AUSTRALIAN MEDICAL ASSOCIATION
ABN 37 008 426 793
T | 61 2 6270 5400
F | 61 2 6270 5499
E | ama@ama.com.au
W | www.ama.com.au
39 Brisbane Ave Barton ACT 2600
PO Box 6090 Kingston ACT 2604

National Health Reform Agreement Addendum 2020-25

AMA submission to the Mid-term Review

NHRAReviewSubmissions@health.gov.au

The AMA appreciates the opportunity to provide a submission to the mid-term review of the National Health Reform Agreement (NHRA) Addendum 2020-25 (the Addendum). We particularly appreciate the Review focusing on whether the stated objectives of the Addendum – improving health outcomes, access and innovation - are being met. The AMA submission will also address whether the Addendum's health funding, planning and governance architecture is fit-for-purpose. The AMA will contend that, with the emerging priorities for better integrated care and more seamless interfaces between health and primary care, mental health, aged care and disability systems, the key objectives of the Addendum are not being met, as evidenced by the data.

The AMA recognises that the reasons for this may be multifaceted and include the impact of Covid-19 pandemic and a growing ageing population living with multiple chronic health issues. However, years of reduction in capacity and available public hospital beds per population, inadequate funding of healthcare (both public hospitals and primary care) and the absence of a framework for performance and accountability enshrined in the Addendum are the key factors that impact the deteriorating performance of our public hospital system.

Furthermore, since the move from the Council of Australian Governments (COAG) to National Cabinet, the AMA has observed a significant, troubling reduction in transparency of actions and decisions made by the Health Ministers. This lack of transparency has further contributed to a lack of accountability for the declining performance of public hospitals.

From the AMA's perspective the key issues to be addressed to support our struggling public hospitals include:

- Improving performance. Reintroduce funding for performance improvement – for example, improvement in elective surgery and emergency department waiting times – to reverse the decline in public hospital performance.

- Expanding capacity. Give public hospitals additional funding for extra beds (along with the staff) and support them to expand capacity to meet community demand, surge when required, improve treatment times, and put an end to ambulance ramping.
- Address demand for out-of-hospital alternatives. Fund alternatives for out-of-hospital care, so those whose needs can be better met in the community can be treated outside hospital. Programs that work with general practitioners to address avoidable admissions and readmissions should be prioritised.
- Increasing funding and removing the funding cap. National efficient price (NEP) and national efficient cost (NEC) must be adjusted in line with the rate of inflation.
- Reforms to primary care, that must include:
    - Voluntary patient enrolment
    - Workforce Incentive Program (WIP) for access to multidisciplinary care
    - "Extended" Level B attendance item.
    - Improved access to GPs after-hours care
    - Wound care for targeted conditions.
    - New primary care in aged care funding model
    - Rural General Practice Infrastructure Grants
    - Continued Covid-19 support.

The AMA was very pleased to see that many of the reforms for primary care that we have been calling for were funded in the 2023-24 Health Budget.[1]

The principles and objectives that underpin the NHRA

The AMA is generally supportive of the principles and objectives that underpin the NHRA, however we argue that they are not being achieved under the current funding and structural arrangements, as we outline below.

Improve outcomes, experiences, quality, safety and efficiency of care objective

The AMA publishes a number of reports that demonstrate that improved outcomes for patients are becoming rarer, due to structural issues, primarily funding. The AMA Public Hospital Report Card 2023 found that wait times in emergency departments in 2021-22 have been at their longest in the last 20 years.[2] While the Covid-19 pandemic may have influenced the performance of our emergency departments (EDs), we contend that this decline in performance occurred because there is not enough capacity in our public hospitals to safely admit all those who require admission. Covid-19 data provide useful evidence: the number of ED presentations in 2020-21 and 2021-22 were roughly the same, but ED wait times in 2021-22 were much longer. This is because the number of hospitalisations in 2021-22 due to Covid-19 was much higher (4,718 in 2020-21 compared with 53,923 in 2021-22). Unable to be safely admitted, patients are kept in EDs for extended periods of time.

[1] https://www.health.gov.au/sites/default/files/2023-05/stakeholder-pack-budget-2023-24_0.pdf
[2] https://www.ama.com.au/clear-the-hospital-logjam/phrc

With limited capacity (i.e. number of available beds), access to elective surgery is limited as well. The AMA estimates that there will be a backlog of 507,764 patients by the end of this financial year waiting to receive elective surgery (2022–23). We are also increasingly seeing ambulance ramping in front of hospitals, as a result of more patients requiring admission, spending longer times in EDs because they cannot be safely admitted, and as a result safe handover from ambulance to ED staff is delayed.

This is an example of a failure to meet one of the key principles of Medicare: *access to public hospital services is to be on the basis of clinical need and within a clinically appropriate period*.

Equitable access to care objective

The AMA argues that the current funding arrangements fail to achieve equitable access to care. This is particularly obvious in relation to the Commonwealth Government's underfunding and under-indexation of Medicare, resulting in shrinking bulk billing rates and limited access to primary care for people who cannot afford to pay the gap. While factors influencing patients increasingly presenting at EDs are multifaceted, the AMA argues that some of it can be linked to limited access to GPs and specialists in public hospitals, which results in patients deteriorating to the point where attending Emergency Departments is their only option. The data available tell us that access to GPs and improved coordination of care can reduce preventable hospitalisations.[3]

We also know that health outcomes for patients living in rural and regional areas are worse than for patients in metropolitan, due to limited options of accessing health care. The AMA argues that the key principle of equitable care is being undermined by the current funding/structural arrangements and that, unless urgent action is taken, Australia is heading towards a health system which is no longer universal nor equitable in access.

