is delivered in General Practice.

The MBS should support patients spending more time with their doctor so GPs can focus more on tackling chronic disease and delivering preventative health care.

Recent Australian Institute of Health and Welfare (AIHW) data showed that GPs are playing a key role in the fight against chronic disease – including high blood pressure, diabetes, osteoporosis, skin conditions and cardiovascular disease.

The AIHW said the number of encounters for chronic disease rose from 46.5 per 100 encounters in 1998/99 to 52.1 per 100 encounters in 2006/07.

In recent years, some adjustments have been made to fee relativities, but the relative fee structure continues to discourage longer consultations.

There is no doubt that GPs play an important role in keeping people with chronic and complex disease out of hospital. The MBS needs to support, rather than frustrate this goal.

The number of Australian trained graduates choosing general practice as a career is at an all time low. It is little wonder that Australians are concerned about access to a general practitioner. The training of the future GP workforce has been neglected for too long. The number of training places needs to be expanded as a matter of urgency and the Government must give GP supervisors much better support. Funding for infrastructure and supervision are desperately needed to increase the number of GPs that can become involved in GP training.

5.4 Independent access to other primary care practitioners

Nurses and other health providers are skilled and respected in their role in assisting patient care but in terms of comprehensive primary care, they are most effective for patients while under medical supervision.

Other countries have attempted to substitute doctors with other health care providers. These are best described as brave experiments – based on little or no evidence. Studies that have attempted to evaluate these experiments have relied on “patient experience” and have not



attempted to evaluate clinical outcomes. There is evidence that where independent nurse practitioners have been trialed the referral rate to doctors actually increases demand. There is therefore an additional layer of cost that is introduced when by-passing the general practitioner's ability to make a cost effective and clinically appropriate assessment of a patient's need in the first instance.

Australians can access other primary care services whenever they like and in general there are no public subsidies available through the MBS for this direct access. We are not suggesting this access should change. Currently through care plans doctors can enable patients to receive a Medicare rebate for specific allied health providers, eg clinical psychologists, physiotherapists, as part of a clinically appropriate and coordinated management plan. The Doctor remains the gatekeeper to ensure the most cost effective utilization of Medicare dollars for best patient outcome.

Giving other primary care practitioners independent access to the Medicare Benefits Schedule, prescribing and referral rights and the ability to order investigations will cause a massive increase in demand on scarce health resources and generate enormous cost without improving health outcomes for patients, and may in fact put patients at risk. The only way this can be avoided is by access to such publicly subsidised services to be through the General Practitioner, not directly.

In reality, the concept of direct access is likely to significantly increase health costs and result in fragmentation of care and the loss of continuity of care. Removing the GP as gatekeeper to the primary care system will mean that the patient will be delivered episodic and fragmented care without the overall view of the General Practitioner of the patient's needs and outcomes. The patient is likely to experience delays and inconvenience in accessing the right treatment.

5.5 Fund holding

The delivery of primary care services in Australia is largely based on fee for service. It is a system that works well. It gives patients choice and allows them to access health care according to need. Fee for service applies a direct responsibility of medical practitioner to the patient. It incentivizes service delivery. We have a strong safety net in place to ensure that disadvantaged patients can afford to access care in a fee for service environment. It is a cost efficient and proven method of primary care delivery.

In contrast, the fund holding model of care essentially rations patient's access to medical services and imposes the rationing of funds between the doctor and the clinical decision that is best for the patient. The primary concern in a fund holding model is not the patient – it's the budget. The budget determines how much access to care patients get. Overseas evidence to support fund holding is weak.

GPs do not support fund holding. Available surveys have shown that only 4% of GPs support fund holding whereas 75% of GPs support fee for service arrangements.

5.6 Recommendations

The Government needs to:

- Remember the value of access to high quality medical services in improving health outcomes for Australians and have this foremost in mind as it formulates its annual budget and develops appropriate health policy;



- ❑ Acknowledge the important role of general practice and increase GP training numbers to meet community need;
- ❑ Ensure reforms to primary care arrangements preserve, enhance and support the key role of the General Practitioner as having overall responsibility for the care of patients;
- ❑ Ensure reforms to primary care funding do not undermine fee for service arrangements;
- ❑ Move quickly to review and simplify MBS GP patient rebate items so that they enable patients to access rebates for the high quality of care that General Practice delivers in acute care, preventative medicine, complex care and chronic disease management; and
- ❑ Reduce red tape.



6 RESOURCING OF PUBLIC HOSPITALS

This chapter focuses on the need to increase resourcing for public hospitals to expand their bed capacity and ensure they are operating at a safe occupancy rate. It also highlights the need to maintain an appropriate public/private sector balance especially in relation to acute care services. It outlines strategies to address the following health and health care challenges identified by the NHHRC:

6. Ensuring timely hospital access
9. Improving distribution and equitable access to services
10. Ensuring access on the basis of need, not ability to pay

6.1 Key Points

- The system needs more real resources (financial and human) and hospital infrastructure has to be expanded to enable the hospitals to operate at safe levels;
- Current high hospital occupancy rates are unsafe and result in access block for patients and long waiting times for elective surgery in the public system;
- Genuine GP type patients presenting to EDs are only about 10% of presentations and consume about 1% of ED resources;
- It is essential for the survival of the public system that the private sector remains buoyant and that public hospitals receive additional resources to cope with any changes in public private participation rates that may occur.

6.2 Resourcing and bed capacity

Public hospitals have confronted both resource constraints and human resource constraints in recent years. There is no point in addressing one of these constraints but not the other. Both need to be addressed for capacity to be increased and safety and quality of public hospital services to be improved.

There is substantial variation in the year by year contribution of the Federal and State Governments towards public hospital funding. There is also substantial variation in the respective shares by State and Territory. In addition, the Federal contribution tends to be smaller for the less efficient States and Territories which are, by and large, the smaller States and Territories.

Historically, the Commonwealth share of public hospital expenditure has remained at or close to 50%. However, the Commonwealth share in 2005-06 had dropped to 41% of the total while the States and Territories share had risen to 51%. Preliminary advice suggests the Commonwealth share has fallen even further in 2006-07.

In summary, at the broad financing level, the Commonwealth Government share of public hospital funding has fallen substantially over the last decade from 50% to 41%.

Although the recent decisions to provide some extra funding to reduce elective surgery waiting lists (\$600 million over 4 years) and to provide additional funding in 2008-09 (\$1 billion) to enable extra time to renegotiate the Australian Health Care Agreements will help, these one-off funding injections will not restore the balance to its historical levels or provide ongoing resolution of the problems being experienced in public hospitals around the country.



As a result of this funding deficit, public hospitals are operating at near total capacity. Desirably, public hospitals should operate at a maximum of 85% of total capacity. At this level, unplanned admissions can be accommodated without undue delays.

The AMA has estimated that close to \$3 billion as an upfront contribution by the Commonwealth would restore its share of public hospital funding to 50/50 and enable the public hospitals in Australia to provide the additional 3,750 public hospital beds needed to ensure maximum occupancy at 85%. This figure was calculated prior to the change in Medicare Levy income threshold surcharge which will shift increasing demand into the public sector and will need upwards revision.

We have an ageing population and the number of beds per '000 population over 65 years has fallen by 67% in the last 20 years.

We know from Commonwealth data that was utilized for the "AMA Public Hospital Report Card 2007" that by State and Territory our public hospitals are working at unsafe occupancy levels.

The public hospitals do not routinely publish bed occupancy data but we know from our members working in the public hospital system that bed occupancy in the big public teaching hospitals in Australia is routinely in the 95-100% range. Bed occupancy levels of this magnitude are unsafe and lead to serious delays in the Emergency Department, treatment in corridors, multiple patients in treatment bays etc.

There is pressure on access for all categories of admissions and there is similarly pressure on access to Emergency Departments (EDs). All the relevant indicators, where they exist and have been consistently reported, are moving in the wrong directions.

It is only when the overall bed occupancy is at the 85% level or lower that EDs can have the level of access to admissions that are required to do the job properly. In the absence of increased public hospital bed capacity, measures such as the elective surgery waiting list reductions can worsen the situation in the ED. Improvements in GP-led primary care and a stronger focus on health prevention, will alleviate only some of the pressure on hospital emergency departments. Genuine GP type patients presenting to EDs are about 10% of presentations and consume about 1% of ED resources. Given this, the expansion of GP-led primary care reforms that we have proposed elsewhere in this submission and an increased focus on health prevention which are desirable from a patient care perspective, will make only a minor difference to EDs.

It must be accepted that with population growth, increased longevity and the ageing of our population with the current severe hospital bed deficit, increasing the number of hospital beds is a priority if we are to restore bed occupancy to safe and manageable levels and improve elective surgery and general public hospital access for patients in the future.

In addition, the requirement for public hospitals to maintain a bed occupancy rate of 85% or lower should become a national performance benchmark of enormous profile and significance. This can only be achieved by a large increase in bed capacity in the public hospitals as we are proposing.

6.3 Morale

Public hospitals are beset by tight resource constraints, high levels of demand, medical and nursing workforce shortages, capital equipment issues and intermittent political crises. This



leads to strong public criticism, political intervention and high profile inquiries and further criticism.

