

**AMA**



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AUSTRALIAN MEDICAL ASSOCIATION  
NEW SOUTH WALES

**AMA (NSW)**  
**Ten Priorities for Health**  
**2011 State Election**

# SUMMARY OF PROPOSALS

- 1. Training our next generation of doctors in order to solve the medical workforce crisis**
  - Include education and training of medical staff as a key performance indicator (KPI) with a significant weighting in local health service chief executive officers' (CEO) performance agreements
  - Support the actions articulated in the joint statement from the AMA Medical Training Summit of September 2010, in particular a guarantee of internship positions and the number of training positions recommended by the proposed national analysis
  - Ensure that all intern doctors spend a minimum of 20 per cent of their time participating in training programs and establish a fully-funded Medical Education Unit within each local health service to support this objective
  - Ensure that 30% of all doctors' ordinary rostered time (Postgraduate Year 2 (PGY2) and above) is recognised as "clinical support time" for the purpose of undertaking roles and functions that, in addition to direct patient care, are a core part of the responsibilities of hospital doctors, including teaching, supervision, research, quality improvement, administration and professional development. For PGY2, this should include 10% of time being allocated to formal training programs
  - Commission an independent auditor to develop an audit plan and conduct annual audits on each local health service's education and training performance
  - Establish a Medical Workforce Taskforce to report to the Minister by the end of 2011 on the training of junior doctors and medical workforce shortages
  
- 2. Lifting the burden of centralised bureaucratic control**
  - Local health services, wherever practicable, to be based around natural communities
  - The governing bodies of local health services to be responsible for the delivery of health services and accountable to the NSW Government
  - The Chair of the governing body to be elected by the governing body
  - The governing body to have the right to appoint and terminate the local health service CEO
  - The removal of any obstacles to genuine local governance, e.g. "clusters"
  
- 3. Involving clinicians in decision-making**
  - Confirm in legislation that the agreements reached about the inclusion of peer-nominated doctors and other clinicians on the governing bodies and clinical councils will be continued (including Medical Staff Council representation)
  - Create formal mechanisms to enable peer-nominated clinician and Medical Staff Council input into the decision-making processes for pathology at clinical, operational and strategic levels
  - Remove duplication of the Clinical Excellence Commission (CEC), Agency for Clinical Innovation (ACI) and Clinical Education and Training Institute (CETI) functions within the NSW Department of Health
  - Include peer-nominated clinicians and Medical Staff Council representatives on the boards of CEC, ACI and CETI (with the ACI board to be 70% peer-nominated clinicians)

- 4. Developing a transparent health infrastructure priority list**
  - Undertake a State-wide audit of health infrastructure needs
  - Develop a public priority list for health infrastructure based on need through extensive consultation with clinical councils
  - Conduct a regular review of this priority list
  - Mandate the involvement of local health services and hospital clinical councils in the planning of local infrastructure projects (the CEO to report to the governing body on where the final plan differs from clinical council recommendations and why)
  - Publish a State annual report on the progress of health infrastructure projects
  
- 5. Improving access to health services**
  - Commit to achieving a target of average 85 per cent bed occupancy within five years
  - Guarantee protected funding for mental health by establishing separate mental health services
  - Give the restructured ACI responsibility for advising the Minister and the Director-General on the allocation of resources to elective surgery, in order to end the “boom/bust” cycle of elective surgery
  - Redefine elective surgery waiting time as “surgical access time” i.e. the time between referral to a surgeon and assessment by a surgeon, in addition to the time from assessment to surgery
  - Develop a key performance indicator (KPI) to measure how many patients are accommodated in inappropriate beds. This KPI should be developed by the Clinical Excellence Commission (CEC) in conjunction with the Agency for Clinical Innovation (ACI), reported on by the Bureau of Health Information (BHI) and included in local health service CEO performance agreements
  - Maintain an appropriate level of services
  
- 6. Improving rural health**
  - Develop a State Blueprint detailing bed numbers and hospital roles, core numbers of staff, medical, nursing and allied health at each facility, and the levels of expertise/training required
  - Freeze all rural hospital role and bed cutbacks until the development of a State Blueprint
  - Increase funding for air retrieval resources
  - In addition, AMA (NSW) endorses the recommendations of the Rural Doctors’ Association of NSW (RDA NSW) contained in the document Proposals for Rural Health for Parliamentary Term 2011-2015, November 2010
  
- 7. Integrating general practice and hospital services**
  - Require GP representation within the hospital management structure
  - Fund the establishment and maintenance of GP/Hospital Liaison Officer positions
  - Require the inclusion of GPs in clinical council meetings as members
  - Mandate, as a specific requirement of hospital accreditation, the provision of timely, useful, detailed and legible discharge information to GPs
  - Invest in information and communication technology that focuses on the opportunities provided by existing GP connectivity in relation to secure and efficient transfer of health information between hospitals and GPs, as appropriate

- Fund more prevocational rotations through general practice
- Provide opportunities, with simplified funding, for GP involvement in hospital clinics, in-patient care and discharge planning where appropriate
- Fund additional transitional beds
- Mandate cooperation between post discharge care by hospital nurses and other hospital outreach programs and GPs