Improvements in outcomes objective

It is hard to measure improvements in outcomes at the population level (outside of life expectancy), but with the limited access to affordable healthcare, it is hard to see how patient outcomes are improved, especially if we are looking at elective surgery and the backlog created there. Every delayed surgery has an impact, leading to loss of quality of life and further deterioration of health. Delaying a minor surgical intervention to improve the hearing of a child may mean they miss crucial time for physical and mental development.

When the AMA published our Public Hospital Report Card in 2022, we had a real-life case study, a child that needed grommets, that would have waited over 2 years, which would have influenced its speech development.[4] This is likely to incur much larger costs throughout their life than the cost of surgery. Or a delayed orthopaedic surgery, for example a hip replacement, will incur further costs to the health system through more consults with the patient's General Practitioner, more medicine subsidised by the pharmaceutical benefits scheme, and through income support from the Government due to an inability to work. This could also lead to further health issues, including mental health issues, for an individual due to their limited ability to participate in work,

[3] https://www.aihw.gov.au/reports/health-care-quality-performance/factors-hospitalisations-chronic-conditions/summary
[4] https://twitter.com/7NewsToowoomba/status/1508355807989366786?s=20&t=deiJHCoFucEba18tllbBCg

physical and social activities. The AMA is familiar with a case of a patient who waited over two years for hip surgery, which made him almost immobile and unable to work.[5]

Improved mental health outcomes objective

This is an area of significant failure of the NHRA. The 2022 AMA Public Hospital Report Card - Mental Health Edition[6] showed that the number of ED presentations of mental health patients per 10,000 people nationally has almost doubled since 2004-05, from 69.2 to 120.6, with increased severity of illness for those presenting. Patients are increasingly relying on public hospitals and EDs to access the care they cannot receive in the community. With the significant reduction in mental health public hospital beds (from 45.5 to 27.5 per 100,000 people between 1992-93 and 2019-20 – an almost 40 per cent reduction) this results in growing wait times in EDs.

Around one in three patients presenting with mental and behavioural symptoms at EDs are subsequently admitted. For patients that are triaged for admission, the wait times in 2022 ranged from 12 hours in Queensland to 28 hours in Tasmania. The national average wait time for the 90th percentile of patients presenting with mental disorders is 19 hours and 29 minutes. That is around 7.5 hours longer than average for all ED presentations, which again points to the lack of bed capacity to admit patients who require admission.

The AMA has observed significant funding from the Commonwealth being directed into mental health organisations (headspace for example) that do not ensure quality of care, nor is it possible to monitor their performance against specific indicators. Despite the growth in the national population and the reduction in reliance on public acute specialised hospitals for care of mental health patients, from 1992-1993 to 2019-20, the Government mental health-related expenditure as a proportion (per cent) of Government health expenditure grew only by 0.32 per cent (from 7.25 per cent in 1992-93 to 7.57 per cent in 2019-20). There are obvious and significant gaps in access to primary and community care, which could be filled by Modernising Medicare[7] to facilitate joined-up care led by GPs. In addition, we have a limited understanding about how federally funded national programs and initiatives like headspace influence tertiary care and hospitalisations.[8]

Nationally unified and locally controlled health system objective

Failures of this objective are particularly visible in areas where public hospital services intersect with Commonwealth funded programs, such as aged care or the National Disability Insurance Scheme (NDIS). Under the NHRA, the Commonwealth is responsible for planning, funding, policy, management and delivery of the national aged care system and continuing to focus on reforms in primary care that are designed to improve patient outcomes and reduce avoidable hospital admissions. Lack of adequate planning and funding of aged care over the last 10 years, as well as inadequate aged care policy that has in the past excessively focused on the needs of aged care providers rather than aged care recipients (as demonstrated by the outcomes of the Aged Care Royal Commission)[9] results in aged care type patients increasingly relying on public hospitals,

[5] The Australian 30 September 2020. Article: Surgery hidden wait list horror
[6] https://www.ama.com.au/clear-the-hospital-logjam/mhrc
[7] https://www.ama.com.au/modernise-medicare
[8] https://www.health.gov.au/sites/default/files/documents/2022/10/evaluation-of-the-national-headspace-program.pdf
[9] https://agedcare.royalcommission.gov.au/publications/final-report

both for emergency care and for extended stays while they await admission to an aged care home or to receive a home care package. The AMA sees this area of significant failure of the NHRA.

Implementation of the long-term reforms and other governance and funding arrangements, and whether practice and policy in place delivers on the objectives of the NHRA and the Addendum

Schedule C of the Addendum establishes the long-term reform principles for the Australian health system. The parties also agree to achieve improved patient outcomes, reducing ED demand, avoidable hospital admissions and extended stays. The AMA argues that none of these objectives are being achieved under the current Addendum.

Reducing ED demand

The AMA's successive Public Hospital Report Cards have all shown increasing pressures on public hospital EDs,[10] preceding the signing of the Addendum, that unfortunately have not been improved by the Addendum. We have seen a continuous drop in percentage of triage category 3 emergency department patients seen within recommended time (< 30 minutes) from 70 per cent in 2013-14 to 58 per cent in 2021-22, the latter being the lowest since the AMA Public Hospital Report Card started tracking the data in 2002-03. Furthermore, the percentage of ED visits completed in four hours or less has been on the decline since 2015-16 when it was 73 per cent, to 61 per cent in 2021-22, again the lowest number since the AMA started tracking this indicator in 2011-12.

