AUSTRALIAN MEDICAL ASSOCIATION
(SOUTH AUSTRALIA) INC.

ABN 91 028 693 268

your AMA your voice your profession

28 November 2022

Hon Connie Bonaros
Chair, Select Committee on Health Services
in South Australia
Parliament House
North Terrace
Adelaide SA 5000

E: schealthservicesinsa@parliament.sa.gov.au

Dear Ms Bonaros

Re: Select Committee of the Legislative Council's review of health services in South Australia

On behalf of the members of the Australian Medical Association in South Australia (AMA(SA)), thank you for the opportunity to respond in writing to your advertised request for input into the Select Committee of the Legislative Council's review of health services in South Australia. This response reflects input from AMA(SA) Council and their many and varied specialties and areas of professional interest.

The impact of COVID-19 over the past three years cannot be ignored or underplayed. Yet in reviewing our records to develop this response, we found that many of the issues that are now contributing to what must be considered a system in crisis were worthy of comment and affecting patient care when then-President A/Prof William Tam responded to an almost identical request for input in 2019. Ramping, mental health access block, access to treatment – especially in rural areas – medical training, rural health, and toxic health workplaces were areas with major concerns. And it is interesting to read in the transcript of A/Prof Tam's appearance before the Committee in April 2019 that he said, 'we are still talking about the issues that we did in 2014'.

Now, as we approach the third 'anniversary' of the arrival of COVID-19 in South Australia, I provide an outline of the issues our members believe are most important when considering 'Health Services in South Australia'. We have chosen not to comment on 'Transforming Health', except to say it is an example of the many changes that have been introduced to 'fix' our health system at great financial and social cost, only to be discarded and replaced by another expensive approach. Otherwise, our comments follow, categorised according to the three items listed in the call for responses.

(a) The opportunities to improve the quality, accessibility and affordability of health services including through an increased focus on preventative health and primary health care

During the early months of the pandemic, South Australia's science-based approach to limiting the spread of COVID led to the pandemic having less impact on our economy than most jurisdictions in Australia and the world. However, since late 2021 that science-led approach has given way to one apparently influenced by business and other interests – and our health system and its workforce are suffering accordingly.

Postal: PO Box 685 Fullarton SA 5065
Phone: (08) 8361 0100 Fax: (08) 8267 5349
Level 1 175 Fullarton Road, Dulwich SA 5065
Email: admin@amasa.org.au Web site: www.amasa.org.au

AMA(SA) members are aligned with our Federal AMA colleagues in continuing to experience frustration at the system of funding healthcare through federal and state silos and the handballing of responsibility between federal and state politicians that leave hospitals, Medicare and the health system at large seriously under-funded. State leaders across the country agreed with the AMA that the federal government alter the national funding agreement so that the states would receive 50 per cent of the health budget. There has been no such change. Now, it seems, the states will receive less to fund our hospitals because of an apparent reduction in the predicted volume of hospital services.[1]

This comes as our hospitals are full, with many patients unable to find aged care or NDIS beds. Our emergency departments are constantly full. People are dying waiting for ambulances or while 'ramped'. People are waiting years for essential surgeries. Mental health services for adults and young people cannot keep up with demand, and the situation is worse in rural areas. There is a pretence that COVID has disappeared; meanwhile, there were 8,346 new cases reported in South Australia during the week ending 18 November 2022, an increase of 1,479 or more than 21 per cent on the on the previous week – despite the belief that fewer people are testing; meanwhile, the waiting times in emergency departments remain a national disgrace.

Our members, like our communities, are tired of the games. Australians are sick of having their health used as a rallying call for election purposes and then seemingly again placed on the back burner. We urge the Committee to recommend that the State Government work with other states to seek a more equitable funding arrangement from the Prime Minister and Federal Health Minister, and to place health front and centre in the May Federal Budget.

COVID and Long COVID

It is astonishing that COVID management responses are barely mentioned in the state and federal budgets released in recent months. Despite the messaging (or lack of it) at federal and state levels, COVID is here and continues to play havoc with the health system. Extra services are needed to close vast health care gaps opened by the pandemic. Allied health practitioners have estimated a 10 per cent increase in services above pre-pandemic levels for many years due to long COVID, and the impacts on other specialties are only now beginning to be understood. Elective surgery waiting times are still unacceptably long.

Patients affected by COVID continue to occupy GP, specialist and allied health appointments that therefore are not available for other patients, who then contribute to ramping and ED presentations. Doctors and other health practitioners are overwhelmed and have not rested for three years. The respiratory clinics which have served many COVID patients well in South Australia will not be funded through the Commonwealth after 31 December 2022.

