11 November 2014

Hon Jay Weatherill
Premier
Office of the Premier
GPO Box 2343
ADELAIDE SA 5001

Premier.Jay.Weatherill@dpc.sa.gov.au

Hon Jack Snelling
Minister for Health
GPO Box 2555
ADELAIDE SA 5001

Minister.health@health.sa.gov.au

Dear Premier and Minister

Abolition, reformation, transition of boards

I write in relation to your intention to make changes to a wide range of Government Boards, including merging, reform, abolition and transition to SACAT.

We have not yet, at the time of writing, reviewed in full the final report as tabled in Parliament, but there are a number of areas in which we have questions, and areas of interest or concern. We appreciate that there may not yet be answers to many of these questions, and we certainly hope that there will be further appropriate consultation on next steps. We are flagging these areas now in order to clarify, open dialogue, and advise of concerns and feedback.

A range of important functions are covered by various boards and committees considered in the report, and while we consider it is entirely appropriate for Government to determine what boards it requires and will support, and we support the concept of reduced bureaucracy, we are concerned that certain key functions and values should not be compromised. Some of the boards proposed for abolition will likely have impacts on how doctors in the public system work day-to-day, as well as the health system more broadly.

We are particularly concerned that independent oversight and reporting on health services should be preserved and in fact enhanced – an element that is particularly important for rural areas. Also, key strengths and functions of entities such as the SA MET and the SA Health Practitioners Tribunal should not be compromised. The AMA(SA) seeks to be part of the discussion regarding models for health-related entities going forward.

In particular we are interested in:
- SA Health Practitioners Tribunal
- SA Medical Education and Training
- Health Performance Council
- Health Advisory Councils
We also have interest in some other entities which have relevance in health and medicine, including the Guardianship Board, Child Death and Serious Injury Review Committee and Firearms Committee. Other boards of interest to the AMA(SA) include the End of Life Ministerial Advisory Committee, Health and Community Services Advisory Council, and Ministerial Advisory Board on Ageing.

We would appreciate the opportunity to be engaged and provide feedback regarding changes to entities with health implications generally and, as we have flagged before, a particular focus is that medical practitioner representation and input, where it has previously been included, should not be diluted. We would also like more information on how the proposed changes will affect the health system, and what kinds of new arrangements would be implemented to fulfil the roles provided by the boards flagged for abolition, or what ‘reclassification’ or replacement with ‘alternative engagement models’ will look like. Our concern is that changes bring improvements, not loss.

In feedback we received regarding this process, there is some scepticism as to whether the reforms will meet one of the stated aims in the introduction to the interim report, namely to facilitate open government and improve stakeholder involvement, with reforms to be delivered using the engagement model outlined in the Better Together document. We are sad to report that there is a sense that trust has become diluted over time, with a perception that, too often, consultation has not been meaningful. The question was put to us: Will the “more direct engagement” facilitated by the government be meaningful, or will it just be a continuation of the briefings we have become accustomed to?

SA Health Practitioners Tribunal transition to SACAT

We thank Minister Snelling for his communication regarding the proposed transition of the SA Health Practitioners Tribunal to SACAT and are glad to advise that we have already had a preliminary meeting with Justice Parker and Ms Clare Byrt. We remain closely interested in this matter and our strong emphasis is that there should not be a dilution of medical or legal input or expertise under the SACAT for matters concerning medical practitioners. There may well be other operational matters of interest or concern and we look forward to the opportunity to canvas and discuss these as they arise. We understand there is a significant timeframe to allow for transition which we anticipate should allow for a sound and responsive consultation process, with time for review and consideration of changes proposed.

Child Death and Serious Injury Review Committee retained

We note the Child Death and Serious Injury Review Committee is marked for retention, and we support this. We understand it to be a useful and sound committee with an important purpose.

Guardianship Board transition to SACAT

We note the concerns previously expressed, for example by the RANZCP, regarding the transition of the Guardianship Board to SACAT, and concerns raised on the culture and milieu of the process. We have had some concern on what we understand to be the loss of the president of the board and therefore the loss of a position dedicated and with authority to administer the legislation, with the view that, regardless of the title, there should be a dedicated and expert position for such a purpose. We would be glad of any clarification or additional information you may have on this area.
We have heard differing opinions about the changes, and we would not want to see the Guardianship Board become more legalistic or ‘threatening’ for vulnerable mentally ill individuals, especially if it is moved to the Adelaide Court precinct. We suggest that the Guardianship Board under the SACAT model should be pragmatic in the implementation of the principles of the various acts for these vulnerable groups. We would put that the new configuration should work to:

- minimise the fear that individuals have of the tribunal in regard to location and format
- minimise the aspects that may appear threatening and legalistic and maintain a more pragmatic approach, focusing on the principles of the Guardianship and Administration Act and also the Advance Care Directives Act.

