

21 April 2009

Dr Christine Bennett
Chair
The National Health and Hospital Reform Commission
PO Box 685
Woden ACT 2606

Dear Dr Bennett

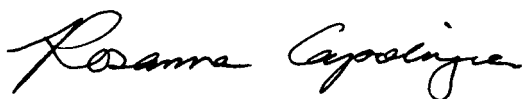
Please find attached a brief summary of the Australian Medical Association's feedback on the National Health and Hospital Reform Commission's interim report.

Dr Pearce has already raised some of these issues when he represented the AMA at the Commission's consultation with GP stakeholder groups on 4 March 2009.

As previously indicated I would also welcome a further opportunity to discuss directly with you a range of issues relating to the Commission's report that affect the broader AMA membership. I understand that our offices are in the process of arranging this.

Thank you for the opportunity to provide input to the Commission's deliberations.

Yours sincerely,

A handwritten signature in black ink, reading "Rosanna Capolingua". The signature is written in a cursive, flowing style.

Dr Rosanna Capolingua
President
19 March 2009



AUSTRALIAN MEDICAL ASSOCIATION: FEEDBACK ON THE NATIONAL HEALTH AND HOSPITAL REFORM COMMISSION'S INTERIM REPORT

1. **Primary care**

- lack of recognition of the central role of high quality general practice
- need to support doctor-led team-based care
- need to further enhance role of general practice nurses
- support view that generally fee for service funding for medical care is good
- support focus on improving medical services in residential aged care
- concern about voluntary patient enrolment and suggestions to bundle the cost of care for enrolled patients;
- concern about pay for performance and benchmarking;
- concern about potential for comprehensive primary health care centres to duplicate and compete with existing services.
- concerns about role substitution and instead consider alternatives to improve access in rural areas e.g. positive incentives to attract more doctors including locum support, rewarding procedural work, support to expand existing infrastructure, outreach services, training in rural areas, support for country hospital infrastructure

2. **Acute and subacute care**

In relation to hospitals:

- there is little recognition that hospitals will need more funding and beds if they are to meet the envisaged access guarantees and targets
- the proposed additional accountability will mean more administration and reporting rather than patient care
- shifting funding towards primary and sub-acute care is not going to reduce the need for, or cost of, hospital care in the short term (if at all)
- too much focus on bonus funding to reward performance and activity based funding instead of recognising that poor performance likely result of insufficient funding
- full activity based funding for hospitals is inappropriate (need block funding for ED, research, training, infrastructure etc)

In relation to subacute care:

- agree with the urgent need to expand the number of subacute services however, also need to improve the co-ordination of primary, acute and subacute care by having the GP central in the communication train at all transition points
- full activity based funding for subacute care is inappropriate (need blended payment to take into account variability in length of stay and complexity)

3. **Workforce**

- insufficient discussion on the need to build capacity including ensuring there is sufficient training support for increased number of doctors in training to grow the medical workforce rather than substitute it with other health workers;
- concern that *commencement in rural areas* of nurse practitioners and other health providers accessing PBS prescribing and referring to MBS rebatable diagnostic and other specialist services is precursor to ongoing, widespread role substitution and provides unacceptable access solution for rural patients
- need more ongoing support for the medical profession to ensure there is appropriate geographic distribution (see 1. above)
- potential for the proposed clinical education and training agency to interfere with medical education and training and standards
- multidisciplinary and competency based training risk compromising existing internationally recognised high medical training standards



AUSTRALIAN MEDICAL ASSOCIATION: FEEDBACK ON THE NATIONAL HEALTH AND HOSPITAL REFORM COMMISSION'S INTERIM REPORT

<ul style="list-style-type: none">• many of the recommendations implicitly require an expansion of the health administration workforce rather than an expansion of the health workforce.
<p>4. <u>Governance and funding options</u></p> <p>The critical issue is how to improve patient care at the bedside, not which level of government does what. In terms of governance and funding, while not lending support to any particular model of funding or rearrangement of intergovernmental roles, we support the following principles:</p> <ul style="list-style-type: none">a) government intervention based on the principle of subsidiarity¹b) government services are best organised and administered as close as possible to the actual delivery of the servicec) the system should enable more decision making by health professionals at the local and institutional leveld) administration, performance reporting and accountability requirements should not be allowed to take precedence in terms of time or resources over the delivery of patient care and health services at a national, state, regional, local or institutional levele) support activity based funding but not payments for people over the course of care or a period of timef) concerned about the perverse incentives inherent in payments to reward good performance, particularly in the absence of any acknowledgement about the need for overall funding to be increased.
<p>5. <u>Administration, performance reporting and bureaucratic structures</u></p> <ul style="list-style-type: none">• many of the recommendations would result in the creation of more health agencies and bureaucracies results in money not spent on patient care e.g. a National Health Promotion and Prevention Agency, National Aboriginal and Torres Strait Islander Health Authority, clinical senates and taskforces, comprehensive primary health care centers, regional fund holding bodies, National Clinical Education and Training Agency and the proposal to expand the role of the divisions of general practice (even if the number of divisions were reduced)• emphasis across all areas in report on performance reporting and accountability risk deflecting resources and attention to administration rather than patient care• all risk diverting funding into structures rather than services
<p>6. <u>Indigenous</u></p> <ul style="list-style-type: none">• we are interested in further discussions on the proposal to establish a dedicated agency to purchase health services for indigenous Australians
<p>7. <u>Other comments</u></p> <ul style="list-style-type: none">• support increased focus on preventive care and Ehealth• support attention being paid in recommendations to address health inequality for patients in remote and rural Australia, those with mental illness, children and youth, aged Australians.• Mental health needs to extend beyond just early psychosis services to encourage better links between psychiatrists, private hospitals, community mental health services and general practices.• support focus on quality and safety• recognise that dental health is important for general health.

¹ fostering a sense of personal self-reliance and autonomy and responsible participation, in terms of individuals and families caring for their own health, while enabling government health departments to intervene in resource allocation when this is required for the good of all, especially the least advantaged.