## **8. Closing the gap - Indigenous health**

- Undertake a comprehensive audit of health service needs in Indigenous communities and for all Indigenous people in NSW
- Undertake an assessment of those health service needs against the existing services, to be conducted in collaboration with Indigenous people and existing health care providers
- Develop a specific NSW action plan for Indigenous health equality in partnership with Indigenous people to meet the 2018 targets, which includes:
  - strategies to address deficits in health infrastructure for Indigenous communities
  - strategies for the training of an Aboriginal and Torres Strait Islander health workforce
  - support for GPs and other existing health care providers to provide community appropriate, comprehensive primary medical care for Indigenous people at a level commensurate with need

## **9. Improving public health outcomes through targeted prevention strategies**

- Require all packaged food products to include simple and uniform 'front of pack' nutritional information, such as the 'traffic light' system
- Ban the use of artificial trans fats in processed foods
- Develop a new campaign to encourage life-long participation in community sport and healthy exercise habits - a 'Life. Be in it' campaign for the 21st century
- Eliminate smoking from public outdoor areas as a means of reducing the passive effects of smoking and discouraging smoking as a practice
- Reduce alcohol-fuelled violence by putting in place the measures identified in the Last Drinks Campaign

## **10. Improving the health status of people with developmental disabilities**

- Guarantee recurrent funding of existing and additional health services for people with developmental disabilities
- Designate funding for Specialist Developmental Disability Physical and Mental Health Services within each Local Health Network
- Enhance funding for training of front-line staff, including psychiatry and rehabilitation physician trainees, in developmental disability general and mental health
- Enhance funding for the Intellectual Disability Network of the Agency for Clinical Innovation
- Establish a Centre of Excellence in research, training and education

# **AMA (NSW)**

## **Ten Priorities for Health**

### **2011 State Election**

#### **PREAMBLE**

A mid-2010 survey of hospital doctors in NSW completed by more than 1200 respondents identified a number of priority issues, including:

- The burden of layers of bureaucracy
- Clinician engagement in decision-making
- Medical workforce shortages
- Health infrastructure (i.e. renovation or replacement of)
- The shortage of beds (access to health services)

The introduction of local health services has the potential to address the first two points, but only if there is the political will to allow genuine local governance and greater involvement of clinicians in decision-making. AMA (NSW) acknowledges that positive steps have been taken, including the appointment of peer-nominated clinicians to local health service governing bodies and clinical councils. However, more needs to be done to embed the principles of local governance and clinician engagement in the culture of NSW Health.

This document also outlines our proposals in relation to the other priority issues identified in the survey responses – medical workforce shortages, infrastructure, and access to services – as well as issues associated with rural health, general practice, indigenous health, primary prevention strategies, and the health status of people with developmental disabilities.

# 1. TRAINING OUR NEXT GENERATION OF DOCTORS IN ORDER TO SOLVE THE MEDICAL WORKFORCE CRISIS

AMA (NSW) calls on government to:

- Include education and training of medical staff as a key performance indicator (KPI) with a significant weighting in local health service chief executive officers' (CEO) performance agreements
- Support the actions articulated in the joint statement from the AMA Medical Training Summit of September 2010, in particular a guarantee of internship positions and the number of training positions recommended by the proposed national analysis
- Ensure that all intern doctors spend a minimum of 20 per cent of their time participating in training programs and establish a fully-funded Medical Education Unit within each local health service to support this objective
- Ensure that 30% of all doctors' ordinary rostered time (Postgraduate Year 2 (PGY2) and above) is recognised as "clinical support time" for the purpose of undertaking roles and functions that, in addition to direct patient care, are a core part of the responsibilities of hospital doctors, including teaching, supervision, research, quality improvement, administration and professional development. For PGY2, this should include 10% of time being allocated to formal training programs
- Commission an independent auditor to develop an audit plan and conduct annual audits on each local health service's education and training performance
- Establish a Medical Workforce Taskforce to report to the Minister by the end of 2011 on the training of junior doctors and medical workforce shortages

## **Workforce shortages**

New South Wales (and Australia generally) is currently experiencing a severe medical workforce crisis, largely as a result of poor policy decisions and inadequate workforce planning. We are highly reliant on the contribution made by temporary resident international medical graduates, especially in rural NSW and parts of the public hospital system.

## **Intern places and doctor training**

Since 2004, the Commonwealth Government has responded to medical workforce shortages by taking several steps to significantly increase the number of medical school places across the country. Graduations from NSW medical schools are projected to almost double over the next few years, from 577 in 2009 to 1,096 in 2014 (Medical Training Review Panel, 2010, pp. 13-14). AMA (NSW) considers that NSW needs all of these graduates to become fully-trained doctors if we are to resolve the existing severe medical workforce shortages and ensure that there are sufficient doctors to care safely for our growing and ageing population. To the best of our knowledge, no comprehensive plan has been developed to ensure that the increased numbers of medical school graduates are provided with the education and training necessary to solve the existing medical workforce shortages.

