



**AMA**

# **PRIORITY INVESTMENT PLAN**

**FOR AUSTRALIA'S  
HEALTH SYSTEM**

Canberra  
16 September 2009

# PRIORITY INVESTMENT PLAN FOR AUSTRALIA'S HEALTH SYSTEM

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

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

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

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

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

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

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

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

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

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

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



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

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

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

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

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

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

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

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

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

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



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

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

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

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

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

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

**The AMA plan requires:**

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

- Implementation of GP referred MRI and point of care testing based on best practice clinical guidelines; and
- \$67 million a year to provide medical services in Residential Aged Care Facilities, as per the NHHRC recommendation.

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

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

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

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

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

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

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

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

#### **The AMA plan for our public hospitals involves:**

- Undertaking a stocktake of the actual number of beds needed in each hospital to ensure no more than 85 per cent average occupancy;
- Undertaking a stocktake of the number of sub-acute beds needed to take pressure off acute hospitals in each area;
- Obtaining formal intergovernmental agreement on the timeframe for their establishment and formal agreement of the evidence that will be provided to demonstrate that the States have also provided the additional required funding in each institution's recurrent budget;
- Implementing a robust accountability system so that the Commonwealth can be assured unequivocally that the funding it is providing under the new National Healthcare Agreements is used to establish these new beds within agreed timeframes - say, within the next 18 months; and



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

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

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

**The critical characteristics of an 'effectiveness payment' are:**

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

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

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

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



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

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

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

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

**We also need rigorous ongoing analysis and debate about:**

- How many different health professionals across all disciplines are required and by when;
- What we mean by collaborative care, and what the risks are to the system of supporting expanded independent practice;
- How we can re-engineer the system to allow health professionals to spend more time in the clinical care of patients and less time on administration and paperwork (the NHHRC's recommended additional reporting and accountability requirements would result in more, not less, time spent on administration); and
- The equitable distribution of the medical workforce, with the right skill mix.

**Under the AMA plan, this would require:**

- By 2013, 3400 intern places guaranteed with processes under which States are accountable to the Commonwealth for delivering on this, and an annual process of monitoring by the Commonwealth to ensure that these places are provided;
- Commensurate increases in prevocational training places to meet the increasing number of junior doctors that complete their intern year;
- To restore the balance of service delivery and medical workforce training in our public hospital system and to support a sustainable and well-trained medical workforce, junior doctors must have better access to protected teaching time, while senior clinicians should be guaranteed at least 30 per cent of their ordinary working time to devote to clinical support activities such as teaching and training;
- Progressively increasing the number of first year vocational training places to 2,000 by 2015, over and above the GP training places outlined above, across both public and private settings;



- The Health Workforce Agency (HWA) – in close collaboration with the medical profession through the AMA – to undertake comprehensive and robust medical workforce modelling of supply and demand requirements for the next 10 years to determine the detailed number of vocational training places required in each discipline. Following this process, there should be a Commonwealth-State Ministers summit to lock in the commitment from governments as required to deliver on these additional vocational training places; and
- The Medical Training Review Panel to report annually on the availability of clinical training places for students at medical school, for doctors in training at prevocational and vocational levels, and to assess progress against the above targets established by the HWA. This should be accompanied by a Biennial Review of Clinical Training Places to identify training bottlenecks or shortages and to provide relevant policy advice to Government.

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

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

### **SUB-ACUTE**

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

### **MENTAL HEALTH**

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

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

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



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

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

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

### **LONG TERM CARE SCHEME**

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

### **RURAL AND REMOTE**

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

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

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

## **6. Taking advantage of the e-Health revolution**

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

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

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

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

## 7. Ending the 'Blame Game'

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

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

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

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

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

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

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

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

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



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

## **CONCLUSION**

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

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

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

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

We are offering the Government real solutions to real problems.

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

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

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