



AMA

Federal Budget Submission
2008-09

Taking Responsibility for Health Care

Taking Responsibility for Health Care



Responsibility for health care is shared by many. This starts with individual lifestyle choices such as diet, exercise, an interest and awareness in health and well being, and the ingestion of potentially harmful substances. These factors affect our own health status. Health professionals bear a large amount of responsibility for the delivery of health care (education and prevention, detection, management and treatment). Governments have a significant role in the financing and accessibility of health care, shaping both the public and private health insurance systems, as well as major roles in the operation of public hospitals, community health centres and public health.

The AMA sees the 2008-09 Federal Budget as an opportunity for the incoming Commonwealth Government to reclaim its responsibility for health care. This is particularly so with regards to public hospitals and Indigenous health care and to strengthen the partnerships with those who share the responsibility more broadly.

The Australian health system continues to rate highly in international comparisons. We benefit from a highly skilled health workforce and a reasonable quality health infrastructure. There are challenges that lie ahead and we need to plan for the future and work to further improve the health system to meet those challenges and needs.

We recognise that there is an increasing number of aged people in the community – some frail and with multiple, complex and chronic health care needs. We brace ourselves for the health costs of poor diet combined with sedentary lifestyles. We acknowledge the sad lack of progress in addressing the poor health of Indigenous Australians. We can define the under-resourcing of public hospital and aged care sectors. It is now about what we do in these areas to solve the problems and to ensure that we do not compromise patient care.

The AMA accepts that if there are unnecessary admissions to public hospitals then this should be avoided. The reality is that we do not have enough hospital beds to meet the needs of those requiring admission. This results in an unacceptably high bed occupancy rate in the public hospitals, pressure on the doctors and nurses and systems, and risks to quality and safety of care and conditions. From the AMA Public Hospital Report Card analysis, an investment of an estimated 3,750 beds on our estimate across Australia will ease the pain.

In any event, efforts to possibly reduce hospital admissions and stays can only be successful if there are resources and programs in the community to support patients. It is always the old and the frail who suffer most when these measures are introduced.

Australia would benefit greatly from longer term planning in health especially for the health workforce which has been subjected to dramatic cuts and surges over the years and again today. Unless we have a 20-30 year planning framework superimposed on the three year electoral cycle, we will continue to face sinusoidal health care delivery patterns instead of positive exponential patterns.

The AMA is particularly concerned to see an increasing incidence of Australian children with health problems associated with lack of physical fitness and poor diet. Strong public health and education campaigns are needed today.

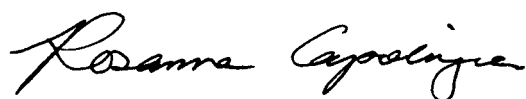
We appeal to the Commonwealth Government to make a much stronger commitment to dealing with the state of Indigenous health. The current situation is simply unconscionable.

Aged care remains a high priority. A missing component of our aged care system is easy access to holistic care from a GP. We present to Government affordable and practical solutions to give older Australians quality health care in their twilight years.

The negotiations over the next 5-year Australian Health Care Agreements provide an opportunity for a new paradigm for public hospital funding less plagued by cost and blame shifting and characterised instead by higher performance and greater accountability.

The plight of rural health care seems to be deteriorating, not improving, and there is much to do on all fronts: access to GPs and specialists as well as hospitals.

This submission addresses a number of other measures to support quality health care for all Australians. The AMA believes the remedies are practical and affordable. We ask the Government to examine this submission carefully and act on its recommendations.



Dr Rosanna Capolingua
AMA Federal President

Aboriginal and Torres Strait Islander Health

The need: Health outcomes for Indigenous people are completely unacceptable: a 17 year gap in life expectancy as well as mortality and morbidity rates far higher than for non-Indigenous Australians. The resolution requires substantial and immediate increases in targeted health spending and the elimination, over time, of economic, educational and social disadvantage.

The opportunity: The Government has made a good start with its commitment to a mothers and babies program. Much more effort is needed to close the gap for Aboriginal peoples and Torres Strait Islanders in both rural and urban contexts. Significantly increased access to appropriate primary care, medical specialists and medications, would improve the health of the most disadvantaged Australians, while reducing, in real terms, the high burden of tertiary health care.

How done? Primary health care interventions that have evidence-based potential include a National Rheumatic Heart Disease Control program and better access to MBS and PBS benefits. Complementary workforce initiatives include strengthening the indigenous specific health sector by training more Indigenous people as health professionals and improving pay levels and training for all staff.

The cost: An additional \$430m per annum for primary health care (\$460 million less the \$30 million already committed to programs including the mothers and babies program), together with:

- Commitment to a target of 2.4 per cent of all health professionals being from Aboriginal and Torres Strait Islander background by 2020;
- Mainstream services to focus current resources to improve health outcomes for Indigenous peoples; and
- Investment in the other social determinants of health — in particular education, housing, physical infrastructure and economic development.