AMA (NSW) has consulted widely to develop the proposals set out above that, if implemented, will significantly improve patient care by increasing the number of fully-trained doctors and by improving the education and training of junior doctors. The proposals will also enhance the competitiveness of the NSW health system as an employer of choice, ensuring we employ, train and retain the best and brightest clinicians in Australia. More details are contained in a separate document entitled *AMA (NSW) Doctor-in-Training 2011 State Election Priorities*.

### **Medical Workforce Taskforce**

In order to urgently address the issue of training the next generation of doctors and solving workforce shortages, we propose that a taskforce, independent of NSW Health, be urgently established and resourced to inquire into and report directly to the Minister for Health on these matters by the end of 2011. We envisage that the Taskforce would consist of six to ten doctors, including doctors involved in CETI and the ACI, and be chaired by an eminent senior specialist. Subject to the nature of the recommendations of the report to the Minister, the Taskforce may need to then take on the responsibility of implementing the recommendations.

## **2. LIFTING THE BURDEN OF CENTRALISED BUREAUCRATIC CONTROL**

AMA (NSW) calls for the following key principles to be implemented (to the extent that this has not already been done) by government to ensure genuine local governance and a clear shift from centralised bureaucratic control:

- Local health services, wherever practicable, to be based around natural communities
- The governing bodies of local health services to be responsible for the delivery of health services and accountable to the NSW Government
- The Chair of the governing body to be elected by the governing body
- The governing body to have the right to appoint and terminate the local health service CEO
- The removal of any obstacles to genuine local governance, e.g. "clusters"

### **Local governance**

The trend in NSW Health over the last ten to fifteen years has been for decision-making to be centralised so that spending can be tightly controlled. While this is perhaps understandable as a response to the ever-increasing demand for health services, it has in fact had the opposite effect to that which was intended. By taking decision-making away from the local level, the people who are providing the services on a day-to-day basis (both management and clinicians) have had very little influence over the allocation of resources. The result has been that the people who understand how scarce resources can best be rationed to maximise the benefit for patients have been shut out of the decision-making. Instead, a remote bureaucracy has adopted strategies that have sometimes been detrimental to patient care, e.g. a blanket refusal to fill vacancies even in relation to front-line clinical positions. A much better strategy would have been to have the decisions made by local management working closely with local clinicians (and a governing body with local community input) to determine where savings could be made.

Local health services have the potential to address some of these concerns. To date, AMA (NSW) has chosen to focus on the governance of local health services rather than where the boundary lines fall. However, we do believe it is important that local health services are based around natural communities so that there is a sense of community ownership and involvement in the local health service. In practical terms, this will require further work on local health services that cross State borders and may also require further consideration of some of the local health services that have been announced where more than one natural community is included.

In terms of governance, it is fundamentally important that there is a clear shift from the centrally-controlled area health services to locally-governed local health services. We believe that this will only be achieved if:

- the governing body is clearly accountable for the delivery of services (i.e. has all the obligations and responsibilities of a board of directors)
- the Chair of the governing body is elected by the governing body rather than centrally appointed; and
- the governing body is clearly responsible for appointing (and terminating, if necessary) the CEO of the local health service. On this last point, it is obvious that the CEO will ultimately be directed by the body that has the right to hire and fire, irrespective of what any organisational chart may say.

### **Removal of clusters**

In accordance with these principles, we do not support the creation of the three “clusters” that have been announced. Even if it is not the intention, we have little doubt that the clusters will evolve into an extra layer of bureaucracy above the local health services and thereby become an obstacle to genuine local governance.

We believe that corporate and other services to be administered by the proposed clusters could instead be provided either at departmental or local health service level, or by one of the “four pillars”. See for example the RDA NSW proposal, outlined below in section 6 of this paper, regarding the establishment of a centralised body to coordinate provision of services to rural hospitals.

### 3. INVOLVING CLINICIANS IN DECISION-MAKING

AMA (NSW) calls on government to:

- Confirm in legislation that the agreements reached about the inclusion of peer-nominated doctors and other clinicians on the governing bodies and clinical councils will be continued (including Medical Staff Council representation)
- Create formal mechanisms to enable peer-nominated clinician and Medical Staff Council input into the decision-making processes for pathology at clinical, operational and strategic levels
- Remove duplication of the Clinical Excellence Commission (CEC), Agency for Clinical Innovation (ACI) and Clinical Education and Training Institute (CETI) functions within the NSW Department of Health (Department of Health)
- Include peer-nominated clinicians and Medical Staff Council representatives on the boards of CEC, ACI and CETI (with the ACI board to be 70% peer-nominated clinicians)

There can be no question that one of the fundamental aims of the health reform process is to move away from the centralised bureaucratic control of the health system to local control and accountability with a much greater degree of clinician and community involvement. This theme runs throughout the COAG Agreement and the other health reform documentation.

One of the main reasons for this theme of local governance with clinician and community involvement is the concern about the lack of clinician engagement in the running of public hospitals. This concern runs throughout the numerous health reform reports at both State and Federal level (including the Garling Report) and the political discussion that has formed part of the health reform process to date.

The major principle that needs to be addressed - and it is a principle that is central to the re-engagement of clinicians and therefore the success of the reform process - is the principle that at least some of the clinicians who are involved in the governing bodies and/or clinical councils must be nominated or selected by their peers.