It would not be surprising in this situation to find that the public hospitals are beset by morale problems. This is precisely the feedback we are receiving from medical practitioners on the ground. The fabric of the system built around the dedication of the medical and nursing workforce which has carried the system through hard times, is showing signs of reaching its limits. There is a declining sense that a public hospital medical appointment is the high point in a medical career making other negative aspects of hospital work tolerable.

There is a strong sense that the system is being managed in the interests of government and bureaucracy but not in the interests of patients and the people who provide their care.

Additional resourcing for the public hospitals will go a long way to rectifying these pressures on public hospital staff. However, there is also a need to recognise the pressures that public hospital staff will always be working under and for governments to avoid criticising problems at the hospital coalface and instead look at systemic failures and solutions when problems do arise.

6.4 Public/private balance

The recent budget announcement by the Federal Government to increase the Medicare Levy surcharge threshold has been predicted by the government to significantly reduce the level of participation. The AMA believes that the impact on future premiums and private health insurance participation rates and the downstream impact on public hospital pressures have been significantly understated.

The public hospitals do 4.45 million admissions per year and the private hospitals do 2.85 million (40%). Private hospitals do more than 50% of all surgery. The public sector shoulders the burden of the more urgent and more complex medical cases. Ten years ago the proportions were different. The majority of elective surgery for those with PHI is now accessed through the private hospital system. The uninsured access elective surgery through the public system but they are only able to do so because nearly half the population chooses not to use the public system for this purpose.

The buoyancy of the private system has been a major factor in the survival of the public hospitals in the last ten years. It is essential for the survival of the public system that the private sector remains buoyant. The private hospital system is not an optional add on or supplement for the public system. It is a key part of hospital Medicare and an important complement to the public system.

The late 80s and 90s saw a “steady as she sinks” approach to the private health system at least as it is financed through private health insurance. Private health insurance participation declined to 30% of the population through the ideologically driven removal of many subsidies and the transfer of additional costs to private insurance. This was not offset by additional public hospital expenditure and a crisis in access was emerging before there was significant intervention in the late 90s.

It took many years to stabilise the situation but it has been in equilibrium for the last 5 years at least and private health insurance participation has held up at 44% of the population. It is of great concern to the AMA that one of the supports under private health insurance is going to be severely and dramatically diluted. Our concern is that this will begin a downward spiral in private health insurance participation that will have a strong and escalating impact on the public hospital system – a snowball effect.



In the short term the government has predicted that most of the people who drop their private health cover will be the young and healthy. However, even these people have accidents, have babies and have other unpredictable health problems resulting in acute care episodes as well as possible chronic needs. In particular Public Paediatric and Maternity Hospitals will feel an impact.

In the longer term this change in health fund member demographic will lead to increases in private health insurance premiums as the remaining health fund members have an increasingly higher and more expensive health care risk profile. This is the downward private health participation spiral that Australia has experienced before and should not experience again.

The public hospitals have barely coped with the increases in demand that are generated by ageing and population growth and would not be expected to cope if there is a significant shift from the private sector.

If the government's proposed changes to the Medicare levy surcharge go ahead, the government will need to consider alternative strategies to deal with the downstream effect. These should include serious consideration of the following:

- ❑ Keeping the existing 30% rebate for everyone and offering additional incentives for low and average income earners to mitigate the impact on families and older Australians of inevitable increases in private health premiums; and
- ❑ Providing separate additional funding for public hospitals through an explicit provision in the next Australian Health Care Agreements (AHCAs) which links each 0.5% decrease in private health cover participation rates to specific additional funding to the States through the AHCAs.

6.5 Remedies

We need:

- ❑ an additional \$3 billion of Commonwealth funding to restore the historical 50/50 share of funding which has applied between the two levels of Government;
- ❑ this additional funding to be used to provide an additional 3,750 public hospital beds which will allow public hospitals to operate at a safer 85% of total capacity;
- ❑ Recognition of 85% bed occupancy as a national performance target;
- ❑ Expansion of GP-led primary care teams to improve patient care and to alleviate the pressure in the EDs from primary care type patients;
- ❑ Recognition of the important role of the private hospital sector and the need to maintain a stable private health environment with strong participation;
- ❑ Additional financial assistance for low and average income earners to help with the cost of increased private health insurance premiums that will result from recently announced government Medicare Levy surcharge changes;
- ❑ An explicit provision in the next Australian Health Care Agreements to provide additional funding for each 0.5% decrease in private health participation rates over the life of the next agreement.



7 WORKFORCE ISSUES

This chapter focuses on the need to increase our current and future training capacity in acute and primary care settings in the public and private sector, to ensure that we make maximum use of the increase in medical graduates. It outlines strategies to address the following health and health care challenges identified by the NHHRC:

- 9. Improving distribution and equitable access to services*
- 12. Ensuring enough, well-trained health professionals*

7.1 Extract from the NHHRC Terms of reference

2h. provide a well-qualified and sustainable health workforce into the future.

7.2 Key points

Australia has a very good record for producing highly skilled health professionals but a relatively poor record when it comes to training the appropriate number in the first place and ensuring, in the second place, that having regard to the high cost of training we retain skilled workers in the system. The loss of skills in some areas, especially nurses, reflects on the quality of management of the hospitals and the failure to properly value and reward skills.

Policy makers have also been very slow to recognise the growing international mobility of health professionals and the unsustainable nature of the policy which depended upon snaring ever-increasing numbers of overseas-trained (OTD) and temporary resident (TRD) doctors.

This submission draws attention to:

- ❑ The delayed response to workforce shortages;
- ❑ Poor preparation for the welcomed increased number of medical students and graduates;
- ❑ The need to build available training resources and infrastructure;
- ❑ The need to utilise expanded clinical settings in the private sector;
- ❑ The need to recognise the untapped potential for training opportunities in General Practice; and
- ❑ The need to retain doctors at the head of the health care team and to avoid the pitfalls of task substitution.

7.3 Workforce shortages

Medical workforce shortages have emerged as a growing problem over the course of the last fifteen years as a result of poor policy decisions and blinkered workforce planning. Just when Australia was slipping into a situation of medical workforce shortage (in the mid-nineties), policy makers decided to restrict the growth in medical school places and seize control of entry into General Practice.

The Commonwealth government deserves credit for responding to medical workforce shortages by significantly increasing its investment in medical school places. By 2012, the number of domestic graduates from medical schools will grow to almost 3,000 per annum compared with fewer than 1,300 per annum in 2002. Over the next few years, we will see a



dramatic increase in total undergraduate numbers (full-fee paying and assisted, domestic and international).

7.4 Current and future training capacity

Assuming that Australia gets the intern and post-graduate training regime right, this surge in medical student numbers will help to address overall medical workforce shortages. Australia now has an ageing medical workforce. In some General Practice and some other specialties, there are quite large numbers close to retirement age. A significant number of extra graduates will be required simply to replace those who will leave the workforce.

There are three parameters which should be the focus for medical workforce training:

- the number of clinical places for medical students;
- the number of intern places; and
- the number of vocational training places.

We need to hit all the bases and make sure that the numbers are adequate in each area. The challenge is enormous:

- As recent as 2007, there were 1,582 domestic medical school graduates. The number of intern places in 2007 was 1,776 while the number of first year vocational training places was 1,957.
- These numbers fall well short of anticipated graduate numbers in the year 2012. When full fee paying international students and graduates of the Australian Medical Council (AMC) exam are factored in, the challenge looks even more immense.

Despite best efforts, we do not have reliable data regarding the current medical education capacity in Australia. Although we have started to collect and publish some data beyond the traditional Medical Training Review Panel reports, there are still significant gaps in our recording and interpretation of medical training data. What data we do have (especially in states that have done analysis of their training capacity) indicates that there will be an enormous shortfall in terms of high quality training positions for medical students through to prevocational doctors and also for vocational training.

There was barely any increase in the number of Australian and international medical graduates for nigh on 30 years. Australia tried to fill the shortfall with OTDs and TRDs. That strategy was not sustainable. One consequence of suppressing Australian medical school places is that we are now struggling to provide adequate training for students and graduates. This will be compounded as more medical students are pumped into the system.

7.5 Competition for training places

In the context of increased pressure for clinical experience, caution should be exercised with respect to the creation of “new health practitioner roles”. It does not make sense to invest in new medical graduates, only to find that they are unable to access quality clinical experience because of an influx into the system of lesser trained health professionals competing for places. Implementation of these new “roles” should be delayed until medical training capacity can be guaranteed. There is also a need for evidence published in a peer-reviewed publication to demonstrate their safety and efficacy.



7.6 Lack of support for medical education and training

In November 2006, the House of Representatives Standing Committee on Health and Ageing released its report on health funding – *“The Blame Game – Report on the inquiry into health funding”*, including pertinent observations regarding health workforce training in general. The Committee noted:

“high levels of stress in the public hospital training environment that leaves less time for quality training. In an environment where staff are trying to respond to demands on service, there is little time to take on professional roles with students, or with other staff.”

And concluded that:

“the rising numbers of medical graduates and allied health graduates will place significant pressure on universities and public hospitals to provide sufficient clinical training opportunities”.

The problem has been known for some time. There are few runs on the board in preparing for it. That is a matter for increasing concern.

7.7 Seeing the solutions

In its April 2008 initial report, the Commission has, in our view quite correctly, identified significant issues in with respect to:

- ❑ the public sector’s focus on service delivery — at the expense of research, education and training;
- ❑ the impact that cancelling operating lists has on teaching opportunities;
- ❑ inadequate access to protected time for research, teaching and training in the public sector;
- ❑ inadequate access to supervisors;
- ❑ problems in accessing suitable clinical placements for medical students; and
- ❑ the importance of better utilising training opportunities in the private sector, including General Practice.