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Revitalised Public Hospitals

The need: Over the term of the current AHCA, the Commonwealth Government share of funding has fallen away. Indexation of funding has been inadequate and public hospitals are struggling to meet the needs of the people. Many major tertiary hospitals are being run at full throttle with accompanying risk to patients.

The opportunity: The Government's "New Directions" policy commitment (\$2b over 4 years) with a focus on reform is a welcome start. More is needed to implement a comprehensive strategic national solution. The negotiations for the next 5-year ACHAs opens the door to a new paradigm stripped of cost and blame –shifting and endowed with proper accountability. There is significant room for improvement with both access to elective surgery and emergency department services. The new AHCA's offer the opportunity to provide for a sustainable indexation framework.

How done? The AMA is calling for a strong commitment from the Commonwealth Government to lift its effort on public hospital funding with parity (50/50 shares) a reasonable aim. It approves of the Commonwealth Government's aim to make the State and Territory Governments more accountable for any extra funding that is provided. There is strong evidence that a bed occupancy rate of more than 85% on average compromises patient safety. The remedies include an increase in bed numbers (an additional 3,750 new beds in our view), more doctors and nurses and the ongoing modernization of hospital infrastructure. Indexation of payments at 8-9% per annum is needed to keep pace with rising demand and underlying cost increases.

Cost: \$3b in the first year of the new AHCA and matching indexation of 8-9% per annum thereafter to seriously address the recurrent and capital requirements of, and increasing demands, on Australia's public hospitals. This amount would re-establish a 50/50 sharing, ensure patient safety and meet demand. This is significantly larger than the current commitment in "New Directions". There is scope for State Governments to run the public hospitals more efficiently and to reduce the dead weight of bureaucratic overlays and redirect that money to health care delivery.

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Doctor Training — the missing links

The need: Medical school intakes have been expanded enormously but Governments at all levels must work together with other stakeholders to ensure that there are enough clinical placements, intern places and vocational training places for the coming surge of graduates. This is an enormous challenge.

The opportunity: There is a window of opportunity right now to build the training infrastructure that will be required. With only 4 years remaining, urgent action is called for. This should be a key aspect of the new AHCA's. At the same time, the Government must explore untapped training opportunities in the private sector.

How done? A comprehensive strategy is required, involving:

- AHCA focus on medical training in public hospitals (specific funding with performance benchmarks);
- Increased support for medical student clinical placements in general practice settings
- 1,000 funded pre-vocational training places (up to three months) in General Practice;
- More support for specialist training in expanded settings.

Cost: AHCA targeted funds are possible within the envelope of a 50/50 sharing of costs. Indicative additional training costs are:

- \$25m per annum to support increased GP clinical training places for medical students;
- \$80m per annum for the pre-vocational GP training (when in full swing); and
- Up to \$200m per annum for specialist training in expanded settings.

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Rural Health Workforce and Infrastructure

The need: People living in rural and remote areas have poorer health outcomes and less access to health services of all kinds (medical, paramedical and hospital) than people in urban areas. Rural areas are heavily reliant on overseas trained doctors. Urgent intervention is required to attract Australian trained doctors to rural Australia. Given faster population growth in coastal areas in particular, action is required to augment health infrastructure, especially rural hospitals.

The opportunity: The AMA warmly welcomes the Minister's announcement of an audit of the shortage of health professionals in rural areas. Workforce is a critical issue. There also needs to be an understanding that the rationalisation of rural hospitals has made access to health care even more difficult for rural patients.

How done? A comprehensive strategy is required, involving:

- More funding for rural hospitals;
- More support for patient transport schemes; and
- A significant incentive package to make it attractive for doctors to work in the rural areas and to secure doctors with necessary skills in obstetrics, surgery, anaesthesia and emergency medicine

Cost: \$300m to \$400m per annum (estimated) for the overall cost of the rural health workforce initiative.

\$36m per annum (estimated) for improving support for patient transport schemes.

A previous item addresses the level of funding and adequacy of indexation of payments for public hospitals. This would allow scope to deal with the rural hospital issue, which should include quarantined funding to support rural public hospital services.