We acknowledge the positive steps that have been taken in reaching agreement around the processes for appointment of peer-nominated clinicians to governing bodies and clinical councils, and confirmation of the role of Medical Staff Councils in representing the views of local health service medical staff at both governing body and clinical council level.

#### **Pathology governance and clinician engagement**

Under the current NSW local health service structures, these principles do not apply to pathology services to the same degree as other health services because management of pathology services is part of the three “clusters” that have been put in place. It is indisputable that pathology is a clinical discipline and there is no doubt that similar governance principles should therefore apply. If the management of pathology continues to be separate from local health services then there needs to be a formal framework to ensure clinical input at clinical, operational and strategic levels. Consistent with the principles identified above, this framework will need to include peer-nominated clinicians and Medical Staff Council representation.

## State-level clinician engagement – the “four pillars”

There is also still some work to be done on ensuring that peer-nominated clinicians are engaged in decision-making at the State level, in particular, in relation to the so-called “four pillars” recommended by Commissioner Garling.

The NSW Government accepted the recommendations of the Garling Report to establish (or continue) “four pillars” – the Clinical Excellence Commission (CEC) to improve quality and safety; the Clinical Education and Training Institute (CETI) to lead and support clinical education and training; the Agency for Clinical Innovation (ACI) to engage clinicians in designing innovative ways to improve patient care; and the Bureau for Health Information (BHI) to provide independent information on the performance of the NSW health system.

With the exception of the BHI, which appears to be operating as envisaged by Commissioner Garling, there is considerable scope to improve the independence of these organisations and their engagement with clinicians. The ACI, in particular, was recommended by Mr Garling as one of the forums through which clinicians could be re-engaged at the strategic level of NSW Health. Unfortunately, there is strong feedback from our membership that the ACI is not carrying out the role envisaged by the Garling Report.

At least part of the problem is that the ACI, the CEC and CETI have not been given sufficient independence from the Department of Health. Moreover, many of the functions of these three bodies are duplicated within the Department. This is not only a waste of resources but also means that proposals put forward by these bodies tend to be overridden by the duplicate sections of the Department. There are anecdotal reports from AMA (NSW) members that the ACI is perceived as ineffective for this reason.

We propose that these problems be addressed in two ways, by:

- removing the duplication within the Department of Health, transferring the necessary resources to the “pillars” and clarifying that the “pillars” have sole responsibility for providing advice to the Director-General and the Minister for their respective roles and functions; and
- engaging peer-nominated clinicians and Medical Staff Council representatives in the governance of the ACI, the CEC and CETI.

The principle of including peer-nominated clinicians should be applied in a stronger way to the ACI. Given that the intention of the Garling Report was that the ACI should be a means of engaging clinicians at the State level, there should be a separate governing body for the ACI (i.e. not shared with the CEC) that consists to a large extent of peer-nominated clinicians. While we acknowledge the obligation of the Minister to appoint the right mix of expertise and experience, we believe that if the ACI is to be successful in engaging clinicians it needs to be governed by peer-nominated clinicians to a much greater degree than local health services or the other “pillars”. For this reason, we propose that a new ACI Board be appointed, consisting of 70% peer-nominated clinicians, and that the newly-appointed Board be empowered to select the Chair and ACI CEO (we acknowledge that a transition period may be necessary). As with the governing bodies of local health services, Medical Staff Council representatives should be invited to attend as observers.

## 4. DEVELOPING A TRANSPARENT HEALTH INFRASTRUCTURE PRIORITY LIST

AMA (NSW) calls on government to:

- Undertake a State-wide audit of health infrastructure needs
- Develop a public priority list for health infrastructure based on need through extensive consultation with clinical councils
- Conduct a regular review of this priority list
- Mandate the involvement of local health services and hospital clinical councils in the planning of local infrastructure projects (the CEO to report to the governing body on where the final plan differs from clinical council recommendations and why)
- Publish a State annual report on the progress of health infrastructure projects

The current system of health infrastructure funding in NSW is essentially a closed book. Doctors and the public can view how much infrastructure funding a particular hospital received from the government, but they cannot see how this decision was arrived at. This has led to baffling results like the continued underfunding of Wagga Wagga Base Hospital, despite its desperate need for infrastructure upgrades.

AMA (NSW) recommends a transparent health infrastructure priority list based on health need rather than political considerations. This should be a list of health infrastructure projects in order of priority, so that hospitals and communities know where they stand. A fully transparent health infrastructure priority list should be backed-up with information about the health infrastructure budget over the last few years, comparison with other states, statistics on whether funding promised has actually been spent and reports from doctors on inadequate facilities.

Recent infrastructure debacles in NSW hospitals have proved the quantum of funding is not the only concern with the existing system. For example, operating theatres have been fully built at Bathurst Base Hospital and Royal North Shore Hospital, only for clinicians to find they were far too small to function properly. Involving clinicians in producing a transparent health infrastructure priority list will avoid such waste.