Avoidable hospital admissions and extended stays

The Australian Institute of Health and Welfare (AIHW) report from 2022 that looked at "*what patient characteristics and care coordination measures are associated with potentially preventable hospitalisations (PPH), with a specific focus on PPH related to chronic conditions (CC-PPH)*" found that "*older age, poorer health and polypharmacy were particularly more strongly associated with CC-PPH*", and that there was a strong correlation between lack of access to GPs for people with chronic conditions and preventable hospitalisations, with "*people who did not see a GP when needing to see one were more likely to have a CC-PPH*".[11]

According to the latest data by the Australian Bureau of Statistics, 46.6 per cent of Australians, almost one half, had a chronic condition, and one in five had two or more chronic conditions, the most prevalent one being mental and behavioural conditions (20.1 per cent).[12]

Under the Addendum, the Commonwealth Government agreed to a range of reforms to primary care to reduce potentially avoidable hospital admissions, including "*investments in national implementation of co-ordination of care models for persons with complex, chronic conditions, and flexible funding models to better support persons with severe mental health conditions, consistent with the November 2015 response to the National Mental Health Commission Report -*

[10] https://www.ama.com.au/clear-the-hospital-logjam/phrc-nphp
[11] https://www.aihw.gov.au/reports/health-care-quality-performance/factors-hospitalisations-chronic-conditions/summary
[12] https://www.abs.gov.au/statistics/health/health-conditions-and-risks/health-conditions-prevalence/latest-release

Contributing Lives, Thriving Communities" (Schedule E40 – b, page 74). The AMA argues that over the last three years not enough has been done to improve coordination of care and develop flexible funding models, which is evidenced by the AIHW data. Accordingly, we were extremely pleased that many of these have been addressed by 2023-24 Health Budget.[13]

For example, and as outlined previously, the AMA Public Hospital Report Card – Mental Health Edition 2022 found that mental health patients are increasingly relying on public hospital EDs to receive mental health care.[14] The numbers presented in our Report Card point to a bed block, a lack of capacity in public hospitals to quickly and safely admit one in three patients who are triaged for admission. But they also point to a lack of adequate community care and care coordination for mental health patients.

Furthermore, there has been a clear lack of focus on reforms in primary care that are designed to improve patient outcomes and reduce avoidable hospital admissions from the Commonwealth side for a number of years. Lack of adequate planning and funding of primary care in aged care over the last 10 years results in aged care type patients increasingly relying on public hospitals, both for emergency care and for extended stays while they await admission to an aged care home or to receive a home care package.[15] The AMA sees this area of significant failure of the NHRA.

The AMA was supportive of the actions agreed to by the Strengthening Medicare Taskforce, that recommended supporting general practice in management of complex chronic disease through blended funding models integrated with fee-for-service, with funding for longer consultations and incentives for quality bundles, as well as continuity of care.[16] We were pleased to see this receive funding in the 2023-24 Health Budget.[17]

The impact of external factors on the demand for hospital services and the flow-on effects on Addendum parameters

In the AMA's view, major external factors that impact the demand for hospital services for years to come include:

- Ageing population - by 2035 Australia is expected to have over one million people over the age of 85. People over 85 spend on average around 5 days in hospital every year. Our public hospital and primary care systems are not set up or resourced to manage this projected increase.
- Population living with more chronic disease. Improved primary care and care coordination will play a key role in preventing hospitalisations, as per the AIHW report on Coordination of healthcare.[18] Significant investment from the Commonwealth in primary care will be required, but that investment is justified as it will lead to reduced cost in public hospital

[13] https://www.health.gov.au/sites/default/files/2023-05/stakeholder-pack-budget-2023-24_0.pdf
[14] https://www.ama.com.au/clear-the-hospital-logjam/mhrc
[15] https://www.ama.com.au/articles/hospital-exit-block-symptom-sick-system
[16] https:/www.health.gov.au/sites/default/files/2023-02/strengthening-medicare-taskforce-report_0.pdf
[17] https://www.health.gov.au/sites/default/files/2023-05/stakeholder-pack-budget-2023-24_0.pdf
[18] https://www.aihw.gov.au/reports/health-care-quality-performance/factors-hospitalisations-chronic-conditions/summary

services. To illustrate using mental health care as an example, according to AIHW, $1.4 billion, or $53 per Australian, was spent by the Commonwealth Government on benefits for Medicare-subsidised mental health-specific services in 2019–20. By comparison, per capita cost (constant prices) of units and wards in specialist psychiatric units of public hospitals was $90.11.[19] We welcome the plan announced by the Federal Health Minister for Health and Aged Care to connect patients living with chronic disease who have a high number of public hospital ED presentations with GPs through MyMedicare.[20] This type of blended payment model is welcomed by the AMA as it will help GPs do what they do best – provide ongoing care to their patients, while at the same time reducing the pressure on public hospitals.

- Mental health of the population. One in five Australians live with a mental health condition. Suicide is the leading cause of death among the 15 to 44 age cohorts in Australia.[21] Australia higher rates of suicide than the Organisation for Economic Co-operation and Development (OECD) average, but Australian health system is failing to provide people suffering from poor mental health with adequate care, that is coordinated, patient focused and that results in their improved outcomes. Instead, we are relying on our public hospitals to provide care without appropriate resourcing or infrastructure.

