AUSTRALIAN MEDICAL ASSOCIATION
(SOUTH AUSTRALIA) INC

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Hon Tammy Franks MLC
Parliament House
North Terrace Adelaide SA 5000

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Dear Ms Franks

Health Care (Governance) Amendment Bill 2018

Thank you for contacting the AMA(SA) regarding the *Health Care (Governance) Amendment Bill 2018*, which was introduced in the Parliament by Minister for Health and Wellbeing Stephen Wade MLC. The AMA(SA) has received an invitation from the Chief Executive of SA Health to a briefing on the Bill to occur this week; however, we are glad to send you our preliminary feedback now, due to the Parliamentary timeframes involved.

Our current response is necessarily limited by the time available, noting the resumption of Parliament this week. Our preliminary feedback is provided in the document attached, and will also be provided to Government and other political parties; we may provide further feedback at a later time. It is not intended as a submission in response to the overall governance reforms proposed, but rather specifically in response to this Bill and some relevant issues raised by it.

While we have feedback on a number of aspects of the Bill, the most critical to the AMA(SA) at this time is that the proposed Boards should each include at least one member who is a medical practitioner, and that the Board chairs should be medical practitioners.

Increasingly, evidence supports the value of medical leadership in health service governance and management, and in fact the best hospital services internationally are medically (doctor) led. Our State Council is of the view that many of the issues our state health system has been grappling with are directly linked with the failure to adequately consult or engage with clinicians, and specifically the medical profession. The AMA(SA) strongly contends that our system needs a governance framework that supports and provides clinician-led policies and practices, with more doctors in senior leadership and management roles within SA Health.

In relation to the Bill at hand, we also have questions about the accountability structure; flag issues for regional SA that would need to be addressed; and hold that the consultation and engagement strategy provisions need to be more explicitly inclusive of health professionals who are not working in the hospitals as employees but may have patients attending or referred to it, and health professional and representative organisations.

We note that this Bill merely represents ‘part one’ of a broader program of change; as with most legislation, much will come down to how it is interpreted and applied. We look forward to being engaged in this important area as things progress.

Yours sincerely

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AMA(SA) BACKGROUND: **HEALTH CARE (GOVERNANCE) AMENDMENT BILL 2018**

AMA(SA) views on governance

The AMA(SA) has been glad to have some discussions with Minister Wade prior to the election regarding governance matters, in particular the AMA(SA)'s interest in better clinical representation and engagement. In our pre-election priorities document, *A People-First Health Strategy for South Australia*, circulated in December 2017, the AMA(SA) stressed the need for evidence-based, clinician-led policies and practices, and a governance framework and investment that reflects that. We called for a new clinician-led senate; an independent clinical analytics unit; and increased local authority for clinical leaders such as unit heads to make decisions within their health network; among other measures. We indicated that many of the current issues facing the health system reflect the fact that policies have been implemented without heeding early, frank advice from clinicians.

The AMA has two national position statements that are particularly relevant:

- Doctors' Engagement in the Management of Hospitals (2010)
- Quality and Safety in Hospital Practice (2013)

The AMA(SA) strongly advocates that governance changes to health in SA should reflect and uphold the principles and guidelines in these documents.

Liberal Party policies and clinician engagement

We note the Liberal Party's pre-election policy 'Engaging Communities and Clinicians for Better Health', which indicates the Party's intention to decentralise the public health system through the establishment of metropolitan and regional Boards of management. The Liberal Party's response to the AMA(SA)'s pre-election priorities agreed that clinician engagement is vital, and proposed the establishment of a Commission on Excellence and Innovation in Health and the decentralisation of the public health system and introduction of boards of management for each Local Health Network as key measures to improve engagement with clinicians. It indicated that clinicians would be included in the membership of each Board and that Boards would also be required to develop a formal clinical engagement strategy.

Timeframes and consultation for the new Government's proposals

We note the Liberal Party's pre-election commitment to a set of actions towards decentralisation and the establishment of Boards, including actions for the first 100 days of government; the appointment of Board Chairs by 31 July 2018; and that by the 2019-2020 financial year all regions will be operating under Service Level Agreements negotiated by Boards with the CE of SA Health, to "reflect local needs while recognising state-wide priorities". We have since been advised by the Government that Board Chair positions are to commence from 31 July 2018 in an advisory capacity, and in full capacity from 1 July 2019, with expressions of interest due by 29 June. These dates, in particular for Board Chair appointments, reflect an ambitious timeframe and have had, it is assumed, the effect of circumscribing consultation. This is disappointing.