## 5. IMPROVING ACCESS TO HEALTH SERVICES

AMA (NSW) calls on government to:

- Commit to achieving a target of average 85 per cent bed occupancy within five years
- Guarantee protected funding for mental health by establishing separate mental health services
- Give the restructured ACI responsibility for advising the Minister and the Director-General on the allocation of resources to elective surgery, in order to end the “boom/bust” cycle of elective surgery
- Redefine elective surgery waiting time as “surgical access time” i.e. the time between referral to a surgeon and assessment by a surgeon, in addition to the time from assessment to surgery
- Develop a key performance indicator (KPI) to measure how many patients are accommodated in inappropriate beds. This KPI should be developed by the Clinical Excellence Commission (CEC) in conjunction with the Agency for Clinical Innovation (ACI), reported on by the Bureau of Health Information (BHI) and included in local health service CEO performance agreements
- Maintain an appropriate level of services

### Bed occupancy rates

The occupancy rate of our public hospitals is a major concern. The only way to fix our emergency departments being overloaded with patients who need an inpatient bed, prevent the disgraceful situation of acutely-ill psychiatric patients sleeping on mattresses in corridors, stop the practice of patients being accommodated in inappropriate wards, and reduce the cancellation of elective surgery, is to reduce the average occupancy level to 85 per cent. “Four hour rules” in emergency departments and 95 per cent targets for elective surgery will be meaningless and unachievable unless the occupancy rate issue is addressed.

Keegan [MJA 2010; 193 (5): 291 – 293] and others have argued convincingly that high rates of bed occupancy increase the risk of hospital-associated infections and have a negative impact on staff health. AMA (NSW) believes that there needs to be a commitment to a target of an average occupancy rate of 85 per cent, acknowledging that this will not be achieved overnight. Given the fluctuation in the occupancy of hospital beds over 24 hours, we note that it is important to define occupancy rate as the number of beds occupied at 5 pm.

We also believe that the reporting of total bed occupancy rates can be misleading, and open to manipulation. For example, a hospital with a paediatric ward with beds only available to children may have a total bed occupancy that appears satisfactory, because few of the paediatric beds are being used at a given time, but the adult ward beds are all full, and the Emergency Department is filled with admitted adult patients awaiting placement in an adult ward. The bed occupancy is therefore unacceptably high, but is not reported as such. The average occupancy rate should therefore be calculated by ward.

### Mental health services

We believe that fundamental reform of mental health services is overdue and that mental health services must be guaranteed protected funding. We believe that this is only likely to be achieved by establishing mental health services as entities independent of the general local

health services. Other measures in policy and practice have consistently failed over decades to guarantee that money intended by Government for mental health is spent on mental health. Even when much-needed additional funding has been provided, attempts to require that funding to be “quarantined” have met with mixed success, with hospitals often shifting funding to other clinical services that are deemed by management to have a higher priority.

Therefore we propose that a minimum of six mental health local health services be created, in addition to the Forensic Mental Health local health service. This will ensure that funds allocated to mental health are spent on mental health. The actual number of mental health local health services should be determined following further consultation.

Mental health local health services (including Forensic Mental Health) should be, like the other local health services, governed with significant input from peer-nominated leading clinicians at both the governing council and clinical council levels.

Community mental health services are the foundation on which care must be based. NSW clearly lags behind other states in this area. We therefore propose that mental health local health services would have a particular responsibility to develop community mental health services in order to lighten the load on hospital services, including emergency departments.

### **Elective surgery**

Perhaps more than any other measure of public hospital performance, elective surgery waiting time has become a political football. One of the results is the creation of a “boom/bust” cycle, with resources being poured into the reduction of waiting lists in the twelve months prior to an election and then withdrawn in between election years. It goes without saying that adequate resources should be provided based on patient needs, not electoral cycles.

In order to overcome this problem (consistent with our proposals above in section 3, Involving clinicians in decision-making), we propose that the ACI (with the governance structure proposed in section 3) be given responsibility for advising the Minister and the Director-General on the allocation of resources to elective surgery.

We also believe that the problem of the “waiting list to be on the waiting list” needs to be addressed, i.e. there is currently no measurement of the time from referral to a surgeon to the time that the surgeon assesses that a patient requires surgery. In particular, this masks the problem of access to surgical outpatient clinics. It is common for patients to wait months for a clinic appointment. Unless this waiting time is measured, the problem will remain hidden and will not be addressed. Consequently, we propose that “surgical access time” i.e. the time from referral to a surgeon until surgery, should be measured and used as the key measure of waiting time for elective surgery. “Surgical access time” would therefore replace the current measure of elective surgery waiting time, being the time from surgeon assessment to surgery.

### **Appropriate beds**

One of the hidden problems in our public hospitals is the accommodation of patients in inappropriate beds. The high bed occupancy levels mean that patients may be accommodated in beds that contravene their right to privacy (e.g. mixed-gender aged care wards) or beds where the level of clinical care is less than optimal for their particular illness (e.g. a bed in a specialist

ward not related to their illness). AMA (NSW) believes that patients are much more likely to be administered timely, appropriate care if they are located in a ward with expertise in dealing with their specific problem.

There is currently no measure of how often patients are allocated to inappropriate beds, and consequently the issue does not receive adequate attention. Therefore, we propose that a key performance indicator (KPI) be developed to measure how many patients are accommodated in inappropriate beds. This KPI should be developed by the Clinical Excellence Commission (CEC) in conjunction with the Agency for Clinical Innovation (ACI), reported on by the Bureau of Health Information (BHI) and included in local health service CEO performance agreements.