For small rural and small regional hospitals, whether they continue to meet the block funding criteria determined by the Independent Health and Aged Care Pricing Authority (IHACPA)

The AMA was supportive of the fixed plus variable model used to determine Commonwealth contributions for smaller rural hospitals with lower patient volumes when it was first proposed by IHACPA.[22] We continue to support IHACPA's approach that takes into consideration concerns raised by stakeholders as issues become known, and undertake additional modelling as needed. Given the complexity of public hospital pricing, the AMA believes it will be important for IHACPA to continue to engage with all stakeholders to get the pricing for rural and small regional hospitals right.

Whether any unintended consequences such as cost-shifting, perverse incentives or other inefficiencies that impact on patient outcomes have arisen, and the capacity of Parties to adopt and deliver innovative models, as a result of financial or other arrangements in the Addendum

Cost-shifting and perverse incentives

The AMA argues that cost-shifting between Commonwealth and the State governments has been an ongoing issue from when the Addendum came into effect in 2020. Looking at the public hospital system, we see the majority of issues that have negative impact on both patient

[19] AIHW 2022. Mental Health Services in Australia. Expenditure on Mental Health Services https://www.aihw.gov.au/reports/mental-health-services/mental-health-services-in-australia/report-content/expenditure-on-mental-health-related-services

[20] https://www.health.gov.au/ministers/the-hon-mark-butler-mp/media/minister-for-health-and-aged-care-speech-national-press-club-2-may-2023?language=en

[21] AIHW 2022. Life expectancy and deaths. Deaths in Australia https://www.aihw.gov.au/reports/life-expectancy-death/deaths-in-australia/contents/leading-causes-of-death

[22] https://www.ama.com.au/articles/2021-22-public-hospital-pricing-framework

outcomes and public hospital performance are at intersections of federal and state/territory funding areas. Obvious examples include aged care and disability, where over the past decade there has been a growing reliance on public hospitals to pick up patients and provide care for patients who are not able to receive the care they need under the aged care and NDIS systems. The AMA argues that mental health care is also one of those intersections.

In the area of aged care, which is federally funded and operated, the data point to a growing number of patients who spend prolonged time in hospitals waiting for aged care services since 2013, reaching almost 20,000 hospital separations in 2020-21 and over 280,000 patient days attributed to patients waiting for a place in an aged care home nationally. The AMA estimates that that these patients waiting for residential aged care services cost the health system between $316.7 million and $847.6 million in 2020–21 alone.[23] This is in addition to the costs incurred by frequent transfers from aged care homes to EDs due to inadequate funding and provision of primary care in aged care and a deliberate separation of health care and aged care implemented by the Commonwealth. A research paper by the Royal Commission into Aged Care Quality and Safety in 2021 found that in 2018/19 36.9 per cent of aged care residents presented to an ED at least once.[24] AMA's own research paper from 2021 found that if the emergency department presentations continued at this rate, the cost over 4 years to 2024–25 for admissions from aged care homes would amount to $1.4 billion.[25]

The NDIS is another Federally funded program where we are seeing an increased reliance on public hospitals. In June 2022, there were 1,433 NDIS-eligible patients in public hospitals waiting to be discharged, with patients waiting around 160 days —over five months —for appropriate supports to be put in place through the NDIS so they could leave hospital. Of these 1,433 patients, 44 per cent had a discharge plan in place. The AMA estimated that these 1,433 NDIS-eligible patients cost the health system between $253.8 to $679.4 million in the 160 days they were waiting to be discharged.[26] The AMA is aware that the Minister for the NDIS announced a new agreement with state and territory governments to improve the hospital discharge process for NDIS-eligible patients. We look forward to this delivering improvements.

Finally, and as outlined previously, mental health is also an area where we are seeing cost shifting through an increased reliance on public hospitals. The shortfalls in primary care, due to the lack of fit-for-purpose general practice Medicare-reimbursed models of care, means patients increasingly rely on EDs and hospitals. And while this reliance may provide an immediate, short-term reprieve, EDs are not appropriate environments for mental health patients. Furthermore, the lack of in-patient bed capacity in public hospitals results in extended patient stays in EDs, exacerbating the problem.

The AMA has been calling for a better and longer-term solution. Based on AMA analysis, that solution must include the modernising Medicare to support GP-led collaborative Primary Care and an increase in public hospital and community service capacity — primarily the number of

[23] https://www.ama.com.au/articles/hospital-exit-block-symptom-sick-system
[24] https://agedcare.royalcommission.gov.au/publications/research-paper-18-hospitalisations-australian-aged-care-201415-201819
[25] https://ama.com.au/sites/default/files/2021-04/130421%20-%20Report%20-%20Putting%20health%20care%20back%20into%20aged%20care.pdf
[26] https://www.ama.com.au/articles/hospital-exit-block-symptom-sick-system

mental health beds in public hospitals to avoid the hospital logjam that particularly disadvantages patients with mental illness. Furthermore, future policy on improving mental health care must be guided by the mental health professional community.

Parties to adopt and deliver innovative models

In the AMA view, the Agreement does not support either innovation nor long term reform. There are a number of reasons why this is the case, but they can primarily be linked to the inadequacy of funding under the NHRA. It is difficult for individual hospitals and local hospital networks to engage in any long term reform when they are struggling financially with the current system of funding and barely managing their current day to day activities.