The AMA supports the solutions articulated in the separate submission by the AMA’s Council of Doctors in Training (CDT). There is an urgent need to strengthen the teaching and training culture.

We need to restore the balance of service delivery and medical workforce training in our public hospital system, to support a sustainable and well-trained medical workforce. We must give greater support to clinical academics and do much more to encourage doctors to become involved in teaching, training and research at all levels.

Protected training time, adequate clinical teaching opportunities, more resources for supervision and better infrastructure in the public sector are all extremely important factors in delivering a culture and an environment that encourages high quality medical education.

The proposed APBs should include robust benchmarks that would provide credible, objective information on the progress of the Commonwealth, states and territories in ensuring that sufficient high quality training places are available. This seems to require going further than the specific benchmark proposals set down in the April report.



The use of benchmarks does amount to the application of negative incentives (with the possibility of financial penalties when the benchmarks are not met). There is a need for careful consideration as to whether negative incentives will be effective given the great importance that must now attach to getting the training equations right. It remains an open question as to whether the Commonwealth government should quarantine training costs and fund training directly, even though this might seem to be a step away from the bundling of many smaller programs that seems to be envisaged.

If not, then explicit targets could extend to all parts of the training matrix:

- ❑ clinical placements in public hospitals to match the requirements of medical schools in the relevant state/territory;
- ❑ accredited intern places in public hospitals to match the increasing output of local medical schools;
- ❑ college accredited vocational training positions in public hospitals;
- ❑ medical school placements, prevocational and vocational training places in general practice; and
- ❑ prevocational and vocational training places in expanded settings such as the private sector.

There has been a tendency on the part of State jurisdictions to manage training issues primarily for their own benefit (using the trainees to shoulder a significant base workload). They rarely look beyond the doors of their hospitals and do not sufficiently take into account the benefits of building the primary care workforce — which they see solely being a Commonwealth responsibility. There can be a disconnect between the immediate needs of the State hospitals and the core aim of providing a well-qualified and sustainable health workforce into the future. In pursuit of that core aim, the AHCA should require State jurisdictions to release junior doctors for specific training programs in General Practice and the private sector, given the educational and long term workforce benefits.

7.8 More solutions — increased GP placements

Funding for infrastructure and supervision support would unleash potential for General Practice to contribute more substantially to medical education and training.

The AMA has previously proposed the investment of an additional \$25m per annum for medical student GP placements. Up until 2008, the Commonwealth had funded 280 prevocational GP training places per annum. The 2008-09 Budget has significantly cut funding to this program in the face of recommendations that it be expanded to provide 1,000 prevocational training places in general practice.

In order to meet projected general practice workforce needs, vocational training positions must also be increased. The 2005 AMWAC report on the GP workforce estimated that Australia needed at least 1,100 new GPs each year. The general practice training program intake is capped at 600 places per annum.

7.9 More solutions — Training in expanded settings

The AMA believes that there is medical training potential in the private sector, as well as other “expanded” settings such as community placements. Training in these settings (across the continuum) provides trainees with broader experience as well as increasing the capacity of the system generally.



The Commonwealth currently provides funding to support around 200 vocational training positions (excluding general practice) in expanded settings. The work of the Medical Specialist Training Steering Committee confirmed this potential. The AMA estimates that the total cost of such a program would be around \$200m per annum.

7.10 Accreditation of medical workforce training

Australia must ensure the quality of new training opportunities with an underpinning of rigorous and independent accreditation arrangements. The AMA believes that the role of the Australian Medical Council, postgraduate medical education councils (PMCs) and the learned medical colleges must be preserved and, where appropriate, given greater recognition and support.

7.11 Medical Training Review Panel (MTRP)

The MTRP has played an important role in monitoring the progress of efforts to expand vocational training places and has overseen an increase in the number of first year vocational training positions from an estimated 1,369 in 1998 to an estimated 1,957 in 2007, an increase of 43%.

The AMA would like to see the MTRP's monitoring role enhanced, with the Commonwealth, States and Territories required to provide annual data to the Panel on the numbers of:

- ❑ public hospital clinical placements for medical students;
- ❑ accredited intern places, broken down according to discipline; and
- ❑ GP pre-vocational training places and Commonwealth funded private sector training positions.

Data such as this could then be used to determine whether or not individual jurisdictions were meeting training benchmarks set under the Australian Health Care Agreements. The Commonwealth, States and Territories should also be required to report annually on activities in place to coordinate and/or provide additional training places.

MTRP should be charged with undertaking a biennial review of efforts to build medical workforce training capacity. This would help identify training bottlenecks and provide clear policy advice on how to address these.

7.12 The workforce imperative

Past experience has shown that you cannot simply turn the tap on or off when it comes to medical workforce. It takes a long time to train a medical practitioner and it is not possible to conjure up new resources such as supervisors, rooms, facilities, new operating theatres etc overnight. It takes time to put all of the supports in place to ensure that a medical practitioner gets the level of training and education that they need.

Australia faces the real prospect of a training emergency. We need to ensure students get the right clinical experience, and that once they graduate they can progress through their training in a timely fashion. An appropriate, independent accreditation process must oversee this training.

The prospect of a training bottleneck is rapidly approaching. The Medical Deans of Australia and New Zealand (MDANZ) has reported that "*medical students are undertaking up to three*



years of supervised full-time clinical placements and the impact of the increased numbers will be felt as early as 2009”.

The clock is now ticking loudly and the alarm bells will soon be ringing. This issue needs to be tackled as a matter of urgency.

7.13 Task substitution

Quality health care for patients depends on a well-trained workforce providing coordinated care under the direction of fully educated, trained and accredited medical practitioners.

The AMA supports appropriate delegation of tasks or referral of tasks to other types of health practitioner where it can be demonstrated that there is an improvement in the access and delivery while maintaining the quality patient care. This is determined by medical practitioners in a clinically appropriate manner. The AMA supports the concept of healthcare teams and believes that this concept underpins the high quality of medical care in this country. A healthcare team is led by a medical practitioner and may involve other medical practitioners as well as other health providers.

Task referral or delegation and doctor led patient care is not new to the medical profession. We do it every day when we work with our nurses, refer to allied health providers, discuss with the pharmacist and consult our colleagues. The “team” is a reality, and it works efficiently without compromising care.

The substitution of medical practitioners with other classes of health practitioner for workforce reasons or cost saving cannot be supported. The compromise of patient care is at stake, and increased costs will be incurred with loss of cost effectiveness. The AMA supports research into the potential impact of the introduction of any new types of health practitioner into the workforce. Any new type of health practitioner must work in a delegated role within the healthcare team.

The impact on training of any reform of the health workforce must be considered.

The AMA does not believe that the substitution of doctors with other health practitioners is the solution for the health of rural Australians. Rural Australians have the right to access medical practitioners and medically supervised services as do their metropolitan counterparts.

The AMA believes that the present and predicted shortages in the medical workforce relate to a lack of funding of the health system and an immediate shortage of fully trained doctors. Medically led workforce reforms may contribute to more efficient use of available resources and may form part of the solution to the current workforce crisis.

However, the overall numbers of practitioners and the quality of their training cannot be ignored. Proper long term health workforce planning and adequate funding of the entire system should result in a flexible but well structured and organised health workforce sufficient to meet the current and future health needs of the community.

7.14 Remedies

The AMA advocates that the Commission consider whether there is a need to go against the trend of broadbanding of Commonwealth payments by quarantining training costs and funding training directly. If not, the Commission is urged to consider:

- explicit targets extending to all parts of the training matrix;



- ❑ clinical placements in public hospitals to match the requirements of medical schools in the relevant state/territory;
- ❑ accredited intern places in public hospitals to match the increasing output of local medical schools;
- ❑ college accredited vocational training positions in public hospitals;
- ❑ medical school placements, prevocational and vocational training places in general practice;
- ❑ prevocational and vocational training places in expanded settings such as the private sector; and
- ❑ an expanded role for MTRP is monitoring progress against targets.

The AMA urges the Commission to take particular care not to harm the system by advocating substitution of lower-trained health professionals in areas which require the skills and experience of a medical practitioner.



8 ACCOUNTABILITY & PERFORMANCE BENCHMARKS

This chapter focuses on the need to improve health system accountability by introducing appropriate performance benchmarks but to be aware of the risks of introducing performance measures that are not well-designed or well-tested. It responds to the NHHRC's initial advice to government on the development of accountability and performance benchmarks.

8.1 Extract from the NHHRC Terms of reference

1. *By April 2008, the Commission will provide advice on the framework for the next Australian Health Care Agreements (AHCAs), including robust performance benchmarks in areas such as (but not restricted to) elective surgery, aged and transition care, and quality of health care.*

8.2 Comments on the NHHRC's April report

In setting the framework for APBs, the Commission has addressed some considerations that are important in the quest for "robust performance benchmarks", observing that:

indicators must be: measurable, including for diverse populations, relevant to policy and practice; able to be understood by people who need to act; feasible to collect and report; and reflect results of actions when measured over time.³

Those are all appropriate aims. However, we are concerned that the Commission is not acknowledging the significant risks that attend the use of APBs. This part addresses those risks.

