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NICK XENOPHON'S SA BEST

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SA-BEST – RESPONSE TO AMA ELECTION PRIORITIES

Dear Associate Professor Tam,

Thank you for your correspondence seeking feedback from SA-BEST on your election priorities. Please accept our apologies for the delay.

A copy of our Health Policy is attached, for your information. In addition, we offer the following response to your Election Priorities Document. Please note that should SA-BEST be in a position of influence after the election, we will seek the input of medical professionals, independent experts and practitioners in considering any health-related matter:

AMA REQUEST	**SA-BEST RESPONSE**
CLINICIAN-LED DECISION MAKING	
1. An independent Clinical Data Analytics Unit and a new Clinical Senate to advise on health strategy.	Supported in principle
2. Expanded medical and surgical service at the Modbury Hospital, with a high-ratio nursing observation unit and priority patient transfers to the Lyell McEwin Hospital (LMH), with six additional intensive care beds for the LMH.	Per Health policy
3. A co-located Women's and Children's Hospital.	Per Health policy
4. A clinician-led Child Health Plan.	Support in principle
INTEGRATED HOSPITAL AND GP SERVICES	
5. Collaborative team-based models of care, and funding for GP-led stepdown/ outpatients.	Support in principle
RURAL AND REMOTE HEALTH	
6. Increased scope of clinical services in larger case-mix funded hospitals.	Yes, per Health policy
7. A hybrid model of care including specialists, rural GPs and medical trainees.	Support in principle
8. Improved access to mental health care.	Yes, per Health policy
TRAINING AND DEVELOPMENT	
9. A strategic plan for training, clinical research funding and collaborative workforce planning. Network training models and increased training places, including in suitable rural locations	Support in principle
MENTAL HEALTH	
10. Multiple medium-size purpose-built, high dependency accommodation for people with severe behavioural problems associated with dementia, mental illness and	Support in principle, per Health policy

impairment.	
11. Specialist training for staff caring for elderly patients with behavioural problems and a dedicated mental health registry to collect data.	Yes, per Seniors policy
PALLIATIVE CARE	
12. $24 million per annum for a palliative care model that enables GPs and allied health professionals to support people to die at home.	Yes, per Seniors policy
13. A new 16-bed purpose-built hospice at Modbury Hospital.	Yes
14. Rural outreach palliative care.	Yes, per Health policy
SUPPORT FOR DOCTORS' WELLBEING	
15. Legislative amendment to remove the mandatory reporting provision for doctors treating doctors.	Support in principle
16. Mentoring, peer-to-peer support networks and commitment to safe working hours.	Support in principle
17. Zero bullying tolerance across all SA Health.	Yes

We sincerely thank you for your interest in our views and look forward to discussion with you in the future.

Yours sincerely

The SA-BEST Team

NICK XENOPHON'S SA BEST

Health

Greater Transparency and Better Outcomes

A Royal Commission
SA-BEST will be insisting on a Royal Commission to conduct a root and branch review of South Australia's health system.

We want that inquiry to be conducted by health experts of the highest authority and expertise. We will want an interim report delivered to government and parliament within six months and a final report six months after that.

We will want that inquiry to look at every scandal, those that are already known, and those still hidden.

We will also want a Royal Commission to give an early opportunity for whistle-blowers to step forward, and for patients and families to tell of their experiences of a health system that has so badly failed many people.

A Royal Commission will come at a cost, but money well spent to get more value out of our huge health budget.

We must uncover the root causes of systemic failure. Only then will we have the evidence and the policy review that will allow real progress to be made.

A Royal Commission need not delay the next government from putting its own health policies into operation, but it will provide an objective lens through which that policy implementation can be assessed.

Alongside the Royal Commission SA-BEST will also work with professional medical associations, health experts and practitioners to refocus health spending with a priority on patient safety, equity of access, a strong public health workforce and a more accountable and transparent health system.

Priorities include to:

Secure our Medical and Health Services
1. Protect existing health capacity with no further beds to be closed.

2. Reinstate acute and critical care and emergency support services at Modbury and Noarlunga hospitals, and maintain acute and special care services at the Queen Elizabeth Hospital.

3. Repurpose the Repat to support community healthcare and suspend any deal or signing of a contract with ACH until after the election.

4. Ensure the commitment to relocate Hampstead Rehab Centre to the Queen Elizabeth Hospital at equal or better standards is honoured.

5. Find a workable solution for Labor's broken promise for a co-located Women's and Children's Hospital.

6. Develop a dedicated Eye Health centre to address the ophthalmology needs of Central and Northern Adelaide and increase resources for eye health in Southern Adelaide.

7. Recruit an additional neuro interventionist to support a 24-hour stroke service at the new Royal Adelaide Hospital, recognising the costs of this will be more than offset by better health outcomes requiring less hospitalisation.