The AMA is aware of the $100 million dedicated to innovation under the Health Innovation Fund,[27] but we have yet to see full implementation of the programs that have shown to produce results. For example, a recent trial of Virtual ED in Victoria has shown a reduction in ED presentations (with 87 per cent of people referred to the virtual service avoiding a trip in an ambulance to the hospital ED)[28] which resulted in its expansion from a single trial site to the whole state. However, the funding for the expansion came from the Victorian Government only. Initiatives that help reduce pressure on hospitals and are still able to provide quality care should be funded and supported beyond the limited innovation funding. Future agreements could be improved by ensuring that initiatives and innovations that have been trialled and have been proven to be effective by independent evaluation should become part of the ongoing funding under NHRA.

Under the Addendum, the parties agreed to *achieving the interoperability of the health, primary care, aged care and disability systems*, recognising that *their interfaces and policy changes in one system can have an impact on other systems particularly in resource constrained environments*. However, we have seen little or no progress on achieving this interoperability over the last three years. The AMA argues that interoperability will be the key to achieving a health system that is fit for purpose, that is more efficient, more conducive to equitable access to care and one that drives the whole of person care.[29] We again note the announcements in the 2023-24 Budget with funding to drive this process.

This lack of progress is resulting in inefficiencies, with patients having to repeat their information multiple times and to multiple providers. Furthermore, in areas such as NDIS and aged care this lack of interoperability and thereby inadequate information sharing between providers results in doctors, particularly GPs having to spend increased amounts of time searching for their patient's information.

One particularly stark example is with aged care assessments through which older people are able to access aged care services. Currently, GPs can refer their patients for aged care assessments that, for patients with more complex health issues, are normally done by Aged Care Assessment Teams (ACATs) that are linked to or based in public hospitals. A majority of GPs are now able to make this referral from their clinical information systems, which is something the

[27] https://federalfinancialrelations.gov.au/taxonomy/term/166
[28] https://www.premier.vic.gov.au/virtual-service-expanding-relieve-hospital-pressures
[29] https://www.ama.com.au/articles/ama-position-statement-system-interoperability-healthcare-2022

AMA has worked hard for with the Department of Health and Aged Care. However, beyond the referral, GPs are completely kept out of the loop as to what happens with the assessment, whether it has taken place, what level of care their patient was assessed for, whether they ended up in hospital while waiting for an assessment (as often happens for patients with dementia for example) and whether as an outcome of the assessment their patient ended up in an aged care home.

This is wrong and inefficient both for the doctor and for the patient, and particularly so for the health system. It commonly results in patients or their carers having to make new appointments with the patient's GP to inform them of the outcome and further progress. In addition to this, ACATs have no access to the patient information available to their GP. Older patients tend to have long term GPs who often have an abundance of health information available to them, which they could share with the ACAT assessors, without the patient having to repeat their story. However, AMA members tell us that this does not happen. If the systems, primarily My Aged Care and My Health Record and the GPs clinical information systems were interoperable, this information would be readily available to ACATs and vice versa.

These are just some examples where progressing the health system interoperability would be beneficial for patients and doctors but would also contribute to lowering health system costs and improved health system planning.

The performance of the national bodies against their functions, roles and responsibilities

National bodies established under the NHRA and included in the Addendum include:

- Australian Commission on Safety and Quality in Health Care
- Independent Health and Aged Care Pricing Authority
- Administrator of the National Health Funding Pool
- Australian Institute of Health and Welfare

The AMA is generally satisfied with the roles and operation of national bodies, as defined under the NHRA. We find in our interactions with these bodies, particularly IHACPA and AIHW, that they are professional, knowledgeable and staffed with professionals who are experts in their respective fields.

One of the bodies where we would like to have more engagement is with the Australian Commission on Safety and Quality in Health Care (the Commission). The AMA believes that the Commission has an important role to play in establishing the standards for psycho-social safety of doctors working in the public hospital system, however we have found it extremely difficult to engage with the Commission on this, even though one of its four priority areas is "partnering with healthcare professionals".[30]

The AMA has been calling for an amendment to the National Safety and Quality Health Service Standards to measure the performance of public hospitals in their ability to ensure psychosocial

[30] https://www.safetyandquality.gov.au/about-us#priority-areas

safety of the medical workforce, acknowledging that the health and psychosocial safety of the workforce have direct impact on health outcomes of patients.

Arrangements for approval and funding of high-cost therapies offered in public hospitals, as outlined in the Addendum Schedule C (clauses C11 and C12) and Appendix B.

The AMA is fully supportive of the arrangements for approval and funding of high cost therapies as outlined in Schedule C and Appendix B, with Commonwealth contributing 50 per cent of the efficient price cost growth and exemption of these therapies from the funding cap.

Policy changes and adjustments to the mechanics of the national funding model

It is the AMA's position that the current funding model for our health system is not fit for purpose, as it is only focused on the number of procedures that hospitals provide. It does not adequately account for the fact that Australia's population is growing, ageing, and developing more complex health needs. Nor does it provide enough funding to keep people out of hospital through preventative and community care.

The AMA believes that following policy changes are needed to the mechanics of the national funding model:

- Improve performance. Reintroduce funding for performance improvement – for example, improvement in elective surgery and ED waiting times – to reverse the decline in public hospital performance.
- Expand capacity. Give public hospitals additional funding for extra beds (along with the staff) and support them to expand capacity to meet community demand, surge when required, improve treatment times, and put an end to ambulance ramping.
- Addressing demand for out-of-hospital alternatives. Fund alternatives for out-of-hospital care, so those whose needs can be better met in the community can be treated outside hospital. Programs that work with GPs to address avoidable admissions and readmissions should be prioritised.
- Increase funding and remove the funding cap. Increase the Commonwealth government's contribution to 50 per cent for activity. The AMA estimates that this represents an investment of $12.7 billion over four years between 2022-23 and 2025-26. Under this model, states and territories would be required to *reinvest the 5 per cent of 'freed-up' funds* to improve performance and capacity. Removing the artificial 6.5 per cent cap on funding growth that is shared between states and territories would represent an additional investment of $7.8 billion over four years between 2022-23 and 2025-26, according to AMA estimate, but we would have a funding model that would be able meet community health needs based on realities on the ground.