Consultation for the existing Health Care Act

We note that the Health Care (Governance) Amendment Bill amends the Health Care Act 2008, under which the previous government brought about its governance reconfiguration. Now Boards are to be returned to govern six 'regional incorporated hospitals', based on current regional boundaries (Local Health Networks), with governing Boards also for the metropolitan and women's and children's health networks.

In considering our response to this new Bill, the AMA(SA) has consulted its records on the Health Care Act 2008. The draft bill for this Act was released for public consultation on 2 July 2007. The then Minister for Health, John Hill, presented to the AMA(SA) Executive Committee on the Bill on 14 August 2007 in advance of its introduction in Parliament on 27 September 2007. We note that the Health Care (Governance) Amendment Bill is merely stage one of a two-stage process, with a further Bill foreshadowed by the government to replace the Health Care Act. The AMA(SA) will be strongly urging an improved consultation process for this latter Bill, and for substantially improved engagement on the current Bill, and any subsequent implementation.

AMA(SA) FEEDBACK: THE HEALTH CARE (GOVERNANCE) AMENDMENT BILL 2018

Board Membership must include at least one medical practitioner, preferably as Chair

The Health Care (Governance) Amendment Bill prescribes who should be on the governing boards of the incorporated hospitals/Local Health Networks. The draft Bill provides for 6 or more members (but not more than 8), with at least two members to be health professionals, defined as someone who holds or has held general registration in a health profession under the Health Practitioner Regulation National Law (SA) *or* "an individual who practises, or has previously practised, a profession providing health services involving the provision of care or treatment to other persons (directly or indirectly)".

Under AHPRA, the national regulator, there are 15 health professions, including podiatry, optometry, chiropractic, etc. The latter definition appears even more broad. Whilst the AMA(SA) has a healthy respect for other regulated health professions that contribute valued, evidence-based care to patients, doctors have an important leadership role in clinical care, and accountability for that care, in particular in a hospital setting. This must be reflected in the new structure.

Mandating health professional membership on Boards makes sense, since the primary role of public hospitals is to provide health care. However, the AMA(SA) holds that the Bill should go further, and prescribe that each Board should have a minimum of one medical practitioner as Chair. That person should be practising, or have practised, at a specialist level, as well as meeting the general registration requirements in the current draft Bill. (The term 'specialist' includes the specialty of general practice.)

That the first listed function in the Bill for governing Boards is "to ensure effective clinical and corporate governance frameworks are established to support the maintenance and improvement of standards of patient care and services by the incorporated hospital and to approve those frameworks" (emphasis ours), further underlines the importance of having at least one medical practitioner on each Board as Chair.

SA Health needs more doctors in top leadership roles

SA Health has essentially adopted a managerial model, with no doctors being appointed to Chief Executive positions within the Department of Health, or the Local Health Networks. The Department has excluded doctors from decision-making and spent large amounts of money to use accountancy/consultancy companies (such as Deloitte, McKinsey, KPMG) to inform and carry out service re-design, such as the controversial and divisive 'Transforming Health' reforms. In contrast, the best hospital systems in the world have CEOs that are doctors – for example, the renowned Mayo Clinic, the Cleveland Clinic, and others. The best hospitals in the world are medically-led institutions – in stark contrast to SA Health.

The lack of medical leadership and authority at the highest levels of SA Health has significantly contributed to what we see at the moment – budget deficits, ambulance ramping, e-health issues, morale issues, a lack of innovation, poor clinical analytics, and a lack of clinical engagement: an issue explicitly acknowledged by the current Government – all resulting in a health system that is significantly under-performing, in our view. This is the reality of years lacking medical leadership in SA Health.

Under the model proposed by Government, we could have one Chief Executive and two Deputy Chief Executives in the Department of Health (as is currently the case), 10 LHN Board Chairs and 10 LHN CEOs – 23 chairs and chief executives in total. The power and authority would essentially lie within this grouping. Unless doctors are hired for some of these roles – which would be contrary to the current practice in SA Health – this would mean that there are 23 non-doctors running SA Health. This would not happen in the best healthcare systems in the world.

Evidence supports medical leadership in health service governance and management. The case for this is well made in the article enclosed ("Expert leadership: Doctors versus managers …"). The primary purpose of health services is patient care. Having expert leadership in healthcare, rather than purely managerial qualifications, is important to repair our health system. It also enhances the understanding of hospitals' vital roles in workforce (teaching) and research. The AMA(SA) strongly advocates for much better representation of doctors in leadership roles in SA Health, including on the Boards.

South Australia has the capacity to be among the leaders in health care and has notably invested in the biomedical/health precinct on North Terrace in the CBD. The AMA(SA) seeks to see the infrastructure investment complemented with leading governance, achieved through meaningful and high-level doctor leadership and input.