8. Provide sustainable operational and administrative resourcing for our Ambulance service, including additional paramedics, ambulances and equipment.

9. Review the capacity of mental health, palliative care and cancer health resources across the state to determine where additional resources are needed.

10. Develop a primary health care plan which supports the integration of community-based health care provision into the management of patients within our public hospitals.

11. Increase sustained investment in community, preventative and lifestyle programs, noting that, for example, even six additional nurses in the community to support patients with Parkinson's disease will have significant social and economic benefits and savings to the health system through reduced hospitalisations.

Country Health
12. Restore and maintain Country Health SA budgetary requirements for country hospitals, including fast-tracking capital upgrades and maintenance that have been neglected by the centralised SA Health administration.

13. Increase the scope of medical services available in regional hospitals to enable more patients to be treated locally and help reduce demand on metropolitan hospitals.

14. Establish a stronger network of drug and alcohol rehabilitation and support services in country communities.

Support Our Hospital and Medical Staff
15. Real protection for whistleblowers to ensure they can speak out on failures in health and health administration without fear of losing their careers or any form of recrimination.

16. Violence against our health care staff is totally unacceptable. We must increase protection for our ambulance officers, paramedics, doctors and nurses who provide emergency services to our community.

17. Greater investment into training to develop stronger own in-house skills rather than the habitual and default use of external consultants.

18. We must have stronger and more pro-active planning and training to address current and future workforce shortages; and we must improve and resource administrative support to let our health professionals do their job.

19. Move to increase availability of permanent and full-time nursing and midwifery roles to levels that meet workforce demand while retaining flexibility.

20. SA-BEST provides a clear and unambiguous commitment to supporting the maintenance of penalty rates in the SA public health sector and categorially opposes any further privatisation or outsourcing of public health services.

Improve Governance, Transparency and Accountability

21. Initiate an online data and performance statistics program for all hospitals including surgical waiting times, outpatient appointment waiting times and medical activity data, consistent with the model in Sweden.

22. Urgently and independently review the Electronic Patient Administration System (EPAS) to address hardware, technical, reliability and operational issues.

23. Implement standard clinical pathways across local health networks for all highly utilised clinical interventions to improve care, quality and consistency of patient stay.

24. Strengthen local decision making and reduce overcentralisation of health administration.

SA-BEST will be making further specific announcements in relation to health that are consistent with this policy.

State and Commonwealth Collaboration

We recognise that many issues relating to our health system require cooperation between State and Federal Governments. We commit to working with our Federal SA-BEST colleagues to:

- Improve focus on integrating patient care from hospital to home and tailoring health services to meet the needs of individuals rather than asking them to navigate a system built around funding models,
- Improve planning and collaboration between state and commonwealth governments, clinicians, students, universities and colleges to ensure we have a strong health and medical workforce to service all South Australian communities,
- Support the development of principles that underpin the concept of advanced nursing practice that will assist necessary workforce flexibility.
- Better coordinate, resource and implement preventative health measures that will improve the health of South Australians, whilst reducing hospital admissions, stays and associated costs.

BACKGROUND

With a net cost to the state government of $3.6 billion and a further $2.3 billion from commonwealth revenue, grants and other sources, $5.9 billion is spent on health and ageing each year, making it the biggest and fastest growing expenditure line in the state budget.

One of the great paradoxes of public health and public hospital spending is that as medicine has become more advanced and sophisticated it seems the way we plan our health system, and changes to it, has not.

That paradox continues with the inescapable fact that before new pharmaceuticals and medical devices can enter the market they must go through a rigorous evidence-based approach - research, lab testing, clinical trials and evaluation - the type of rigour that seems all but lacking in planning our health system.

Labor's Transforming Health has inflicted substantial and ongoing damage in the delivery of public health care services in this state. There have been serious flaws in planning and implementation that has left many essential health services depleted, putting further strain on the entire health system.

We have had scandal after scandal, a politicised health administration, waste, massive cost overruns, declining services and tragedy for patients.

It hasn't 'transformed health', it has simply 'transferred health' away from patient-focussed outcomes because it has ignored those at the front-line.

Waiting lists are blowing out, medical services in other metropolitan sites are being withdrawn or left stranded, the loss of services and backlog of maintenance in country hospitals is putting lives in danger and further increasing the pressure on city facilities.

Many of these issues reflect the fact that policies have been implemented without proper planning and without early, frank advice from the front-line practitioners who deliver our health services.

The medical professionals we rely on so much feel pressured, under-supported and ignored. There are increasing reports of a bullying and an oppressive culture within SA Health and an increasing rate of burnout, psychological distress and self-harm in our medical professionals.

Morale amongst ambulance employees is at an all-time low. Our nursing and midwifery workforce is too highly casualised.

There is a lack of pro-active training and workforce development in our health and medical professions.