8.3 Setting the background for developing APBs

APBs are applicable to all areas, but the immediate focus of the Commission's work is their application to the next set of AHCAs. The structure of the public health care system under AHCAs can be broadly broken down into quasi-autonomous state and territory health authorities providing a range of public hospital services, and the Commonwealth government partially governing delivery of these services through financial and regulatory mechanisms.

When examining the ability of APBs to shift the health care system towards meeting the twelve health and health care challenges outlined by the Commission, it is essential to have an understanding of the strengths and weaknesses of using APBs in such a quasi-market environment.

The objective of the health care system is to maximise health while seeking to ensure equity, efficiency, and sustainability. However a change in population health as a result of actions undertaken by health authorities (and their hospitals) is difficult to observe. Hence, the Commission has proposed to use APBs to measure the performance of health authorities in delivering implied health outcomes.

The distinction between the true health outcomes and the health outcomes implied by the APBs is important. As information asymmetries will exist between health authorities and the Commonwealth government, and there is uncertainty between true health outcomes and APBs, the emphasis on using APBs to hold health authorities accountable for meeting APB

³ NHHRC, "Beyond the blame game: Accountability and performance benchmarks for the next Australian Health Care Agreements", Canberra, April 2008, page 27



targets may lead to serious unintended consequences. These include tunnel vision, suboptimisation, myopia, misrepresentation, gaming, and ossification.

We believe that without consideration of these unintended consequences in the development and implementation of APBs, the health care system may be retarded away from its intended goals, leading to impaired health outcomes. The extent to which this happens does depend upon the weight of any financial penalties that might attach to under performance.

We appreciate the care that has gone into the drafting of the April report to give COAG advice without over-reaching the terms of reference and venturing too far into areas which COAG might deem to be the realm of political decision. Nonetheless, the Commission has succeeded in conveying, in a non-offensive way, its view that there ought to be financial consequences for under-performance against the APBs. There is, indeed, little point in pouring scarce financial and human resources into APBs if they end up as toothless tigers. That point accepted, the greater the financial “sting” attached to under-performance, the sharper the risks in using APBs as a proxy measure of health system performance.

If the effect is to shape the system around the fiscal needs of the jurisdictions, then it violates the very first design principle the Commission has articulated — that the health system should be shaped around the health needs of individuals, their families and communities. The cause of accountability will be set back if the first set of APBs within AHCA is remembered only for the harm that results.

8.4 The risk of tunnel vision

If health authorities are held financially and/or politically accountable against APB outcomes (as proposed by the Commission), health authorities are likely to focus on achieving APB targets rather than true health outcomes. Consequently a degree of tunnel vision may ensue.

The degree of tunnel vision, and its impact on health outcomes, will be determined by the level of disconnect between true health outcomes and APBs. If there is a large disconnect, a health authority is less likely to consider health outcomes when allocating resources across specific hospital areas. Consequently their pursuit of improvements in performance may have no bearing on improved health.

There is also a risk that limited resources are shifted to those areas that are being measured by APBs to the detriment of health outcomes being delivered in hospital areas that are not being measured. In the quest for ever better performance, the health gain from each additional dollar spent in these measured hospital areas will decrease while the health loss from diverting limited resources away from unmeasured areas will increase. Consequently the ‘bang for the health care buck’ is likely to become smaller and smaller over time.

8.5 The risk of suboptimisation

If APBs do not align with local objectives, health authorities may pursue local objectives at the expense of the targets set by the APBs. This is because health authorities may feel that more rewards will flow from pursuing local strategies that have a greater expected benefit. For example, demonstrating reduced waiting times to a marginal electorate may be perceived as more beneficial than demonstrating efficiency improvements within an AHCA.

The segmentation of the hospital system within states and territories means suboptimisation is likely to be significant. Not only do health authorities have their own objectives to meet, which will not always be in alignment with objectives measured by the APBs, area health



services and health care institutions (such as hospitals) have their own corporate objectives. These are typically micro focused and may discount higher level objectives.

The extent of suboptimisation will be determined by the level of uncertainty between effort of the health authority and APB outcomes. The larger the impact of other factors that affect APB outcomes (for example, environmental, demographic, and socioeconomic changes), the more difficult it will become for the health authority to demonstrate their contribution, or effort, to changes in APBs. Conversely, the more difficult it will become for the Commonwealth government to hold health authorities accountable. Consequently it is likely that health authorities will have little incentive to pursue goals implicit within APBs beyond those that are aligned with their own goals.

8.6 The risk of myopia

The use of APBs provides an incentive for health authorities to pursue short term objectives that are immediately measurable at the expense of long term goals.

The majority of APBs advocated by the Commission are curative services that are measured by short term processes, rather than preventative services that are measured by long term outcomes. The use of APBs means there is large scope for health authorities to become myopic, thereby shifting resources away from long term health prevention goals to the detriment of overall health and well-being.

As the timing of AHCA's will be every five years, there is scope for health authorities to invest in long term outcomes, such as a steady improvement in APBs. We welcome the Commission's recommendation that APBs should be measured over time as this will provide some opportunity to measure the impact of long term investment for those health care areas where APBs are measured.

8.7 The risk of gaming the system

Gaming may occur if health authorities strategically manipulate their performance over time in order to maximise their total revenue, or minimise financial penalties, associated with AHCA's.

If the Commonwealth government increases their expectations of health authorities based on good performance from the previous year, one problem that could result is known as the 'ratchet' effect. This will occur if APB targets are irreversibly 'ratcheted' up. The increase in expectations imposes an implicit penalty on health authorities as the risk of missing targets in subsequent years, and the associated financial penalties, are also increased.

The ratchet effect provides an incentive for health authorities to minimise an increase in expectations on performance. It is likely that health authorities will weigh expected higher rewards (lower penalties) from improved performance against the higher targets that may be set by the Commonwealth government.

There is a risk that the introduction of APBs will lower effort made by health authorities from the outset. For example, if performance improvements can be made within the first year of an AHCA term, health authorities may delay these improvements by spreading them across the full AHCA term. This will lower the expectations of the Commonwealth government in the next round of AHCA negotiations thereby providing health authorities with 'room to move'. The delay in performance improvements from the 'ratchet effect' means a delay in improved health outcomes.



8.8 The risk of misrepresentation

Health authorities may selectively use data, or change data, to represent the health care system in a better light to avoid penalties. Alternatively, health authorities may represent the health care system in a worse light if trying to game the AHCA's. Misrepresentation can be undertaken through 'creative reporting' or outright fraud.

The past experience with APBs both Internationally and over many areas of Government within Australia suggests that Governments move quickly to "cook the books" whenever performance falls short of the benchmarks. A small selection of examples follow:

For a period, the State of Victoria misrepresented hospital waiting times data. If an operation was cancelled, the patient was re-listed as joining the waiting list for the first time.

In the UK, a benchmark of access to a GP within 48 hours meant that health services ceased taking appointments if there was no appointment available within 48 hours.

New Zealand redefined elective surgery waiting times as the time between seeing the consultant to the time of surgery. The waiting time for elective surgery was shorter with the new definition and administrators were able to hide the average 2-year waiting time to see a consultant.

A performance indicator for NSW public transport services is the proportion of peak-time services arriving on time. The performance indicator for on-time running was a train that arrived within 3 minutes and 59 seconds of the scheduled time. In July 2005, faced with deteriorating performance, the on-time running indicator was increased to 5 minutes. The NSW Government now also publishes another indicator using 10 minutes as the threshold. If the trend continues, a train arriving the next day will be deemed to have run on time.

There are many more like examples.

There can often be a conflict of interest in data collection within the health care system. Due to the technical expertise that is required to evaluate and collect data, those who are collecting the data are usually the same people who are having their performance implicitly measured by the data. Although data sets can be audited, this is also often undertaken by the same staff, or staff that are closely related to the data collection process.

This is a significant risk, one with the capacity to substantially undermine the usefulness of APBs. It suggests the need for a significant remedy comprising both a strong framework of independent audit (which will incur a cost) and effective financial penalties when reporting entities are found to have distorted their data.

8.9 The risk of "benign reform"

We have observed a pattern of "benign reform" of indicators, a process whereby measures are redefined so as to make health system performance appear to be better and/or to make it easier to achieve performance benchmarks. Nowhere is this more apparent than in the area of hospital waiting lists and average times. For years the jurisdictions fiercely resisted national reporting standards so as to avoid the situation where one State could be compared adversely with another.

Definitions were "reformed" progressively over time so that it is not possible to get any meaningful data to see what is happening over time (whether and when the waiting list and



time problems are getting worse or improving). The catch-call from the jurisdictions is paraphrased as: “our systems are different because we all do things differently and this means we cannot/ought not be compared”. These arguments reduce to arrant nonsense. To take one example, in Australia, patients are waiting too long in the public system for cataract operations and experiencing impaired quality of life as a result (cannot read, cannot drive, etc). The health outcome is bad regardless as to whether the patient is living in Toorak, Tocumwal or Tutunup.

8.10 The risk of ossification

Ossification may occur if health authorities become set in a rigid framework imposed by APBs. This can inhibit innovation, reduce their ability to mitigate threats, and can lead to missed opportunities.

Ossification is likely to arise from performance targets being set in advance. Due to the long time period required to determine a proper trend in APBs, there will be an inevitable delay in changing the performance scheme to meet new needs.