Health Performance Council, and ‘alternative engagement models’

In relation to the Health Performance Council, we note the interim report marked it for abolition in favour of “alternative engagement models”. We are unsure what this means and whether alternative engagement models would satisfactorily replace an expert Council charged with a clear mission. The role of the Health Performance Council is as we understand it one of independent reporting on health system performance rather than as an engagement entity per se, which makes the proposal for its replacement somewhat puzzling.

Setting that aside, while we are not sure what is proposed, in the current context the phrase “alternative engagement models” suggests to mind mechanisms such as the Citizens’ Juries the government has recently explored, and initiatives such as the yourSAy website. Neither, in our view, could take the place of the Council as it stands, and while the principle of community and stakeholder engagement via websites that facilitate comments and feedback has its attractions, we would worry about the degree of engagement with them, and their utility. The AMA(SA) itself has ‘missed’ some matters of interest placed on the yourSAy website for consultation, and we are better placed than some others would be.

We note the comment in the Government media release of 30 October 2014 that “For too long, we have had the same voices leading the public policy debate – we want to open up the debate for more people.” While transparency, openness and opportunities for broad comment are welcome, expert informed review and feedback also has its place and arguably is not universally well supported either. A lack of genuine consultation and engagement by government with key stakeholders and populations has been an enduring issue raised with us by our members over some years – and many would argue that our members are in fact well placed to be heard in the system and by Government. Yet we hear that, too often, this is not so. This includes both clinical and service considerations but also attempts to advocate for those patients more vulnerable and disadvantaged in the system.

In relation to the Health Performance Council, we in fact recently provided feedback to the Council on their role and function (https://ama.com.au/sa/amasa-submission-health-performance-council), and we are glad to provide for your information some of the comments that we made. The AMA(SA) supported the continuation of the Health Performance Council because we believe that there is a definite role for an independent body to be able to investigate, gather data and provide recommendations for change. It is important to have an independent body that can assess/investigate the performance of SA health systems, and the HPC provides a safety check on performance. Also, having an entity with the ability to be independent of the Department of Health and public-based hospital system, that can have some overview of Commonwealth/state, public/private interface, primary/tertiary, is of value. We have also received feedback that it is of value to have an entity outside of the Department of Health, where bureaucracy has been described as “entrenched”.

2301 PM Weatherill boards 11-04 f
The Health Performance Council is of particular importance due to the abolition of the hospital boards (replaced by the Health Advisory Councils, which are now to be reclassified), and we consider it to be more important still in a context in which other Boards and Committees are being abolished. We received some feedback that the HPC is in fact essential in the absence of the hospital boards, and concern that abolition of such a Council would result in inadequate scrutiny of performance of government services, suggesting that the only reason that one could condone the dissolution of HPC would be if the Boards of independent institutions, with original authority, would be reinstated – however, this would still not answer the more ‘whole of system’ aspects of the HPC’s role/capacity.

One matter raised with us was a lack at the early time of the HPC of the Department of Health collecting outcomes measures for its activity. Also raised was the capacity for the HPC to gain data from sources outside the Department of Health. The area of federal/state gaps was raised; also the fact that much of health care occurs outside of the Department of Health, in the private sector (for example, in primary health) and that the Department of Health is not well informed of what occurs outside of its remit. This theme has come up again in relation to the Transforming Health initiative, which examines metropolitan public hospitals rather than the system more broadly. There is considerable benefit in having an entity that can examine an issue in a view that encompasses the interface of primary care, tertiary care, public/private, federal and state. The view was expressed to us, in relation to the Health Performance Council, that "No other group exists that is trying to look at health across the boundaries”.