Appointments to the Boards

As with other Board members, medical practitioners appointed to the Boards should meet appropriate merit-based criteria. The AMA(SA) supports a skills-based board and a merit-based selection process for board members. 'On merit' needs to be clearly defined. The boards must contain sufficient expertise in particular areas, including skills unique to clinicians. The AMA(SA) advocates for use of a 'skills matrix' to introduce objectivity to this process, ensuring the optimal composition of the Board. Diversity and gender balance are important, and personal attributes will be as important as knowledge, skills and experience. It is important that Board membership is determined by the diversity and collective capabilities within the Board as a whole. Local talent should be preferred, though not mandatory, to ensure we don't have fly-in fly-out executives without any long-term commitments and responsibility. We would also raise the question of consumer representation on the Boards.

Selection of Board members should be a rigorous, consistent and competitive process that is open to scrutiny and subject to due diligence. There should be transparency to Parliament that the outcome of the selection process, with oversight of the Minister, produces the stated outcomes of a skills-based board – and the appointed membership should be openly defensible. If the Boards are to have some genuine autonomy, the selection process should be independent of the Minister. This is not to say that the Board and its Chair would not be answerable to the Minister. The importance of due process to explicitly avoid any conflict of interest cannot be gainsaid. We note from the eligibility criteria that employees of local health networks (LHNs) and contracted staff to LHNs would need to apply to 'neighbouring' LHN boards to avoid conflicts of interest (COI).

Accountability

The AMA(SA) is interested in questions of accountability under the proposed new structure, and the distancing of the Minister and SA Health Chief Executive (CE), which co-exists with significant powers to the Minister. The functions of the Boards is of interest, including expected governance and strategy functions, as well as compliance with directions from the Minister and CE of the Department of Health. Would this structure mean ‘all care and not enough responsibility’ for the Chief Executive of SA Health? Does it provide too much distance of the Minister from the activities at a hospital level? Does the Minister’s power to appoint/dismiss the chairs and members harm the independence of the Board? We also note the reference to inspectors and advisers; the latter, in particular association with future financial management over time within LHNs. The AMA(SA) would be interested to know more about the spheres of responsibility and accountability under the model proposed, and how interstate models function, including strengths and issues.

Country services and relationships with metropolitan services

We note that there is a section in 33(2) seeking to promote boards working together for local and statewide services. This will be an important factor for country health services. Currently, the metropolitan LHNs have had one Country Health SA LHN to work/collaborate/liaise with, but in the new arrangement it will be important for a collaborative working relationship between six regional LHNs and metropolitan services. The risk of fragmentation of service delivery/patient flows, etc will be higher in the new arrangement and this risk should not be underestimated.

The opening statements refer to LHN boards applying hospital resources equitably to meet the needs of the community served – it is important to preserve the interpretation of larger tertiary sites to continue to provide commissioned services in a statewide framework, and not a geographic LHN boundary.

The optimum number of Boards is debateable. However, the major change is for regional south Australia, which will move to six new Boards. The AMA(SA) would stress that there should be no

loss of funding/resources for regional health/clinical services due to costs associated with establishing the Boards. We also seek to know what residual central governance may remain for regional SA. Rural medical workforce management is one significant area of concern.

The AMA(SA) favours certain functions of statewide significance to remain centrally managed. For example, the Rural GP Service Agreement has significant workforce implications. It is not reasonable or sensible for 6 regional Boards to negotiate across the over 60 relevant rural health services for GP services. This function should remain the responsibility of a small central executive which would be responsible for other statewide functions also.

Provisions for consultation and engagement strategies need to be more inclusive

Including an explicit requirement for clinician and consumer engagement processes, and optimisation of those processes, is essential. However, the AMA(SA) seeks that the provisions in the Bill be made more inclusive with the following additions.

- One of the roles of the Board is to prepare and keep under review "strategies to promote consultation with health professionals working in the incorporated hospital" 33(e)(ii). This should also include:
    - health professionals who do not work in the hospital but whose patients may attend it, including general practitioners and other medical specialists.
    - professional associations and representative bodies of health professionals
- Likewise, section 33A "Engagement Strategies" provides that the governing board for an incorporated hospital must develop and publish "a strategy to promote consultation with health professionals working in the incorporated hospital (a *clinician engagement strategy*)". This should also include, as above:
    - health professionals who do not work in the hospital but whose patients may attend it, including general practitioners and other medical specialists.
    - professional associations and representative bodies of health professionals
- Needless to say, in both the above points, the somewhat amorphous term 'clinician' should include the range of health professionals, including visiting medical specialists to the hospitals, general practitioners, doctors in training and medical students, as well as nurses, allied health professionals, salaried medical specialists, and others.