The growing levels of centralised decision making, administration and bureaucracy are making matters worse.

There are serious concerns across the medical profession about whether the Electronic Patient Administration System (EPAS) is fit-for-purpose or at all workable.

There have been too many near-misses.

We have dilemma of commitment. We have already spent over $470 million on EPAS - we need to make sure we are not continuing to throw good money after bad.

Our health system should provide seamless care for patients from hospital to home and the flexibility to tailor health services to meet the needs of individuals rather than the needs of funding models and central bureaucracies.

The state has a preoccupation with hospitals and not how to build health services.
The importance of appropriate planning in our health system based on appropriate data and rigorous modelling would help to provide the evidence base to justify the level of resources to achieve better health outcomes. Such modelling can also be used to improved efficiencies that will, in turn, free up resources to achieve better outcomes such as reduced waiting times in emergency and for surgery. The cost of such modelling will be more than offset by the savings delivered. The savings could be in the order to ten to twenty times the cost of the modelling, based on overseas research and experience.

The role of our doctors, nurses, midwives and allied health professionals cannot be overstated. They must be fully engaged in setting out a clear, long-term and sustainable pathway for planning and future delivery of health services in this state.

SA-BEST recognises that many external determinants of health must also be considered in any policy setting. This includes the impacts of domestic violence, gambling addiction and substance abuse to name a few key issues.

Unacceptable waiting lists
Waiting lists for elective surgeries in South Australia are unacceptable and, in many cases, a disgrace.

Orthopaedic operations such as knee and hip replacement waiting lists have increased by 100% in just three months from November 2017.

Medical professionals are frustrated that waiting times for colonoscopies are over two years and up to four to five years at the Lyell McEwin, and for cataracts - over three years.

We know that colon cancer is highly treatable if detected and managed early.

Unfortunately, the waiting list for colonoscopies means many will die from this preventable disease. That is scandalous.

And up to 13 years wait on eye health appointments, with over 3600 people on the waiting list shows just how broken the system is.

We also know that cancer treatment waiting lists are also blowing out, with category one patients - who should be seen within thirty days - regularly being bumped to category two, with a wait time of sixty days.

The 'big squeeze' - medical services strained and patient safety compromised
Doctors in South Australia are predicting this coming winter as a disaster waiting to happen, with health services unlikely to cope.

Medical staff at Modbury have already operated under 'code yellow' - an imminent risk to life. Noarlunga and Flinders are rapidly heading the same way.

Emergency care resources at Noarlunga, Modbury and the Queen Elizabeth hospitals have been downgraded and acute care bed capacity reduced, without adequate replacement in the new Royal Adelaide Hospital.

The issue of emergency department ramping is still not resolved.

The decision to build a new Women's Hospital in the biomedical precinct and leave the Children's Hospital in North Adelaide is a broken promise by Labor. It means a fragmenting of care for women and children, double handling within the system and inefficiencies that clinicians and patients can ill-afford.

There is no plan for providing transitional hospital and community care arrangements for young people with chronic disease or disability as they move to the adult system.

There are no comprehensive lymphoedema clinics, dedicated public lymphoedema practitioners or clear referral or treatment pathways for lymphoedema.

Access to appropriate palliative care is severely limited because funding models have made it difficult for general practitioners and allied health to provide these services. There is no integrated palliative care model for home care and specialist support for patients, palliative care accommodation for patients in the Northern Adelaide region is in very poor condition and funding for palliative medicine specialists to visit country regions was withdrawn last year.

Cardiology services at the Queen Elizabeth Hospital are under threat.

Veteran services at the Repat have gone.

And it goes without saying, the recent power failure at the new RAH is totally unacceptable.

Country Communities Sold Out

For years country communities have seen a decline in services and funding into local hospitals.

There is now a country hospital capital works and maintenance backlog of $150 million and an ongoing shortage of doctors, registered nurses, allied health professionals and visiting specialist services.

Many of our country hospitals are not appropriately equipped with neo-natal and paediatric resuscitation equipment, colonoscopies, anaesthetic supplies and ophthalmology equipment. The annual training allowance for country doctors falls well short of that provided to practitioners in city hospitals.

Money raised for local hospitals through decades of volunteer fundraising effort has been ripped out of communities and is now controlled by bureaucrats in Adelaide.

And to rub salt into the wound, the State Treasurer last year declared "our largest regional hospital is the new Royal Adelaide Hospital".

Not only is the lack of focus and support for our country hospitals insulting, it means substantial travel, accommodation and emotional costs for patients and families spending extended time in Adelaide, away from their own communities, and simply adds to the pressure on metropolitan services.

Many who do need to travel to Adelaide for medical treatment or to support family members experience significant financial hardship. The new RAH only provides short term, single daybed accommodation and the Patient Assisted Travel Scheme (PATS) still does not adequately meet the expenses of country patients and families.