In relation to review and reporting, we would make the point that the AMA(SA) has been critical of a number of reviews commissioned by the Department of Health on various areas and undertaken by external agencies, which we have considered flawed for various reasons. For example, we considered that the McCann Review into non-hospital based services was insufficiently informed and insufficiently informative for an appropriately considered decision on the continuation of various programs and other measures proposed. A Deloitte budget performance review regarding the Women’s and Children’s Hospital we considered flawed on the basis of inaccurate comparisons, and an apparent failure to adequately recognise differences between hospital services at WCH compared to other hospitals, and other differentiating factors. These are just a couple of relatively recent examples indicating some reporting processes that we have considered flawed or insufficiently informed.

Good decisions require good information. This applies for patients, doctors, ministers, advocates, policy makers, health service providers and government departments. Good data, an understanding of varied contexts and complexities (which abound in health), evidence and independence are all vital components.

Whenever a saving is sought in health by ceasing a service or entity the AMA(SA) tends to strongly advocate that such savings be directed back into health, and in particular the AMA(SA) will often advocate for investment in frontline services as opposed to ‘bureaucracy’. However, in the case of the Health Performance Council it appears a very lean operation with only a very small staff, perhaps detrimentally small. A saving via its abolition would not seem to contribute any meaningful budget benefit that could significantly benefit health services, but the system would lose the HPC as a resource and the capacity it has to offer independent advice, which would be a notable loss. With the Council just approaching the release of its second four-yearly report on the health system, it could also be construed as somewhat ‘early days’ in that regard.
Concluding comments on the HPC –

The AMA(SA) does not support the abolition of the Health Performance Council as this represents the loss of an independent reporting voice that can inform better practice and performance in health. We understand that its abolition will require the passage of legislation, proposed as part of omnibus legislation. If the Health Performance Council is abolished, as has been indicated, we strongly advocate that rather than just being removed or replaced with a nebulous engagement function it must be enhanced, supported to grow into, or be replaced, by something better, and without the loss of key benefits it provides. The people of South Australia deserve more, not less.

Health Advisory Councils

The interim report indicated the HACS would not continue as government boards or committees. We were not sure what this would mean for their continuation and sought feedback from our Council and some interested members on the role and function of the HACS. We are glad to share an overview of this feedback for your information. Since that time we have received a reply to an inquiry made to Country Health SA which advises that while the LHN Governing Councils, including the Country Health Governing Council, will remain government boards or committees, the CHSALHN Health Advisory Councils “will be reclassified but this will not change how they function”. We take this to refer to the HACs in rural/regional SA such as Southern Flinders Health Advisory Council, Waikerie and Districts Health Advisory Council, Berri Barmera HAC etc (42 in total). We further understand the HACs to represent a fairly low/minimal cost to the health system, particularly with members of the HACs fulfilling their roles in a voluntary capacity.

Establishment of HACs

We understand HACs’ role, constitution and composition was determined by the previous Health Minister in detail, and that they were presented as an effective avenue of communication to the Health Minister for remaining hospital boards, which feared a loss of representation on local issues due to their abolition. It promised local representation, while freeing board members up from decision-making processes related to running hospitals.

We raised a number of questions with then health minister John Hill on the HACs, as proposed under the Health Care Bill 2007 when it was in draft form. Among other areas, we raised a lack of income stream for HACs to undertake their functions, being dependent on health units to provide them with resources. We also considered possible effects for other areas receiving donations. We understood HACs to “advise” and not hold funds, except those donated for specific purposes, and received feedback that they in many ways fulfill the role of previous auxiliaries rather than necessarily or uniformly being effective advisory bodies (reports are variable). Criticisms of the HACs concept included the risk of representing single-interest groups, a perceived lack of mandate, and in some cases a lack of outcomes despite including often very dedicated and well intentioned people. There has been concern that they have lacked voice, and not been heard.

The closure of country hospital boards was of concern as it was feared that centralisation to Hindmarsh Square would reduce the effectiveness of local management. At that time, country centres were experiencing unacceptable delays and bureaucratic frustrations with the Department. Rural boards represented long-term community memory, and served a purpose. There was, and is, concern that the role of local communities is increasingly being bypassed, with people in the regions having ‘less say’, and the role of the ‘centre’ strengthened to the detriment of communities and the individuals they comprise.
HACS, engagement and local voices

On the topic of engagement, the 2011 Health Performance Council report on the Country HACs concludes with suggestions for “strengthening country HACs as a critical and significant community engagement mechanism of the health system with local country communities”. Also, one of the Health Performance Council’s roles is to “independently look at how the health system engages health consumers, the community and stakeholder organisations” (emphasis ours). Now the HPC is going and there was concern that HACs may be downgraded. There is concern that disengagement of health care workers and the community from the Government over matters relating to health will continue to increase.