Levels of long COVID and the range and severity of its symptoms are unknown. However, using a UK formula of 4.5 per cent of Omicron cases developing long COVID, SA Health has provided an estimate of 34,000 cases from the 750,000 cases reported in South Australia to mid-November 2022. The large-scale impact and cost of this on existing health and mental health services into the future is unknown; however, additional capacity for medical, nursing, allied health, and Aboriginal health practitioners to support optimal patient recovery will be required.

[1] https://www.ama.com.au/ama-rounds/28-october-2022/articles/hospital-funding-flaws-exposed-deep-budget-papers

The crisis in general practice

Our members appreciate the inclusion of 'primary care' as a specified item in your review. While the State Government does not directly fund general practice, it is our belief that the crisis in general practice is having a major impact on the ongoing catastrophe in our hospital system, and so worthy of this Committee's consideration.

South Australians need and deserve a well-funded network of general practitioners who are themselves adequately supported by a Medicare system that works for patients and doctors. After three years in which general practice 'carried' the health system through GPs' management of ever-changing protocols relating to COVID infection, quarantine and isolation and vaccinations, recent media attention has unfairly damaged both the reputation of general practice and the capacity of GPs to perform their invaluable work. General practice is the heart of healthcare in this country and keeps thousands of people away from more expensive hospital services. But in 2022, there are GPs leaving their long-held posts in South Australian practices because they cannot tolerate conditions any longer, and with vacancies in training positions there are predictions of significant shortfalls in GP numbers in just a few years.

General practitioners – and particularly those in rural areas – should be supported by:

- reducing their bureaucratic workload so they can increase patient contact and decision-making time
- developing pathways for GPs to access senior clinical decision-makers and patient data and records, and to arrange patient transfers
- the provision of funded wound treatments and nurses to manage many aspects of wound care
- easy and sustained access to Sunrise, including with logistical support
- funded research, including through paid clinician time
- adequate remuneration and attractive working conditions – including the single employer model – so junior doctors of today and tomorrow will consider general practice as a viable career choice
- recognition of and support for the additional services they provide to care properly for their patients in areas such as aged care and in managing and following up referrals, hospital discharges to services such as 'hospital at home', etc.

It has been suggested that a single point of access to care coordinators for the arrangement of appropriate care after discharge would eliminate much of the red tape that occupies doctors' valuable time.

At the same time, the Federal Government has announced that 'urgent care centres' will be introduced – centres that reportedly will be staffed by GPs and will bulk bill their patients. If this is the case, existing practices will be further starved of staff and will watch their patients leave their practices, which can no longer afford to bulk-bill, for the cheaper alternatives. AMA(SA) has joined other medical groups in drafting a paper for Health Minister Chris Picton that demonstrates how other services can be established that will 'avoid hospitals' without further destroying general practice in this state.

The Committee may also wish to examine the model under which the 'PHNs' – the primary health networks – are funded and their KPIs, as it seems there is little funding or other resources that are provided through the PHNs. The Adelaide PHN has a budget of $60 million but doctors in that area report they can see little evidence of spending on GP practices and services. For example, when PPE was desperately needed in rural areas in mid to late 2021, there was little or no support from the PHN to help GPs access it.

Ramping and bed block

Our hospitals are log-jammed. Expanding the physical size of EDs and commitments to increase bed numbers do not solve this without fixing the pipelines in and out.
The number one focus needs to be on the pipe in – extending primary care services. We need more resources for hospital step-down sites such as rehabilitation, respite and mental health facilities to alleviate the pressure on EDs. We also need to improve hospital capacity.

Staffing is a major issue, including with doctors, nurses and other practitioners. A member reported that at one metropolitan hospital, gynaecology clinics are cancelled almost daily because staff are sick and cannot be replaced; patients are having their appointments cancelled five times and waiting 12 months for post-op reviews. Public patients are experiencing a second-class health system and we shouldn't accept that.

'Hospital avoidance' services

The pandemic has led to the quick introduction of many successful innovations, including telehealth. However, while virtual health services are in the main beneficial and valuable in expanding access, they cannot and do not entirely replace face-to-face care. AMA(SA) raises concerns that there will be patients whose medical problems may only become apparent by seeing a doctor face-to-face. Many patients who want to 'see' their doctors have very relevant reasons for doing so; they should not be forced to use virtual appointments in all cases, especially if they cannot access the technology required.

We support 'advanced triage' systems such as the virtual services at CAHLN and WCH but acknowledge that referring a patient back to a GP without adequate support for primary care significantly reduces the effectiveness of these services.

At the same time, there must be rigorous analysis of where all funding is allocated and evaluation of funded programs. For example, the unfortunately named 'hospital avoidance programs' include 'My Home Hospital' and have been allocated $870 million with no evidence-based planning or targets.