Ossification could also result from health authorities not being rewarded for behaviour that identifies new areas of health care need. Although it may be the responsibility of both the Commonwealth government and health authorities to determine new areas of need, it will be the health authority that has immediate access to data. Even though the health authority may be able to identify these areas, they may not have an incentive to pursue these areas unless APBs are incorporated within the AHCA to ensure health authorities are recognised and rewarded for their efforts.

8.11 Evolution of APBs

The Commission’s April report offers two reasons why performance benchmarks and indicators “should not be enshrined in tablets of stone”⁴. The first is that developmental work may result in measurable benchmarks becoming available in areas where there are currently none. Secondly, the health system is dynamic and so what might be a critical performance deficiency in 2008-09 might be resolved in 2010-11, creating room for an old benchmark to be dropped and a new one introduced.

We would offer two more reasons:

- First, we can expect to see a rise in patient and community expectations of what is achievable and acceptable. The medical profession is on a never-ending quest for better health outcomes and better quality of care. These are rightly the focus of health and medical research. Were COAG to “dumb down” the APBs and set low hurdle rates at the outset, a shorter shelf life for the APBs is assured.
- Second, some of the current indicators are informed by current levels of knowledge and current clinical standards. It is very important that APBs keep abreast with, and not impede the adoption of, new clinical standards that will inevitably emerge. Otherwise, they will rapidly fall into disrepute.

Professor Dick Telford is conducting the Australian arm of the LOOK (Lifestyle Of Our Kids) study. This is a longitudinal project studying the physical and psychological health of primary school children over a four-year period from Grade 2 to Grade 6. Special attention is applied to the relationship of health and development with physical activity, incorporating a design so that the research may continue into later life.

⁴ NHHRC 2008, page 29.



The study has found that body mass index (BMI) is too simplistic an approach for addressing issues of obesity and has uncovered many “fat kids” who are nonetheless very fit.

8.12 The need for a stable “core set” of APBs

We have a particular concern that if the next AHCA does incorporate APBs, there should a substantial set of “core” APBs that will not change over time and will allow the performance of the systems to be tracked longitudinally without “noise” from changing definitions or a deterioration in the quality and consistency of reporting. The Commission has recognised the need for “*some stability of benchmarks to give certainty to managers and to allow tracking of performance over time*”² but without giving it too much air. We suggest it requires more serious consideration.

8.13 The risks that nobody wants to talk about

The available data indicates that major teaching hospitals in Australia are being run “full throttle”, with bed with occupancy rates averaging around 95%. This information should be available for every teaching hospital in the country and its absence in some jurisdictions is an indictment of the poor quality of their accountability to their constituencies.

Very high bed occupancy rates are dangerous, resulting in periodic system failure. No matter how hard clinical staff members try to attenuate the risk in system failure, it threatens patient-well-being — fatal for some patients, and long term ramifications for other patients.

The AMA believes that there is substantial and convincing evidence that bed occupancy rates should average no more than 85% in any year to ensure patient safety. Even at that rate, there will be periods of very intense pressure on hospital staff and resources. We see this is a key measure of safety and quality and urge its adoption. The adverse impact on staff morale from the persistent and pernicious under-resourcing of the public hospitals should never be under-estimated. This issue has been addressed in more detail in Part 5 of this submission.

There are other performance measures the AMA would like to see included.

One is the measurement of the overhead costs incurred within each jurisdiction. What is the cost of the overlay of Health Departments, Area Health Authorities, health regulatory agencies and hospital administrators that do not provide any clinical care? These data are now carefully hidden.

Another measure is the proportion of the Australian population holding private health cover. Responsibility for this benchmark is assigned to the Commonwealth Government. The AMA expects the decision (in the 2008-09 Federal Budget) — to sharply increase the thresholds for the Medicare Levy surcharge — will have a deleterious impact on the financial viability of private health funds. The expected initial impact will be the loss of younger and healthier members who would normally be net contributors despite their preference for low-cost front-end deductible and exclusionary products. Their withdrawal will trigger PHI premium increases with the risk that older, higher using members are no longer able to afford their PHI policies. Down the track, the impact on public hospital workloads is expected to be increasingly adverse. When the Commonwealth harms the viability of the private health system, it also harms the viability of the public health system. The next AHCA should formally recognise this reality.



8.14 Costs and benefits

The cost of a system of APBs will be influenced by the extent to which the measures rely on data which are now readily available as a by-product of extant systems.

The next AHCA should incorporate an independent high-level review of the system of APBs with clinician involvement (and including a public reporting obligation). There will need to be a proper assessment of the costs and benefits of the system of APBs that is proposed. That evaluation should extend to an assessment of the extent to which APBs divert clinical staff from patient care.

Given the likelihood of teething problems, this cost/benefit assessment would be in parallel to any detailed assessment of the particular APBs.

8.15 APBs that fail the credibility test

The Commission's April report contains at least one APB that bears little or no relation to the performance of the system as regards any of the key objectives such as quality, safety, access or equity.

The report suggests an 80% benchmark for the proportion of GP services that are bulk-billed. The AMA rejects the view that bulk-billing is a meaningful measure of access. The rate of bulk-billing has, from time to time, served as a political objective. Bulk-billing has been pursued as an objective in its own right despite the adverse impact on the quality of GP consultations. This objective completely lacks credibility.

8.16 Summary of the AMA position re APBs

For the system of APBs to have any chance to work, the doctors and the paramedical health professionals have to be persuaded to come on board and there will need to be attention to their views. However, that alone will not ensure that the system works. If the measures are not well designed, the risk is that the APB system itself fails to perform. As we have noted above, APBs are, in essence, proxies for good health outcomes. If the particular measures turn out to be poor proxies dogged by measurement and compliance difficulties, they will not contribute to the objectives articulated by the Commission.

Likewise, if the measures are not well designed, there can be a significant adverse impact on staff morale if an individual hospital is failing to reach the benchmarks.

As things stand, the medical profession has significant reservations in relation to APBs. There is a general perception among doctors that significant improvement will be needed before APBs are useful for anything. This part has commented on some of the unintended consequences that can result from the use of APBs. These include:

- ❑ The significant and concerning risk that jurisdictions divert scarce resources into the limited areas that are measured so as to avoid financial penalties. Consequences include a misallocation of resources and impaired health outcomes;
- ❑ The risk that other factors impacting APB outcomes (such as environmental, demographic, and socioeconomic changes) limit the ability of health authorities to demonstrate their efforts or the Commonwealth government to hold health authorities accountable;
- ❑ The risk that health authorities will pursue short term objectives at the expense of long term health goals



- ❑ The risk of health authorities delaying performance improvements to lower Commonwealth government expectations and APB targets;
- ❑ The risk that jurisdictions will misrepresent their data (“cook the books”) so as to appear to meet the benchmarks and to avoid any financial penalties that might apply;
- ❑ The risk of “benign reforms” that undermine and dumb down the benchmarks to make them easier to achieve at the outset;
- ❑ The risk of health authorities becoming set in a rigid framework that inhibits innovation, reduces their ability to mitigate threats, and leads to missed opportunities;
- ❑ The need for a stable set of “core APBs” so that the performance of systems over time can be measured in a reliable and meaningful way;
- ❑ The need to include other measures of quality, safety and jurisdictional performance with the dual aims of ensuring that health systems are properly resourced at the outset and that resources are not wasted in overhead costs; and
- ❑ The need to incorporate an independent high-level review of the costs and benefits of APBs.

The AMA agrees with the Commission’s conclusions that accountability has been wanting, that the APBs in past AHCA have been ineffective and that the obligations should be mutual with benchmarks applying to all levels of government in their areas of influence and responsibility.

Bellwethers for the disablement and destruction of the proposed system of APBs will be if:

- ❑ the Commonwealth Government itself will not agree to meaningful APBs applying in areas of its influence and responsibility;
- ❑ COAG dumbs down the benchmarks and disarms them by setting such low hurdle rates that underperformance is unthinkable;
- ❑ Jurisdictions start gaming the system, cooking their books and introduce administrative procedures that destroy the integrity of the data; and
- ❑ the views of medical and paramedical health professionals are dismissed and/or ignored.

The Commission’s April report takes the matter forward. There is still a great deal more work to be done to address the risk factors identified here.



9 COMMONWEALTH/STATE ISSUES

Four large programs consume the great bulk of Commonwealth government health and aged care spending. These are public hospitals (payments to the States pursuant to AHCA's), medical benefits, pharmaceutical benefits and aged care packages (residential and community care). The federal system has a significant impact on the funding and operation of the public hospitals, but the other three programs are effectively a Commonwealth government responsibility.

Until the early 1970s, public hospital funding was a State government responsibility. The Commonwealth government had little or no role. The paradigm change came with the Whitlam government. Over some 35 years, the system of Commonwealth payments to the States for public hospitals has undergone one change after another. It has swung from general purpose to specific purpose with ever rising complexity and the introduction of blockbuster reforms such as casemix which invariably promised a great deal more than they have ever delivered.

Over time, the Commonwealth has sought to attach ever more onerous conditions upon the States to the funding for public hospitals.

Throughout this 35-year period, one thing has not changed — and that is the cost and blame-shifting mindset. There is little doubt that the Commonwealth/State imbroglio generates adverse outcomes for the performance of the health system as a whole as well as impairing the performance of the hospital system.