The interim report and prior questions about HACs raised concern about the loss of HACs. While the feedback we received on HACS was variable, reflecting perhaps both varying performance among HACs but also individual engagement with them from the perspective of the person providing feedback, a strong theme and concern in the feedback we received was that community voices need to be strengthened in rural areas, not dissipated, and as another voice for the community, HACs, in principle, have an important function. We received feedback that HACs were constrained in terms of public comment but failed to gain the impact sought on ministerial decision-making. There is concern about any reduction in respect of the needs of country people and their capacity to advocate and achieve a level of health care to which they are entitled. This is intrinsic to regional development.

We received some feedback that Country Health SA communicates poorly, making the role of HACs even more important. We also received feedback that has reflected frustration with CHSA failing to address long term structural issues, for example in relation to workforce issues. We would also note, in regard to liaison with Medicare Locals, these will now be abolished and replaced with Primary Health Networks, making for further upheaval and uncertainty. A medical practitioner linked with one HAC told us that if they receive any complaints or enquiries they direct them to the HAC, and grievances are listened to and brought up with the appropriate authorities, and that HAC members regularly drive to Adelaide to sit on committees and meet with politicians on behalf of their community. We also received positive feedback about a HAC being constructively involved in advocating for nurses at a local hospital, a HAC’s work on hospital rostering resulting in significant savings for the hospital, and HAC consultation with management to help facilitate more provision of local services.

HAC fundraising and other activities

We received feedback about the many less formal contributions that HACs make to the community, which include scholarships, and their success in fundraising. The scholarships can be a very helpful contribution to the recruitment of health workers. We received feedback that one HAC mentioned to us raised a significant amount last year, and that the amount of money rose considerably since community members have been confident that the money would be spent on equipment, and not go into consolidated revenue. The money raised in 2013 bought new equipment for the regional hospital, and we understand the community was very proud of the fact that they donated this equipment.
Concluding comments re HACs –

We gained the above feedback and considered our past statements and questions regarding HACs in response to the proposal under the interim report suggesting they be abolished as no longer to be considered government boards or committees. Our present understanding based on information from Country Health SA, is that the country HACs will continue as before but not be considered as government boards or committees. We are passing on the above feedback for the consideration of the Government in regard to the role of the HACs into the future. We would emphasise that the country HACs should be supported to be independent entities that can advocate for their communities and support the better provision of health services in their area, with the support and ear of Government. We strongly emphasise that rural and regional communities are better served when country HACs are heard by government, which has at times failed to adequately support and listen to rural and regional communities.

SA Medical Education and Training

We note that South Australian Medical Education and Training (which we understand to be classified as a HAC) is not actually an advisory board, it is an accreditation body, and it is marked for reclassification in the interim and final reports as not being considered a government board or committee. We are unsure what is planned for SA MET and how reclassification would or may impact upon it. However, the proposed re-classification of SA MET is concerning to junior doctors (and to the AMA(SA)) because it serves a critical accreditation function which helps to maintain the standards of junior doctor (especially intern) rotations. Apart from the obvious possible impact on rotation standards, compromising the function of SA MET could potentially lead to issues with AMC accreditation of internship in the state. It is also significant as a mechanism for junior doctor feedback to the Minister.

Concluding comments re SA MET –

We strongly ask to be a part of any discussions or consultations regarding changes to this entity and for clarification as soon as possible as to its future structure, given the proposed reclassification. We appreciate that the interim document notes that re-classification does not necessarily entail cessation of function and that Country HACS (which are similarly treated) are to continue in their function, but nonetheless we highlight the importance of this entity and seek more information as to its future role, support, configuration and place in the system. The right outcome is crucial and must support the vital functions, strength and role of SA MET.

We offer the comments and feedback in this letter for the consideration of the Government in the wake of proposed changes to the wide range of boards and committees considered in the recent report. We hope that they prove useful and welcome further information and clarification, as well as ongoing dialogue, through appropriate forums, where changes impact on the health system, the medical profession and the patients and communities we serve.

Yours sincerely

Dr Patricia Montanaro
AMA(SA) President

Cc Hon Stephen Wade, Shadow Minister for Health