Rural services

The crisis in general practice is worse among rural GPs. Many have worked with few or no breaks for some time. Some positions are filled by locums who cost the system many times what a contracted rural generalist would cost and do not know their patients. AMA(SA) worked with the Rural Doctors of SA to negotiate a contract that appropriately compensated GPs who support their communities through emergency, obstetrics, anaesthesia and other services, but there is much to be done to create a 'level playing field' with metropolitan colleagues and other specialties.

Rural patients are also missing access to other medical care. Non-GP specialists who visit regional centres such as Broken Hill, Kangaroo Island and Mount Gambier report that the rural patient experience dramatically differs to that of an urban patient in everything from timely access to services (e.g., mental health and palliative care) to up-to-date equipment, technology and communication. choice (such as antiquated endoscopy equipment). The supply-demand imbalance is even more pronounced and if we are to improve equity of access to quality healthcare, this seems like a good place to start.

Mental health services

The level of mental health services in South Australia was dire before the pandemic and is worse now. The AMA Mental Health Report Card released on 7 November 2022 noted that South Australia now has 27.1 mental health beds per 100,000 population – down from 744 in 1992-93 – while mental health presentations have increased by 50 per cent in 15 years (just over 100 per 10,000 population in 2004-05 to 155.1 per 10,000 population in 2020-2021). Our GP members report that in metropolitan Adelaide it is 'impossible' to access private psychiatry treatment for a new patient, 'let alone public'. GPs are trying to manage conditions they have no choice but to treat – and so may be forced to diagnose conditions such as attention deficit/hyperactivity disorder (ADHD) or borderline personality disorder – despite not having the training required or support needed.

Access to mental health care in regional areas is also limited. In Mount Gambier, for example, GPs are expected to see more than 95 per cent of psychiatry cases, whether or not they have counselling or psychiatry training. Unlike management of physical conditions, there is no pathway or network to offer support. And these appointments, which should be longer consultations when necessary, are not adequately funded via Medicare.

GPs are also asked to care for patients with drug and alcohol abuse issues that should be managed by trained professionals. GPs in metropolitan and regional areas report that methamphetamine misuse is presenting complex mental and physical problems that require a new approach and early intervention before patients' physical and mental health is damaged beyond repair.

More, connected and coordinated community services and outreach programs for patients who need it – not fragmented if well-meaning non-government services – would reduce ED presentations, lead to better outcomes for the patient and probably be much cheaper than the current crisis to crisis care that inevitably occurs with reduced availability of services.

Women's and children's health

AMA(SA) has been calling for some time for a Child Health Strategy. There is no such strategy, yet the State has decided to build a Women's and Children's Hospital at a cost of more than $3 billion that is expected to cater for the needs of the state's women, babies and children for many years after its planned opening in 2030-31.

With the State Government abandoning the previous government's site and plans, the AMA has repeatedly asked for more clinical engagement in planning a fit-for-purpose hospital at the 'new' site. Valuable engagement requires listening to and addressing to clinicians' perspectives and needs, which are essential for best-practice medical care and patient outcomes.

Our WCH clinicians have asked that project directors discard any previous designs, many of which were the result of compromises necessary because of the limited space. It is also important to consider not only patient numbers within population modelling but the composition of the population and what that may mean for health services; and to factor in the flexibility required to manage changes in medicine and technology over the next decade. The new proton therapy centre being built in the SAMHRI precinct is an example of newer technologies that will impact on the new WCH.

In addition, given that the new WCH is not expected to open for at least eight years, the need for ongoing significant capital works at the existing WCH has escalated. While the refurbishment of the WCH emergency department, operating theatres and inpatient mental

health facilities has been showcased in recent years, many medical subspecialty units have been struggling to care for patients with sub-standard, small and/or outdated facilities and equipment. This precarious balancing act cannot be sustained for the eight or more years until the new WCH opens.

At the WCH, too, workforce is an issue. We question where South Australia will find the doctors, nurses and other practitioners to fill new positions, as well as those needed to fill the gaps in the system and compensate for COVID burnout in the months and years ahead.

Otherwise, the Pregnancy Advisory Centre is still struggling with a fragmented service across two sites. It is unclear what the long-term plan is to support this service as a fully integrated service providing medical, surgical, telehealth, and related reproductive health services. This uncertainty affects morale as the staff feel they are providing a service that is less than they would like to provide.

AMA(SA) supported the decriminalisation of abortion in March 2021 and welcomed the enactment of the legislation in July 2022. Now, delivering early medical abortion (EMA) by publicly funded telehealth is a priority. To facilitate EMA by GPs through telehealth, the regulations around the prescription of mifepristone should be relaxed so it is treated like any other prescription medicine. While a federal issue, this has implications for care in South Australia – particularly for patients in regional and remote areas.