The AMA has very low expectations of what can be achieved through the reform of Commonwealth/State financial relations. The inertia against meaningful reform is huge simply because the current framework allows governments at all levels to avoid responsibility and accountability for their actions.

COAG has a very modest record of achievement when it comes to health care. Commonwealth and State Health Ministers meet regularly to deal with a variety of health financing and workforce issues. In this work, they are well protected from the views of the medical professions by a labyrinth of Committees and working parties. The idea that they can solve the ills of the system in isolation is really quite quixotic given that both levels of government have a vested interest in keeping the system more or less as it is so as to avoid accountability and responsibility.

Despite our pessimism that any useful progress can be made in the current framework, this part offers some comments on what might be done in this area.

9.1 Cause and effect

To make real progress, it is first necessary to understand which of the problems in the public hospital system can be traced back to the Commonwealth/State imbroglio. It is very clear that the public hospital system is a very difficult one to manage. In essence, the model is Moscow 1953, a command economy where resource allocation decisions are made at many different levels by different bureaucrats seeking to satisfy incompatible objectives. There is virtually no scope for price signals to inform resource allocation decisions. This is inherent in the public sector trying to provide a free service in a context of non-price rationing. The Commonwealth/State imbroglio has little bearing on it.

The issues that can be tracked back to the Commonwealth/State imbroglio are often related to the ambiguities as to who is responsible for what. The respective roles are poorly defined.



That is no accident. It has served political purposes to keep it that way. The clarification of respective roles would put the lie to a lot of the blame shifting.

There is another set of issues around the interface between the public hospital system and the other parts of the health and aged care system. This is amply illustrated by reference to aged care. The aged care “silo” is a Commonwealth responsibility. States bear part of the burden of aged care through public hospitals whenever there are too few aged care places. At times, the debate over these issues has not been evidence based.

In the 2008-09 federal Budget, the Commonwealth wisely increased funding for transitional care beds. However, the arguments that go on between the Commonwealth and States create a completely inappropriate institutional focus. As the population ages, the distinction between health care and aged care will become more blurred than ever. We can expect that:

- ❑ there will be insufficient residential aged care beds to house them all;
- ❑ people won't want to go into nursing homes anyway;
- ❑ they will need and want more support to help them stay at home;
- ❑ they will need and want more medical services as they live longer with illness; and
- ❑ changing clinical practice and medical technologies make this possible.

The risk is that COAG clings to a debate about the balance between hospital and aged care beds and completely missed the paradigm change in service delivery.

9.2 Building on strengths

Arguably, the Commonwealth has a comparative advantage in health financing. When it did run hospitals, they were typically the most costly in the country. One might also argue that the States have the comparative advantage in the delivery of hospital services, that is, a comparative advantage over the Commonwealth (but not necessarily over the private sector). Were we to build on our strengths — which seems to us to be the most sane way to go forward — then any moves to untangle the imbroglia would seek to rearrange the respective roles so that each level of government is focussing on the things it can do best. There is little evidence to support the proposition that the Commonwealth is good at delivering services at the local level.

9.3 Empowering patients

There is little doubt that as Australians become wealthier and better educated, they will want more say, not less say, in their health care. Real progress in preventive care will only be possible when patients are fully engaged and seeing health prevention first and foremost as a personal responsibility. It is difficult to persuade patients to engage when there is no financial responsibility, yet at the same time, equity demands access for those who cannot afford to contribute financially to their health care. If Australia truly wishes to have a health system that is patient and community focussed, then it will have to consider ways of making the money go with the patient. That is, of course, a very significant paradigm change as it radically changes the balance of financial powers between patients and providers.

The implications of this sort of change are substantial:

- ❑ For a start, we can expect that an increasing number of Australians would prefer to avoid hospitalisation were there alternative arrangements for community-based medical care. In this context, the lack of interest on the part of private health insurers



since they were freed up for this type of reform may come under pressure. Then again, we should not be surprised that the health insurers have not been innovators in health care. Their focus is firmly on their bottom line and, as the mutuals give way to corporate players, the dividends to their shareholders.

- At another level, one effect of empowering the patient would be to generate competition between providers both as to price and quality.

Doctors are used to dealing with financially empowered patients but public hospitals are not.

9.4 Eschewing “big bang” reforms

The AMA does not believe that “big bang” reform in Commonwealth/State health financing is feasible. There is too much inertia and too strong a vested interest on the part of governments in the system as it is. A major change in responsibilities would have a high chance of raising complex and hotly contested issues such as a redistribution of tax powers. We expect that these issues will remain insoluble.

There is plenty of untapped potential for incremental reforms that could lift system performance and improve patient outcomes. However, as we have noted in Part 5, efficiency gains cannot solve the under-resourcing of the sector. More funding is needed and the Commonwealth government needs to pick up the ball it previously dropped.

9.5 Reducing the bureaucratic overlay

It is time to take a step back and to examine the actual outcomes from the multiple tiers of bureaucracy, not only between Commonwealth and State but also the multiple tiers within State administrations.

There is nothing to be gained by pretending that the system is working properly now. It is not. Not too long ago, a major teaching hospital in NSW was given its budget for the year in May, one month before the end of the year. That is the sort of stupidity that a clever country would not tolerate.

It is time for the members of COAG to put their numbers on the table, openly and honestly, and to allow public scrutiny and debate over the proportion of health funding that is absorbed in management overheads before a single health service is delivered.

9.6 Engaging the health professions

The AMA firmly believes that governments have to start listening to the voices of the health professionals on the front line, those who are doing the clinical work. This has not been happening, and the system has suffered as a result.

Without strong input from clinicians, resource allocation will be poor, health outcomes sub-optimal and the community will get poor value for money from this, the largest component of national health spending.



10 MEDICAL MEDICARE

This chapter focuses on the need to review and reform Medicare Benefits arrangements to ensure that patients are able to receive appropriate and timely care and new treatment modalities as required. It outlines strategies to address the following health and health care challenges identified by the NHHRC:

9. *Improving distribution and equitable access to services*
10. *Ensuring access on the basis of need, not ability to pay*

The medical component of Medicare is a core item in the Australian health financing matrix. Its strengths and weaknesses are quite well understood by the Commonwealth government and the medical profession. This Part is concerned with particular issues which, if not addressed, have the potential to exacerbate community discontent and sap public confidence in Medicare.

10.1 Key Points

- ❑ Mortality rates have been lowered dramatically over the last 30 years. Health and medical research has made a huge contribution. Advances in medical knowledge and technology are readily apparent. New pharmaceuticals are another important factor in health gains. Better access to health and medical services is also a factor;
- ❑ Access to medical services is threatened currently due to shortages in the medical workforce, maldistribution of the medical workforce and by the large financial gaps which have emerged between fees charged and Medicare benefits paid;
- ❑ These gaps have emerged because the indexation of the Medicare Benefits Schedule has not kept pace with the costs of running a modern medical practice;
- ❑ New Items coming on to the Medicare Benefits Schedule are subjected to examination by the Medical Services Advisory Committee which takes on average > 12 months to report and a further 6-12 months before the item is included on the Schedule. We need a process for interim listing;
- ❑ The enhanced Medicare Safety Net has helped in certain situations but does not take the place of proper indexation across the whole of the Schedule; and
- ❑ There is a pressing need to review and reform the GP items in the Medicare Benefits Schedule to simplify them and support the delivery of preventative health care and the fight against chronic disease.

10.2 Discussion

The Productivity Commission has analysed the differences in mortality rates between 1971 and 2002 in Australia. This includes the introduction of Medibank in 1975 and its reintroduction as Medicare in 1984. It is a relatively short period of time in the evolution of medical services but nevertheless the analysis shows a major change in mortality rates over that time. Under the humorous heading “*death as a dying phenomenon*”, the analysis shows that from 1971 to 2002, there was at least a 50% fall in the yearly probability of death for every age from 42 to 77 years for both sexes. At younger ages, the reduction in the yearly probability was even greater.

The report provides no analysis as to the reasons for the reduction and this would be a very useful study for another time. The really significant change over that period of time was the improvement in access to medical services which was created by the establishment of



Medibank and subsequently, Medicare. It would be reasonable to conclude that a good part of the explanation for the improvement in mortality rates was in simply being able to access good medical care.