The Covid-19 pandemic including both the response to the pandemic and its ongoing implications for health services

In terms of response to future pandemics, increased capacity or the ability to rapidly increase hospital capacity will be crucial. The AMA believes that the future Centre for Disease Control (CDC) will have a crucial role to play in this. The AMA has a substantive policy on the role of CDC in health system planning and epidemic preparedness.[31]

Better integration at the Local Hospital Network (LHN)-Primary Health Network (PHN) level will also be crucial. We have seen an example of how better integration at the local level helped prevent the spread of Covid-19 in Victoria, with the establishment of the Victorian Aged Care Response Centre.[32] The *AMA Local Hospital Networks and GP-led Primary Care Services Designed to Reduce Potentially Preventable Hospitalisations position statement* details also provides examples of successful models of LHNs supporting GPs to proactively support patients to better manage their health and manage acute and chronic conditions in a primary care setting.[33]

With regards to the ongoing impact of Covid-19 on health services, the AMA has called for additional funding be allocated to support general practices with this increased demand, and ensure access to the required resources. Long Covid will have impacts on the entire health system. GPs will be on the front line and will need appropriate resourcing to manage the expected increase in patients. GPs cannot be expected to take on this additional burden with no additional resources as they have throughout the pandemic. It will also impact hospitals and aged care which require additional support.

However, the AMA believes that the single best way to protect Australia against Long Covid and future pandemics is to fix our health system. We need to ensure our hospitals are staffed and resourced to continue to manage waves of Covid-19 infections while managing patients presenting with more serious health issues due to delayed care and the growing backlog of elective surgeries.

The restructure of national governance arrangements as they apply to the operation and oversight of the Addendum

The AMA calls for a full restructure of the national governance arrangements as they apply to the oversight and operation of the Addendum. The AMA would support a return to the Performance and Accountability Framework that was agreed under the National Health Reform Agreement 2011.[34]

In the AMA's view, a key issue with the Addendum is around the accountabilities of the parties involved and what happens when parties fail to implement their end of the agreement. The Addendum is significantly lacking in that domain. For example, under the Addendum, the Commonwealth agreed to fund *the Medicare Benefits Schedule to ensure equitable and timely*

[31] https://www.ama.com.au/articles/ama-submission-department-health-and-aged-care-consultation-role-and-functions-0
[32] https://www.health.gov.au/our-work/victorian-aged-care-response-centre/about-the-victorian-aged-care-response-centre
[33] https://www.ama.com.au/position-statement/local-hospital-networks-and-gp-led-primary-care-services-designed-reduce
[34] https://federalfinancialrelations.gov.au/agreements/national-health-reform-agreement

access to affordable primary health care and specialist medical services. It is arguable that this has not been met by the Commonwealth over the last three years, but this is point is largely redundant as there are no mechanisms for States and Territories to hold the Commonwealth accountable for this.

At the same time, inappropriate Medicare Benefits Scheme (MBS) billing by public hospitals was recognised as "opaque" by the recent Independent Review of Medicare Integrity and Compliance that expressed concern that medical specialists in public hospitals have little or no visibility of what is billed in their name.[35] Yet the onus of responsibility for inappropriate billing falls on medical professionals, with States/hospitals expected to repay only 35 per cent of the debt.

The National Health Reform Agreement 2011 provides a template of the appropriate governance arrangements that the AMA believes would be reinstated either during this mid-term review of the Addendum or failing that, when a new Agreement is signed in 2025. The key features of the Performance and Accountability Framework from 2011 NHRA that the AMA would like to see reinstated include:

- Reinstating of national standards to drive improved performance across the health system in relation to emergency departments and elective surgery (previously 80 per cent of ED visits completed within 4 hours, and percentage of elective surgeries completed in specified time frames).
- A National Health Performance Authority that would implement regular assessments against the measures in the new Performance and Accountability Framework that would be binding for parties to implement, including by addressing poor performance and rewarding improved performance and achievement of targets in EDs and elective surgery.
- Transparent and public reporting on GP and primary health care services and outcomes at PHN level, including on local demography and health status, local services and health outcomes, as well as how primary health services interact with public hospitals.
- Transparent and public reporting report on public hospital service staffing, financial resources and performance outcomes and standards.

Reform in the primary care, aged care, disability and mental health systems as they relate to the operation of the Addendum

Under the Addendum, *the Commonwealth affirmed its commitment to funding the Medicare Benefits Schedule to ensure equitable and timely access to affordable primary health care and specialist medical services*. The AMA argues that this Commonwealth commitment has not been met. This is evident by the declining bulk-billing rates and growing wait times for patients to be able to see their GPs.

[35] https://www.health.gov.au/resources/publications/independent-review-of-medicare-integrity-and-compliance?language=en

The AMA argues that the Commonwealth investment in general practice has not matched the increase in the cost and demand for providing high-quality patient care. Notwithstanding new funding announced in the 2023-24 Budget to begin to address this, general practice has been underfunded with the Medicare Benefits Scheme (MBS) systematically devaluing GP services through inadequate indexation and a consultation item structure that fails to keep up with the growing complexity of care and the need for GPs to spend more time with their patients. With a population that is growing, ageing, and increasingly developing more complex health needs, general practice funding models need to change to meet the needs of the community.