### **Maintain an appropriate level of services**

We are concerned to ensure that NSW does not lag behind other States in the scope of its publicly funded health services. Over the past few years, there have been a number of services which have either been quietly removed from NSW hospitals or which are being successfully provided elsewhere in Australia but not available in NSW. Two examples of such services are mother and baby units and deep brain stimulation (DBS) for patients with movement disorders. By providing these two examples we do not in any way intend to suggest that they are the only two services that need funding.

#### *Mother and baby units*

Mother and baby units are psychiatric facilities designed to allow women with a psychiatric illness to be treated in hospital along with their infants. The purpose of this is to ensure that there is no break in the mother/infant bond and to allow the mother to be able to develop her skills in looking after her newborn baby.

The perinatal period is one of the highest times for onset of psychotic disorders in women, with 1-2 women per 1000 deliveries having a new onset psychosis. Women with schizophrenia and bipolar disorder are also at high risk of relapse postpartum. Mother and baby units can play a very important role in the treatment of these women.

NSW is the only state that does not have a publically-funded mother and baby unit. NSW Health does not permit babies to be admitted with their mothers if the mother requires admission to hospital for psychiatric treatment. The consequence of this is that in many instances (where there is no family support) the NSW Department of Community Services will assume care of the baby. This is a devastating situation for the mother and potentially harmful for the infant. It also prevents the mothers from being able to develop the skills in looking after their baby under close supervision.

In brief, a mother and baby unit should be:

- designated specifically for mothers and infants (capacity for specialist in-patient care of late-term pregnant mothers should also be considered)
- staffed by specialist peri-natal mental health staff
- staffed to provide appropriate care for infants (i.e. ready access to Paediatric Consultation and mothercraft nursing staff)
- provide a full range of therapeutic mental health and general medical services
- closely integrated with community based mental health services

We propose that two mother and baby units be established as a matter of urgency. Further discussion with the profession is required to identify the best location for these units.

### *Deep brain stimulation*

DBS is a proven surgically based treatment for movement disorders such as Parkinson's disease, dystonia and tremor, and is used when there is unsatisfactory symptom control despite the optimal use of medications. Parkinson's disease, which affects approximately 1% of people over the age of 50 years, is the most prevalent movement disorder requiring DBS therapy. DBS has been the standard of care for mid-late Parkinson's disease in many countries for the past 10 to 15 years.

Currently in NSW, DBS is only provided in private hospitals to private patients. The therapy is unavailable in the public sector and to public patients due to the cost of the DBS hardware. There currently exists a major inequality of access to what is for many patients the only remaining effective therapeutic strategy for control of disabling motor symptoms.

The clinical expertise and ability to perform DBS currently exists at three NSW public hospitals, Royal North Shore, St Vincent's and Westmead Hospitals. AMA (NSW) calls on the government to fund Movement Disorder Surgery Units in these three hospitals, resourced to provide DBS and other surgical therapies for patients with movement disorders.

## **6. IMPROVING RURAL HEALTH**

AMA (NSW) calls on government to:

- Develop a State Blueprint detailing bed numbers and hospital roles, core numbers of staff, medical, nursing and allied health at each facility, and the levels of expertise/training required
- Freeze all rural hospital role and bed cutbacks until the development of a State Blueprint
- Increase funding for air retrieval resources

In addition, AMA (NSW) endorses the recommendations of the Rural Doctors' Association of NSW (RDA NSW) contained in the document "Proposals for Rural Health for Parliamentary Term 2011-2015", November 2010

Access to health services is a key determinant of good health outcomes. It is therefore imperative that all NSW residents have access to the most comprehensive health services possible, regardless of where they live. AMA (NSW) supports the view of RDA NSW that rural patients are entitled to receive an equivalent level of health care to patients in metropolitan centres. Achieving this end requires reforms unique to the rural setting.

AMA (NSW) considers that a State Blueprint must be developed through thorough consultation with rural communities and doctors, detailing bed numbers and hospital roles, core numbers of staff, medical, nursing and allied health professionals, and the levels of expertise/training required at each rural health facility. The Blueprint should also address the resources required to ensure timely access to tertiary centres of excellence for rural patients and fully-funded

access for ongoing training of rural medical staff at tertiary centres. Until a Blueprint is determined, there should be an immediate freeze on all rural hospital role and bed cutbacks.

In addition, air retrieval resources must be boosted immediately to enable timely evacuation of rural patients requiring urgent tertiary care.