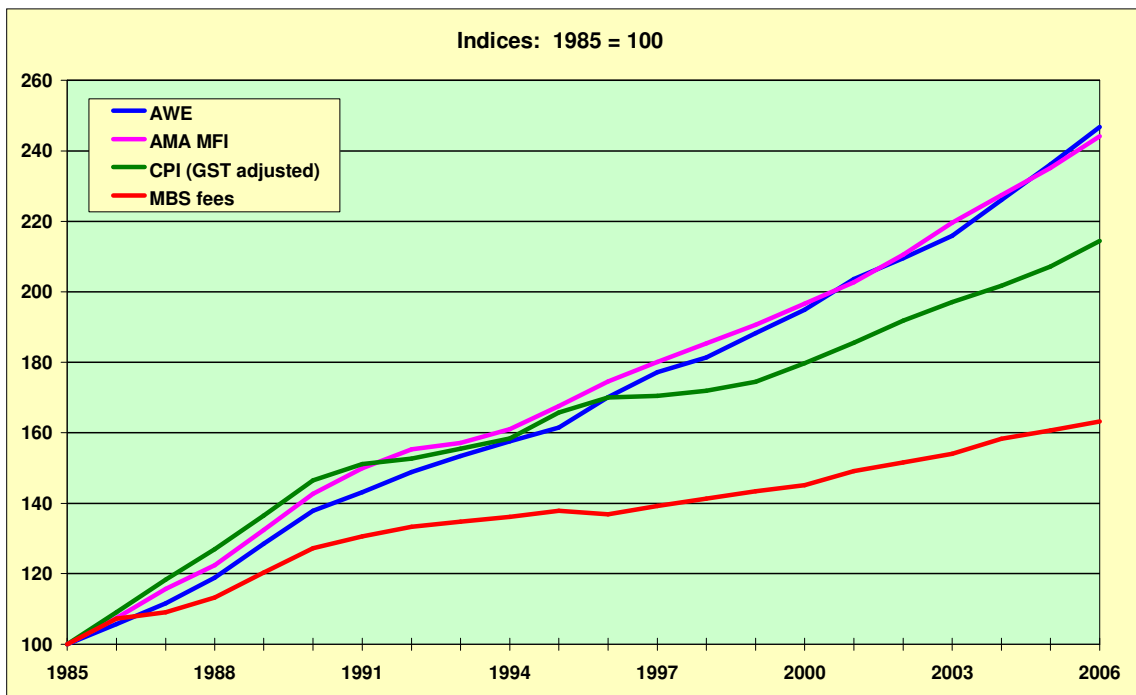
We should not under-estimate, forget or become blasé about the importance of access to medical services for improved health outcomes. We have discussed in the previous section the need to convert the large increase in medical undergraduates to large increases in the fully trained medical practitioner workforce for the benefit of all Australians.

Financial impediments to access have emerged despite the introduction of the enhanced Medicare Safety Net. The benefits of the enhanced Medicare Safety Net are not spread evenly across the system either in terms of the location of the patient, the type of medical service required or the level of need for services.

The difference in aggregate fees charged and aggregate benefits paid under Medicare including the safety net has grown to \$3 billion per annum being met by households either as out of pocket expenses or expenses covered by privately financed third party payers. This is a significant imposition on households each year and it is growing. Although fees charged for a fixed bundle of services have moved broadly in accordance AWE/CPI, MBS indexation has moved well below that level. The previous two governments set about studying and remedying this issue through an exercise called the Relative Value Study but the findings of the Study were never implemented. The AMA's final modelling of the results of that Study showed that in the year 2000, an additional \$1.6 billion was needed to modernise the Schedule and bring it into line with the costs of running a modern medical practice.

The situation is represented dramatically in the following graph which shows the differences in indexation between regular measures such as AWE/CPI and MBS indexation. The area between the lines represents a widening patient gap.

Chart 1: CPI, AWE and Medical Fees



A further barrier to access to medical services is caused by significant delays in the introduction of new items onto the Schedule. The government has dictated that each new



service must be fully examined by the Medical Services Advisory Committee which takes on average >12 months with a further 6-12 months for successful applications to get on to the Schedule where patients can use them. In order to minimise the impact on patients, the government needs to establish a fast track interim listing process for items which offer promising results or significant benefits for patients.

10.4 Recommendations

The Government needs to:

- Remember the value of access to high quality medical services in improving health outcomes for Australians and have this foremost in mind as it formulates its annual budget and develops appropriate health policy;
- Index the Medicare Benefits Schedule at a rate which keeps pace with the annual increased costs of running a medical practice and which closes the gap between aggregate fees charged and aggregate benefits paid over time;
- Improve the MSAC processes by establishing a fast track interim MBS listing process for items which offer promising results or significant benefits for patients;



11 RURAL HEALTH

This chapter focuses on the need to improve rural Australian's access to health infrastructure, medical practitioners and other health care providers. It outlines strategies to address the following health and health care challenges identified by the NHHRC:

- 9. Improving distribution and equitable access to services*
- 10. Ensuring access on the basis of need, not ability to pay*
- 12. Ensuring enough, well-trained health professionals*

Rural communities are suffering. More than 6.7 million Australians live in regional, rural and remote areas. The Australian Institute of Health and Welfare (AIHW) reports that they generally have poorer health status than people who live in major cities⁵, with lower life expectancy; higher rates of disability and higher injury rates. It is estimated that there are around 3,300 additional deaths annually in these rural and regional areas than would be expected if the death rates were the same as in major cities⁶.

Many rural people face the prospect of the closure or downgrading of their local hospital. It is estimated that more than 130 maternity units have closed across Australia since 1995⁷.

Country communities are finding it harder and harder to recruit and retain doctors. The recently released report on an audit of the rural health workforce⁸ found that the number of full time work equivalent GPs per 100,000 population is 97 in urban Australia. This compares to 74.2 in outer regional areas, 68.2 in remote areas and 47.1 in very remote areas. The report states:

- Rural and remote Australia has experienced medical workforce shortages for a considerable period, particularly in terms of general practice services and some specialist services, such as obstetrics and gynaecology.*
- Numbers of GPs in proportion to the population decrease significantly with greater remoteness, with the lowest supply to 'very remote' areas, particularly in New South Wales and Western Australia.*
- There is also considerable variation across jurisdictions. Northern Territory and Western Australia, as well as the Australian Capital Territory, have lower number of GPs proportional to the population.*
- In recent years, the medical workforce in rural and remote Australia has increased modestly, mostly due to restrictions on Medicare provider numbers for overseas trained doctors to encourage them to work in rural and remote areas of workforce shortage.*
- One-third of doctors currently working in Australia were trained overseas.*
- The proportion of overseas trained doctors is significantly higher in rural and remote areas where 41% of all doctors have trained overseas.*
- Although the number of GPs continues to grow, this growth does not indicate increased availability of GPs over time, as the growth in the medical workforce has not kept pace with the rate of population growth.*

⁵ *Australia's Health 2006*, Australian Institute of Health and Welfare, June 2006.

⁶ *Australia's Health 2006*, Australian Institute of Health and Welfare, June 2006.

⁷ *Maternity Services for Australia*, Rural Doctors Association of Australia, February 2006.

⁸ Report on the Audit of Health Workforce in Rural and Regional Australia April 2008



11.1 GPs are the backbone of rural health care delivery

GPs operating in rural and remote areas often have an expanded skill set, including emergency care and public health activities due to the lack of close supporting medical specialists and professional and geographic isolation.⁹ In addition, to compensate for limited specialist availability, GPs often extend their skills to include procedural skills in areas such as obstetrics, general surgery and anaesthetics. To maintain these skills, it is essential that these doctors have access to rural and remote public hospital facilities.

11.2 Impact of existing Government programs

Governments at both Federal and State/Territory levels have in place a multitude of programs that attempt to improve rural medical workforce. While they are having an impact, they are not keeping up. Program funding is not properly indexed and the funding pool is too small.

The closure and downgrading of rural public hospitals also detracts from these programs. Doctors will not practise in rural areas if they cannot give their patients access to decent facilities, or they do not have access to proper supervision and training, or they are unable to use, maintain or improve their skills.

Patient Assisted Travel Schemes (PATs), which are designed to assist patients who need to travel to access appropriate care, have been widely criticised as being under-funded and too limited.

11.3 What needs to be done?

Rural communities want to be able to see a doctor when they need to, and want to know that their local hospital can provide them with good quality care when required. They also want to know that when they need to travel to access services that are not available locally, that they will not be disadvantaged financially.

The AMA believes that the following steps are essential if the delivery of health care in rural areas is to be brought up to a standard comparable with urban Australia:

Rebuilding country hospital infrastructure

The closure and downgrading of rural hospitals are seriously affecting the future delivery of health care in rural areas. These decisions are often driven by economic rationalism, without sufficient regard to the significant consequences for local communities and the sustainability of the rural medical workforce.

In last year's AMA Rural Health Issues Survey, rural doctors rated the need to lift support significantly for rural public hospitals — particularly in the area of facilities, equipment and staffing — as the highest priority to fix rural health.

Additional funding needs to be directed to rural hospitals through the Australian Health Care Agreements — with appropriate accountability measures attached.

⁹ Australian Medical Workforce Advisory Committee, (AMWAC) "The General Practice Workforce in Australia: supply and requirements to 2013" Report 2005.2 (2005), p97.



Rural retention programs

The Government's recent rural workforce audit confirmed that existing retention programs are not even keeping up with population growth. Provider number restrictions on overseas trained doctors appear to be the major mechanism by which Governments push doctors into rural Australia. This is not sustainable or equitable.

A substantial program of incentives is needed to attract and retain doctors in rural areas. Incentives need to recognise the isolation of rural practice and reward the development of procedural skills. This will ensure that rural areas will not only have access to more doctors, they will have access to doctors with the broad set of skills required. The AMA's proposals for particular incentives have, so far, fallen on deaf ears.

Encouraging more young doctors to work in rural areas

To address workforce shortages in particular areas, the Government now offers 500 unfunded bonded medical school places (BMP) each year. Students taking up the positions are bonded to work for up to six years in workforce shortage areas. International evidence shows that these schemes are ineffective.

The AMA believes that what is needed is more carrot and less stick. Scholarship schemes backed by well-resourced, worthwhile training experiences represent a much more effective way to encourage doctors to get a taste of rural medicine. Evidence shows that if they get a good experience they are more likely to stay.

Outreach services

The Medical Specialist Outreach Program is a good example of how to deliver services to rural areas in an innovative, sustainable way. Through integration with local services it helps build local skills. There is little doubt that patients also prefer to be treated where they are close to friends and family.