The AMA has been calling for following reforms to the primary care:[36]

- Voluntary patient enrolment (VPE). The AMA firmly believes that, provided GPs are appropriately resourced, formalising the doctor patient relationship through VPE will strengthen the continuity and longitudinal nature of care provided. It will give general practices the ability to define their patient population, better understand and address patient needs and gaps in care, as well as measure care outcomes.
- Workforce Incentive Program (WIP) supports access to multidisciplinary care as part of a GP-led and coordinated team and provides incentives for GPs to work in rural areas.
- "Extended" Level B attendance item – linked to voluntary patient enrolment for consultations between 15 and 19 minutes. This will reward quality and value-based care and ensure that patients can spend the time they need with GPs.
- Improved access to GPs after-hours care – definition of after-hours for general practices to be aligned with the Approved Medical Deputising Service (AMDS)
- Wound care for targeted conditions. The Commonwealth should establish a funded wound care scheme to cover the costs of dressings provided in general practice for patients with hard-to-heal wounds.
- Aged care funding model. Review the incentives for GPs to attend RACFs and establish a new funding model which makes it sustainable for GPs to deliver increased and continuing services in RACFs, including via telehealth with RACF staff in circumstances where patients are unable to effectively communicate due to underlying health conditions.
- Continued Covid-19 support. The AMA recommends that additional funding be allocated to support general practices with this increased demand, and ensure access to the required resources.

As noted previously, the AMA was pleased to see that many of our recommendations were taken up in the 2023-24 Health Budget.

Activity Based Funding (ABF)

The AMA has been supportive of the ABF principles, however we believe that the constraints placed on it, including the 6.5 per cent annual growth cap, have had detrimental effect on the viability of ABF and sustainability of our public hospital system.

[36] https://www.ama.com.au/sites/default/files/2022-03/AMA%20Pre-Budget%20Submission%202022-23_Chapter%204_Primary%20healthcare.pdf

This 6.5 per cent cap, when combined with the recent impact of Covid-19 on the public hospital performance, acts as a barrier to providing services to all patients that require them, especially in the elective surgery aspect of it. With the growth in ED presentations that result in growing costs, the only area where states can limit their activity is in elective surgery.

According to our information, since the introduction of ABF, no State has ever reached or exceeded that 6.5 per cent cap. We argue that this is because hospitals tend to restrict their activity to avoid hitting the cap and losing Commonwealth funding. This is evidenced by the numbers of people added to the elective surgery wait lists every year and the number of elective surgeries performed, which results in the growing elective surgery backlog. While some of it has to do with lack of hospital bed capacity, this is also likely to be a deliberate design of the system.

Australia's shifting demographics are having a significant impact on the public hospital system. If the current trend of restraining public hospital elective surgery performance continues, it will result in more patients relying on EDs to access the care they need either for urgent surgery or for prolonged hospital stays. The AMA estimates that over the next 10 years the number of admissions from EDs will exceed all other hospital admissions, including for elective surgery.[37] Therefore, we believe that changes to the ABF are due and should be developed in consultation with all relevant stakeholders.

Improving performance of public hospitals

As outlined previously, in the AMA view the best way to achieve this would through rewarding rather than penalising our public hospitals. We support the reinstating the national standards to drive improved performance across the health system in relation to emergency departments and elective surgery, in accordance with the standards set by the original NHRA 2011.

Sustainability of the public hospital system

With a growing, ageing population increasingly living with chronic conditions, the number of Australians aged 85 and over expected to exceed one million by 2035,[38] and with the hospitals already operating at capacity, the AMA argues that Australia's public hospital system is at risk of becoming unsustainable.

As an illustration, in the year between 2019-20 and 2020-21, the number of hospital separations for 65 and older cohort increased by 260,337, with number of patient days increasing by 440,518.

This means that a 0.8 per cent increase in the population 65 and over in the same period resulted in 5.43 per cent increase in hospital separations and 2.87 per cent increase in patient days.[39]

[37] https://www.ama.com.au/public-hospitals-cycle-of-crisis
[38] Parliament of Australia 2008. Department of the Parliament Library – Publications. Population projections 2007 to 2057
https://www.aph.gov.au/About_Parliament/Parliamentary_Departments/Parliamentary_Library/pubs/BriefingBook43p/ageingpopulationfigure
[39] https://www.ama.com.au/clear-the-hospital-logjam/phrc-nphp

It is also important to note that this happened in the year where there were minimal Covid-19 related hospital separations: in 2020-21 reporting period there were total 4,718 separations with Covid-19 diagnosis according to AIHW, vast majority of which were in Victoria.

Unless public hospital capacity is increased and the funding system is reimagined through an improved NHRA, Australia's universal healthcare is at risk.

Suggestions how to improve future agreements

As outlined previously in more detail, the AMA suggestions for improvement of future agreements include:

- Improve performance.
- Expand capacity.
- Addressing demand for out-of-hospital alternatives.
- Increase funding and remove the 6.5 per cent annual growth cap. By increasing the Commonwealth government's contribution to 50 per cent for activity, states and territories would be required to reinvest the 5 per cent of 'freed-up' funds to improve performance and capacity.
- Reinstating of national standards to drive improved performance across the health system.
- Reintroduce the Performance and Accountability Framework as per the NHRA 2011 model.
- Consider the reestablishment of the National Health Performance Authority that would implement regular assessments against the standards.
- Reform to primary care (as outlined above).
- Changes to medical training and retention of workforce (as outlined below), including via establishing a statutory and independent health workforce planning and analysis agency that produces robust supply and demand workforce models.