AMA (NSW) endorses the document *Proposals for Rural Health for Parliamentary Term 2011-2015*, RDA NSW, November 2010, and the recommendations for rural health reform contained therein, which are in summary:

- A centralised body to coordinate service provision at small rural hospitals
- Local health service CEOs to have performance judged on rural service provision
- Replace current NSW GP procedural training program with a new Rural Generalist Training Program
- Provision of a dedicated five year rural pathway for GP training in NSW
- Expand general physician and general surgeon training in NSW
- Increase Rural Skills Incentives Grants
- Incentives for rural nurses
- Backing for federal initiatives to support rural medicine

## **7. INTEGRATING GENERAL PRACTICE AND HOSPITAL SERVICES**

AMA (NSW) calls on government to:

- Require GP representation within the hospital management structure
- Fund the establishment and maintenance of GP/Hospital Liaison Officer positions
- Require the inclusion of GPs in hospital clinical council meetings as members
- Mandate, as a specific requirement of hospital accreditation, the provision of timely, useful, detailed and legible discharge information to GPs
- Invest in information and communication technology that focuses on the opportunities provided by existing GP connectivity in relation to secure and efficient transfer of health information between hospitals and GPs, as appropriate
- Fund more prevocational rotations through general practice
- Provide opportunities, with simplified funding, for GP involvement in hospital clinics, in-patient care and discharge planning where appropriate
- Fund additional transitional beds
- Mandate cooperation between post discharge care by hospital nurses and other hospital outreach programs and GPs

Removing the barriers between GPs and hospitals can lead to improved patient health outcomes through better clinical management, improved continuity of care and reduced readmission. The need for GP-hospital integration has become more pressing as early discharge strategies in the hospital sector have increasingly shifted acute care and its associated complexity to general practice. In addition, the care of patients with chronic and complex conditions is also increasingly being managed in the community setting by GPs, and may include only occasional hospital admissions, furthering the need for GP-hospital integration.

AMA (NSW) proposes that GP-hospital integration be strengthened by increased GP presence in public hospitals, and improved communication and information sharing between hospitals

and GPs. In particular, there needs to be GP representation within the hospital management structure and inclusion of GPs as voting members of hospital clinical councils. In addition, each hospital should have a GP/Hospital Liaison Officer who can promote initiatives aimed at further integration between hospitals and GPs and informing hospital doctors on the role of their GP counterparts, and vice versa. Specific investment should also be put towards information and communication technology, more prevocational rotations through general practice, GP involvement in hospital clinics and transitional beds (aftercare beds for step down).

Critical to patient continuity of care is the provision of accurate and comprehensive discharge summaries. They must be typed where possible and include a full medication list, relevant tests that were carried out, and any follow up planned. As a condition of patient discharge it must be compulsory for the hospital to complete and transfer a discharge summary to the patient's GP. Discharge summaries must be accompanied by detailed information relevant to the patient's post admission care that will contribute to the GP's ability to provide the care needed. AMA (NSW) considers that the provision of timely, useful, detailed and legible discharge information to GPs should be a specific requirement of hospital accreditation.

## **8. CLOSING THE GAP - INDIGENOUS HEALTH**

AMA (NSW) calls on government to:

- Undertake a comprehensive audit of health service needs in Indigenous communities and for all Indigenous people in NSW
- Undertake an assessment of those health service needs against the existing services, to be conducted in collaboration with Indigenous people and existing health care providers
- Develop a specific NSW action plan for Indigenous health equality in partnership with Indigenous people to meet the 2018 targets, which includes:
  - o strategies to address deficits in health infrastructure for Indigenous communities
  - o strategies for the training of an Aboriginal and Torres Strait Islander health workforce
  - o support for GPs and other existing health care providers to provide community appropriate, comprehensive primary medical care for Indigenous people at a level commensurate with need

The gap in life expectancy between Indigenous and non-Indigenous Australians remains one of the most significant problems confronting Australia today. Indigenous health must be a primary focus of the next state government if the gap in life expectancy is to be closed within a generation. To achieve this, the NSW government needs to put in place concrete measures in accordance with the aims of the *Close the Gap Steering Committee for Indigenous Health Equality Report* (February 2010) to bridge the gaps in health standards by 2018.

A comprehensive assessment of current health services and needs is required in order to ascertain deficiencies and inequities in provision of services. Indigenous people must be fully engaged in this assessment and be partners in the design of appropriate health care solutions. These deficiencies and inequities must be addressed through ensuring adequate health infrastructure in communities, integration of services to ensure appropriate continuity of care, and the delivery of comprehensive primary health care services. Cultural awareness campaigns and training should also be available to primary health care services to improve the ability of those services to provide appropriate care.

In order to meet the 2018 target, there needs to be a comprehensive plan of action for the training and development of the health workforce required to improve Indigenous health, which should include:

- grants to allow Aboriginal Medical Services in NSW to offer mentoring and training to Indigenous and non-Indigenous medical students and vocational trainees; and,
- funded education, recruitment and retention strategies for clinically and culturally competent primary care practitioners and specialists.

## **9. IMPROVING PUBLIC HEALTH OUTCOMES THROUGH TARGETED PREVENTION STRATEGIES**

AMA (NSW) calls on government to:

- Require all packaged food products to include simple and uniform 'front of pack' nutritional information, such as the 'traffic light' system
- Ban the use of artificial trans fats in processed foods
- Develop a new campaign to encourage life-long participation in community sport and healthy exercise habits - a 'Life. Be in it' campaign for the 21st century
- Eliminate smoking from public outdoor areas as a means of reducing the passive effects of smoking and discouraging smoking as a practice
- Reduce alcohol-fuelled violence by putting in place the strategies identified in the Last Drinks Campaign

Our changing lifestyles are leading to new community health challenges. AMA (NSW) has identified a number of crucial public health issues which require urgent Government attention and leadership.