Research funding

South Australia attracts a less than proportionate amount of research funding. Our Council believes clinical research is undervalued, as evidenced by the non-existence of paid FTE (except for academics employed by universities) for such research.

Clinicians who provide direct patient care are in a unique position, not only to recruit patients to research but to recognize the questions that need to be explored and respond by designing targeted research studies. If clinicians were properly funded, so much more could be achieved in this realm, with success building upon success and South Australia ultimately attracting its fair share of research funding. A data analytics facility will be key to the success of such an endeavour.

Junior doctors and workforce

After nearly three years of the pandemic, staff are sick, burned out and stressed. Their capacity to care for patients as they should is severely limited. South Australia needs more staff in our health system; we must attract people to work here by offering good working conditions, including flexible training and working options and potentially financial incentives like other states have done.

The impact of workforce issues on patient care and health system capacity is a recurrent theme of this submission. While the State Government has announced funding for staff in various services, we question how South Australia will attract sufficient staff when South Australia's EBA for junior doctors is not competitive in comparison with other states, and states such as Victoria and Tasmania are offering attractive incentives for international doctors.[2] Incentives such as these not only deny South Australia of the best international talent but may restrict international medical graduates coming to the state, thereby increasing the pressure on the existing workforce. Reasonable, safe and flexible working hours are not

[2] https://www.health.vic.gov.au/jobs/migrating-to-victoria/support-for-international-healthcare-workers

only important for trainees to give adequate learning time and patient safety, but also could be methods to attract and retain the next generation of doctors.

Doctor training continues to be a concern. COVID has led to the cancellation of important teaching sessions numerous times over the past few years. While we acknowledge that service provision must be prioritised in emergency situations, this has been allowed to continue in numerous sites without adequate solutions.

We understand that for 2023 there is a current shortage of at least 106 Junior Medical Officers across the state. This is general trainees only so does not include specific RMO roles (e.g., the prevocational psychiatry program.)

End of life care

After the passing of legislation last year, South Australia will in January 2023 introduce voluntary assisted dying (VAD) as an end-of-life option for eligible residents of the state. As an active participant in the drafting of the VAD legislation, and similarly as a contributor to the wording of the new Advance Care Directives legislation, AMA(SA) appreciates the government's efforts to plan and establish implementation policies and programs, including in recognising the need for adequate training of everyone involved in VAD cases and in applying the new legislation. However, we also recognise that many South Australians will not choose VAD at the end of life, and many people in ill health will seek palliative care services. We ask the Committee to consider how funds should be allocated to care for and support all patients and their caregivers, including their doctors, through the complex situations that will arise in the months and years ahead.

(b) The South Australian experience around health reform in the State, specifically Transforming Health, EPAS, the reactivation of the Daw Park Repatriation Hospital and other related projects and or programs

AMA(SA) does not wish to occupy the Committee's time with comments about Transforming Health or other former policies.

(c) The Federal Government's funding of State Government services and the linking of other federally funded services in South Australia, such as Medicare funded GP services, and Adelaide Primary Health Network and Country Primary Health Network

Medicare and general practice

It is the AMA view that the Medicare system is outdated and inadequate to manage the complex area that is the health environment of 2022. Much has changed since the 1980s, when Medicare was introduced, but what has not changed is the place of the general practitioner as the heart and spine of community care. Yet Medicare funding does not support GPs to provide the services patients need and the system requires if those patients are to seek care in their communities and not head for EDs.

The AMA proposal to 'modernise Medicare' envisages more care delivered in the community by GPs who develop relationships with their patients and who are compensated to spend more time with them in delivering wound care, aged care, after hours care or telehealth, when and where required.

A fairer Medicare system would do much to solve the GP crisis, so that junior doctors are again attracted to general practice. It would also enable many GPs to reintroduce bulk-billing, which in recent months has been abandoned because doctors cannot afford it.

The 50:50 funding split

As discussed above, AMA(SA) members and our colleagues are tired of never-ending debates between federal and state politicians about whether the federal or state governments should pay more to improve the nation's failing health systems. Before the federal election in March 2022, the AMA urged state premiers and chief ministers to agree to seek a commitment from the Federal Government to increase the federal contribution to each jurisdiction's health budget to 50 per cent. This would add about $50 billion to the health system across the nation over four years; South Australia's proportion would be invaluable in funding much-needed services in this state.

We understand our submission outlines many areas in which this state's health services are in dire need for improvement or complete revitalisation. Should you wish us to provide more information or clarify any issue, please contact me via my Executive Assistant, Mrs Claudia Baccanello, on 8361 0109 or at president@amasa.org.au at any time.

Yours sincerely

Dr Michelle Atchison

BM, BS, FRANZCP, GDipArtHist

President
Australian Medical Association (SA)