The Commonwealth and State/Territories need to do more to support outreach services and ensure that appropriate facilities, including IT infrastructure, are available to support the delivery of outreach services. Funding increases such as the \$12m allocated for specialist outreach services in the 2008-09 federal budget are a welcome move in the right direction.

Patient assisted travel schemes (PATS)

The reality is that in some areas it will not always be possible to deliver health services locally. Properly funded, expanded and nationally consistent PATS arrangements provide a cost-effective way to give country people better access to these services.

The AMA believes that the Commonwealth should work with the States and Territories through the Australian Health Care Agreements to improve PATS funding and expand arrangements to cover other treatments available under the Medical Benefits Schedule (MBS) — including access to allied health professionals where a doctor coordinates the patient's overall care.

PATS arrangements should be harmonised and funding boosted so that patients are no longer disadvantaged when they must travel for treatment.



11.4 Summary of rural health care recommendations

In summary, the AMA feels very strongly that the implementation of the Commission's design principles would make it imperative that action be taken to bridge the rural health divide. To this end, it advocates the following practical solutions:

- ❑ Rural hospital infrastructure needs to be rebuilt and properly funded and staffed;
- ❑ A substantial program of incentives is needed to attract and retain doctors in rural areas;
- ❑ Scholarship programs to attract young doctors to rural areas;
- ❑ Further investment in outreach services;
- ❑ Harmonisation and augmentation of patient assisted travel schemes.



12 INDIGENOUS HEALTH

This chapter focuses on the need to implement concerted strategies to address the gap in indigenous health compared to that of other Australians. It outlines strategies to address the following health and health care challenges identified by the NHHRC:

1. Closing the gap in Indigenous health status

12.1 Issues

The strategic focus on Indigenous health signalled by the recent COAG undertakings to close the gap in Indigenous health is long overdue and welcome. COAG has committed to closing the Indigenous life expectancy gap within a generation, and halving the mortality gap for children under five within a generation.

There have been various national policy frameworks in the past for addressing Indigenous health inequalities, but these have not achieved the improvements expected of them. Three factors account for this:

- a reluctance to propose specific targets for improvement, and monitoring of progress;
- an insufficient allocation of resources to make sustainable improvements, as well as allocations that have not always been well-targeted, and
- insufficient cooperation and co-ordination between and within jurisdictions.

Building the imperative to close the gap into the COAG process signals potential improvements in jurisdictional coordination and cooperation. Similarly, the Prime Minister's signing of the Statement of Intent developed at the National Indigenous Health Equality Summit in March 2008, bespeaks a positive outlook regarding collaboration and partnerships between government and the Indigenous and mainstream health sectors.

However, the success of this emerging re-commitment to Indigenous health now heavily depends on governments committing to appropriate goals, specific targets and timelines for improvement in the following key areas:

- Maternal and Child health – reducing low birth weight, controlling infections, providing maternal education and dedicated services for mothers and babies;
- Incidence of chronic diseases – prevention through risk identification and management including health checks; reduced time to admissions for treatment of CVD, diabetes, chronic kidney disease; appropriate services for cardiac rehabilitation, stroke and kidney disease
- Mental health and social well-being – reduce suicide rates and mental health disorders, including depression and psychosis.

12.2 Recommendations

Achieving these overarching goals will require:

- A very significant boost in the capacity of primary care services for Indigenous people (\$500 million per annum), to include infrastructure, capital works and equipment;
- Significant expansion of the medical and health workforce; and
- Sustainable improvements in the social correlates of health, including education, employment and community safety.



13 COMPENDIUM OF RECOMMENDATIONS

Design Principles and Challenges

The AMA recommends that the Commission enhance the value of its work articulating fifteen design principles and twelve challenges by exploring the priorities (reconciling the aspirations for the health system with the limited resources that are available).

Longer term fiscal framework

The AMA recommends that the Commission have regard to the longer term fiscal framework and the significant likelihood of fiscal stress by the year 2020 which will make it very difficult for the public sector to continue financing nearly 70% of national health spending. The Commission should therefore consider what could be done to enhance and sustain the capacity of private health insurance and open the door to more innovative private sector health financing options.

First, do not harm

The AMA urges the Commission to take particular care to ensure that its proposals for reforms build on the strengths of the system and do no harm. It advocates careful, incremental reform that takes the patients and providers along for the ride as active participants in system redesign, not as silent spectators to a debacle.

The Role of General Practice

The AMA urges the Commission to have particular regard to the key role of General Practice in primary and preventive care and as the “gatekeepers” to the tertiary healthcare system and actively consider ways in which GPs can be better equipped and better supported for this key role.

Public hospitals

The AMA urges the Commission to develop recommendations with the aim to:

- ❑ make the joint responsibility for financing of the public hospital system work more effectively by clarifying and rationalising roles and responsibilities;
- ❑ commit more resources to the public hospital system (including more beds), and with a significantly enhanced contribution from the Commonwealth Government;
- ❑ achieve better quality management of the public hospital system, focused on the needs of medical and nursing staff delivering care to patients rather than on the needs of Government and bureaucracy;
- ❑ recognise an 85% bed occupancy rate as a national performance target; and
- ❑ recognise the important role of the private hospital sector and the need to maintain a stable environment with strong participation.

Workforce issues

The AMA draws attention to the critical importance of strengthening public policy with respect to the health workforce and the urgent need to expand investment in training resources and infrastructure. Having regard to the poor preparation for the forthcoming “flood” of medical students and graduates, the AMA advocates that the Commission consider whether there is



a need to go against the trend of broadbanding of Commonwealth payments by quarantining training costs and funding training directly. If not, the Commission is urged to consider:

- ❑ explicit targets extending to all parts of the training matrix;
- ❑ clinical placements in public hospitals to match the requirements of medical schools in the relevant state/territory;
- ❑ accredited intern places in public hospitals to match the increasing output of local medical schools;
- ❑ college accredited vocational training positions in public hospitals;
- ❑ medical school placements, prevocational and vocational training places in general practice;
- ❑ prevocational and vocational training places in expanded settings such as the private sector; and
- ❑ an expanded role for MTRP is monitoring progress against targets.

The AMA urges the Commission to take particular care not to harm the system by advocating inappropriate substitution of lower-trained health professionals in areas which require the skills and experience of a medical practitioner.

Accountability and Performance Benchmarks (APBs)

The AMA agrees with the Commission's conclusions that accountability has been wanting and that performance benchmarks should be mutual, applying to all levels of government in their areas of influence and responsibility.

It advocates that Commission should:

- ❑ undertake further developmental work on APBs with a very keen understanding of the significant risks they entail;
- ❑ adopt a "core set" of APBs that do not change over time so that it is possible to get consistent measures of improvement over time;
- ❑ consider the inclusion of additional benchmarks including the 85% average bed occupancy rate (as a safety and quality benchmark), the overhead costs incurred within each system (as a cost-effectiveness benchmark) and the proportion of the population with private health insurance (as a benchmark of the sustainability of the health financing system);
- ❑ remove the bulk-billing rate as a benchmark of access; and
- ❑ defer recommendations that financial penalties should attach to non-compliance with APBs until the indicators themselves are proven to perform. With this end in mind, the next AHCA's should incorporate an independent high-level review of the system of APBs (with clinician involvement) charged with a proper assessment of the costs and benefits of the system of APBs and of the extent to which they divert clinical staff from patient care.

Commonwealth/State health financing framework

The AMA advocates that:

- ❑ further efforts be made to overturn the cost and blame shifting culture which has bedevilled Commonwealth/State health funding arrangements for decades;



- the Commission understand that the dysfunction in the running of the public hospital system is not simply the result of a federal system with shared and ambiguous financial responsibilities, but also reflects the “command economy” system of administration. It therefore recommends that the Commission start with a broader vision and examine the actual outcomes from the multiple tiers of bureaucracy, not only between Commonwealth and State but also the multiple tiers within State administrations;
- the Commission look for incremental reforms that clarify the respective roles and responsibilities of each level of government; and, in doing so
- not lose sight of the need for the Commonwealth government to pull its weight in public hospital funding.

Medical Medicare

The AMA recommends to the Commission that it:

- frame its recommendations for reform against a clear understanding of the value of access to high quality medical services in improving health outcomes for Australians;
- support the indexation of the Medicare Benefits Schedule at a rate which keeps pace with the annual increased costs of running a medical practice and which closes the gap between aggregate fees charged and aggregate benefits paid over time;
- Support improved MSAC processes by establishing a fast track interim MBS listing process for items which offer promising results or significant benefits for patients; and
- Support early steps to review and simplify MBS GP items so that they encouraged GPs to deliver high quality care and so as to remove non-essential levels of red tape.

Rural and Regional Health Care

The AMA advocates that the Commission endorse the following practical steps:

- rural hospital infrastructure be rebuilt and properly funded and staffed;
- a substantial program of incentives be implemented to attract and retain doctors in rural areas;
- scholarship programs be implemented to attract young doctors to rural areas;
- there be further investment in outreach services; and
- patient assisted travel schemes be harmonised and augmented.

Indigenous Health Care

- A very significant boost in the capacity of primary care services for Indigenous people (\$500 million per annum), to include infrastructure, capital works and equipment ;
- Significant expansion of the medical and health workforce;
- Sustainable improvements in the social correlates of health, including education, employment and community safety