### **Obesity**

Tackling obesity is fundamentally about encouraging healthy active lifestyles - through better eating and participation in regular exercise. There are a number of ways that the government can assist and influence individuals to make healthy choices.

One of these ways is to improve and simplify the nutritional information displayed on food products to make it easier for consumers to make healthy shopping choices. AMA (NSW) looks forward to the report of the Australia and New Zealand Food Regulation Ministerial Council in relation to food labelling.

AMA (NSW) recommends the introduction of a simple and uniform 'front of pack' nutritional labeling system such as the 'traffic light' system, which indicates overall nutritional content and the level of saturated fat, total fat, sugar and sodium in food using red, amber and green colour codes, and thereby provides consumers with a quick reference guide to determine the nutritional value of the product.

Another way that the government can impact obesity is through banning the use of artificial trans fatty acids. AMA (NSW) proposes a phasing out with mandatory labeling, and eventual ban of these harmful additives that increase the risk of coronary artery disease.

AMA (NSW) also proposes that the government develop a major public education campaign with simple, clear and consistent messaging to encourage life-long participation in community sport and healthy exercise habits in the style of the 'Life. Be in it' campaign.

### **Smoking in outdoor areas**

NSW is a leader in funding for public education on the harmful effects of smoking and has good tobacco control legislation. However, the NSW Government's commitment to protecting non-smokers is undermined by a weak definition of enclosed public places and minimal action on outdoor settings. AMA (NSW) calls on the government to ban smoking in all public outdoor areas as a means of reducing the passive effects of smoking and discouraging smoking as a practice.

### **Alcohol-fuelled violence**

The epidemic of alcohol-fuelled violence in NSW is a major concern to health professionals. Not only are emergency doctors seeing more cases of alcohol-related illness and injury, especially on weekends, many patients who are affected by alcohol can become violent and dangerous. This is not just a community health issue, it is also an occupational health and safety issue for emergency service workers who have to clean up the mess every weekend.

AMA (NSW) supports the Last Drinks campaign ([www.keepourcops.org.au](http://www.keepourcops.org.au)) to tackle alcohol-related violence through stronger restrictions on the late night trading activities of licensed venues. While alcohol abuse is a complex issue requiring a comprehensive response, AMA (NSW) believes that the measures proposed will have a significant impact on the number of alcohol-related assaults and injuries in NSW.

## **10. IMPROVING THE HEALTH STATUS OF PEOPLE WITH DEVELOPMENTAL DISABILITIES**

AMA (NSW) calls on government to:

- Guarantee recurrent funding of existing and additional health services for people with developmental disabilities
- Designate funding for Specialist Developmental Disability Physical and Mental Health Services within each Local Health Network
- Enhance funding for training of front-line staff, including psychiatry and rehabilitation physician trainees, in developmental disability general and mental health
- Enhance funding for the Intellectual Disability Network of the Agency for Clinical Innovation
- Establish a Centre of Excellence in research, training and education

Developmental disability is a term that refers to a permanent cognitive and/or physical impairment that usually occurs in the early years of life but can occur any time before the age of 18 years.

It is imperative that the poor health status experienced by people with developmental disabilities compared with the general population be addressed. This will require ongoing funding of existing and additional services in this area as well as a more proactive and comprehensive approach to general health and mental health policy for people with physical and/or intellectual developmental disabilities.

Currently, there are very few specific health services for people with developmental disabilities. Some of these experience limited or non-recurrent funding which inhibits service development and delivery. The NSW government should ensure recurrent funding of existing health services and should fund additional multidisciplinary health services across the State.

Recent calls for pilots for enhanced services for people with developmental disabilities resulted in three eligible bids. One of these bids was allocated \$500,000 to extend services in an underserved area. AMA (NSW) calls on the government to fund the other two eligible bids, each seeking in the order of \$500,000 in funding.

Mental disorders are at least 2.5 times more common in people with intellectual disability than in the general population. Many people with intellectual disability, especially those with complex developmental disabilities, experience atypical profiles and presentation of mental disorders and thus require a high level of psychiatric expertise. However, apart from isolated pockets of expertise, the specific mental health needs of people with developmental disabilities are poorly met. The strong link between physical and mental health in people with severe and multiple disabilities highlights the importance of specialist Mental Health care for people with developmental disabilities.

Specific funding should therefore be designated for Specialist Developmental Disability Mental Health Services which:

- Form a core component of Specialist Multidisciplinary Disability Teams. This would enable complex case review and adequate support for front line clinicians within mental health.
- Form distinct developmental disability mental health teams within Mental Health Services for each Local Health Network.

In addition, increased funding is needed for training in developmental disability general and mental health for front-line staff working in this area.

A separately funded State based Centre of Excellence in research, training and education, hosted by a tertiary institution, should be developed. Such a centre would work in close collaboration with the newly formed Intellectual Disability Network of the Agency for Clinical Innovation to develop and evaluate evidence-based health interventions, and education and resource materials for health professionals.