Medical and health workforce

Under the Addendum, the States are responsible for system management of public hospitals including planning, funding (with the Commonwealth) and delivering teaching, training and research. The Commonwealth contributes 45 per cent to teaching and training functions funded by States undertaken in public hospitals or other organisations (such as universities and training providers). Teaching, training and research functions that are undertaken at the Local Hospital Network level are normally included in the Local Hospital Network Service Agreements, so that the funds for training can be then further transferred to hospitals in those LHNs that provide training.

Furthermore, under Schedule C of the Addendum, the Commonwealth and States agreed that "*reform to funding and payment mechanisms should be sustainable and holistic, and aim to improve the extent to which funding is … flexible with funding conditions giving providers the necessary discretion to provide care in the right place, at the right time, by the right workforce*." Addressing workforce matters is also part of the Addendum, including "*capability gaps for*

effective health services commissioning, and exploration of innovative workforce models and potential new roles to support better care coordination."

Under Schedule D, the parties agreed to develop and implement enhanced performance "*reporting across the whole care pathway including health system outcomes including: health outcomes, clinical outcomes, safety and quality, workforce outcomes and health system sustainability*."

Finally, under the Addendum, the Commonwealth is responsible for functions transferred from Health Workforce Australia and the National Health Performance Authority when these organisations ceased operations on 6 August 2014 and 30 June 2016 respectively.

The AMA is unaware of any progress on these commitment since the Addendum was signed.

The AMA argues that the Addendum is failing to achieve its core objectives, including equitable access to care for all. However, none of this is due to the workforce in our public hospitals who are doing the best they can within the system that faces significant funding and resourcing shortfalls. It is commonly the trainee medical workforce that has to bear the brunt of increased workload, working long, often unsafe hours, and being exposed to bullying, harassment and physical violence from patients and supervisors.[40] As a result, a growing number of medical trainees are considering leaving the profession.

Furthermore, there is an evident lack of commitment from the States and Territories to improve working conditions for young doctors and ensure psychosocial safety in the workplace. The AMA has been lobbying for legislative changes at the State/Territory level as well as for changes to the National Safety and Quality Health Service Standards to measure the performance of public hospitals in their ability to ensure psychosocial safety of the medical workforce, acknowledging that the health and psychosocial safety of the workforce have direct impact on health outcomes of patients.[41]

The AMA suggests following actions to be implemented under the Addendum and to be included into the upcoming NHRAs, that aim to improve the medical training and medical workforce outcomes:

- A commitment by the Health Ministers and the Commonwealth to progress on measuring and reporting on workforce outcomes, as outlined in the Addendum.
- A commitment by Health Ministers and the Commonwealth (through the Australian Commission for Safety and Quality in Healthcare, which is established and its mandate determined under the Addendum) to amend the National Safety and Quality Health Service Standards to measure the performance of public hospitals to provide a safe psychosocial work environment for healthcare workers, acknowledging that the health and psychosocial safety of the workforce have direct impact on health outcomes of patients.

[40] https://www.ama.com.au/e-dit/edit-issue-23-number-1/articles/release-2022-medical-training-survey-results
[41] https://www.ama.com.au/sites/default/files/2022-12/ama-psychosocial-safety-briefing-paper.pdf

- Progressing the commitment undertaken by Commonwealth for health service planning, as per the Addendum, for functions transferred from Health Workforce Australia and the National Health Performance Authority when these organisations ceased operations. The AMA is calling for this to be done by establishing a statutory and independent health workforce planning and analysis agency that produces robust supply and demand workforce models to guide medical student and training numbers in line with community need.
- In relation to capability gaps for effective health services commissioning, and exploration of innovative workforce models and potential new roles to support better care coordination, the AMA calls on the parties to the Addendum to implement a structured education and training framework in the post-graduate year 3 doctor in training space to support pre-training registrars, including accreditation of prevocational training positions.
- Funding from Commonwealth for implementation of the National Medical Workforce Strategy 2021-31, including for evaluation and governance.

However, none of these will be possible to achieve without changes to the funding model as outlined previously. The AMA believes that underfunding of public hospitals contributes to growing numbers of doctors leaving the public hospital medical workforce. Therefore, significant commitments to retention of medical workforce and improved training pathways will be needed from both levels of governments and parties to the Addendum. This includes increased funding for training in public hospitals (specifically that the funding dedicated to training supports access to protected teaching and training time[42]) and funding for appropriate staffing and rostering. Without these, we risk a growing number of doctors ultimately leaving the system and public hospitals continuing to fail to meet community needs.

The AMA is concerned that the current solutions being explored rely too heavily on increasing the number of medical graduates through Commonwealth supported places and international medical graduates, without looking at the whole of system change required to achieve a sustainable medical workforce.

The AMA welcomes the current Commonwealth pilots whereby States and Territories are working together to support general practice training through a Single Employer Model and we look forward to further expansion of the model, including through a commitment to extra funding to support this beyond the pilot stage.

19 MAY 2023

Contact

president@ama.com.au

[42] https://ama.com.au/sites/default/files/documents/Clinical_support_time_for_public_hospital_doctors_0.pdf