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Assistance for Bonded Medical School Students

- The opportunity:** Unfunded bonded medical school places are intended to boost the medical workforce in rural and regional areas. Overseas evidence shows that the Government's existing scheme will not lead to sustainable long-term increases in the rural medical workforce. Unfunded bonding is based on conscription and offers no support and no incentives. It short-changes medical students and, ultimately, rural Australia.
- How done?** The Government should introduce equitable arrangements that include HECS relief and targeted financial incentives.
- The cost:** \$6m per annum.
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More Support for General Practice Nurses

- The need:** General practice has embraced the use of practice nurses as part of a team based approach to delivering health care. There are now more than 6,000 practice nurses across the country. However, many practices such as those in outer urban and regional areas cannot access support to employ practice nurses.
- The opportunity:** Practice nurses can deliver a range of services for and on behalf of GPs such as antenatal care, immunisation, pap smears and wound management. This relieves pressure on GPs who can instead concentrate on more complex cases.
- How done?** The AMA is calling for the extension of existing practice nurse grants to all general practices.
- Cost:** \$35m per annum.
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Funding Medicare for the Future

The need: Patients are being short-changed with their Medicare rebates due to inadequate indexation of the Medicare Benefits Schedule (MBS). In November last year patient rebates were lifted by only 2.2 per cent, while the Australian Bureau of Statistics (ABS) has health inflation running at 4.3 per cent. When rebate increases do not match inflation, then patients have increased out of pocket costs for their health care.

The burden of chronic disease in Australia is growing. While some efforts have been made to address specific issues, the structure of GP consultation items in the MBS generally discourages longer consultations appropriate for the prevention and management of chronic disease.

The opportunity: Simplifying and reforming GP consultation items in the MBS will encourage better prevention and management of disease. More realistic indexation of the MBS will ensure that out of pocket expenses do not grow over time.

How done? During the 2007 Election campaign the ALP committed itself to a review of the Medicare Schedule. The AMA supports this review and urges the Government move ahead with it as a matter of priority. A great deal of work has already been done in this area including the recommendations arising from the report of the Attendance Item Restructuring Working Group (AIRWG).

Adopt a Medicare indexation formula that better reflects the actual increases in the costs of delivering health care.

The cost: \$150m per annum additional to current provision for indexation, to properly index all Medicare benefits, including \$52m per annum to properly index Medicare benefits for GP consultation items.

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Efficient Medicare Claiming

- The need:** The new Medicare *EasyClaim* system is a needlessly complex solution to the high cost of processing patient-billed claims. With the bulk-billing system well protected by the bulk-billing incentive, it is time to consider a single low-cost system for the payment of all Medicare rebates.
- The opportunity:** The potential cost savings and efficiency of a fully electronic claiming and payments system have been obvious for some time. It has become apparent, however, that the bulk-billing incentive is the far superior way to achieve public policy objectives in that area and that the log-rolling approach to patient-billed services imposes needless cost and complexity on the system. *EasyClaim* was a genuine attempt to find a solution, but Australia can do much better than that.
- How done?** Patients should be given the right to assign their Medicare benefit direct to the service provider regardless of the existence or not of a patient co-payment. The mechanism already exists, but access to it is denied where the service is patient-billed. The existing bulk-billing system provides a low-cost method for processing all claims. It is simply a matter of removing the legislative impediments.
- The cost:** The proposal would ultimately generate cost savings to Government of the order of \$200m per annum, considerably more than the cost savings potential of *EasyClaim*. A much greater benefit would accrue directly to patients through a much more convenient system of claiming rebates.
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Aged Care Services

- The need:** Demand for aged care services (both community care and residential) is growing rapidly. There will be many more “very old” people (those aged 85 years and over) than ever before. Future generations of older people are likely to have more complex health problems and demand a high quality and level of service. The AMA is keen to see more adequate provision of aged care services and the augmentation of the workforce that is a necessary part of that.
- The opportunity:** By avoiding a shortage of aged care services, there is an opportunity to avoid extra pressures on the public hospitals. Given the lead times in bringing on new infrastructure, early action is rewarding. There is also an opportunity to address medical, nursing and allied health workforce issues (with something approaching wage parity between the acute care and aged care sectors).
- How done?** The AMA welcomes the Commonwealth Government’s commitment to provide 2,000 transition care beds (at a cost of \$158m over 5 years) and to support the industry to bring on 2,500 permanent residential aged care beds sooner. A careful review of the effectiveness of the full range of existing aged care services and models of care (spanning acute, sub-acute, transitional, residential and community care) is called for. This review should involve all key stakeholders, and is a pre-requisite for the development of evidence based, integrated service delivery models to meet emerging future demand of an ageing population.
- Cost:** Cost will depend upon the outcome of the review process. Given the rising wealth of the “baby boomers”, there may be a need to rethink the mix of personal and taxpayer contributions to as to more effectively mobilise private capital.
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Medical Care for the Aged

- The need:** Demand for aged care services is growing rapidly. Future generations of older people are likely to have more complex health problems and demand a high quality and level of service. The difficulties faced by general practitioners (GPs) to provide medical care for patients in aged care facilities have led to a situation where fewer GPs are prepared to visit aged care facilities.
- The opportunity:** Restructuring the relevant Medicare Benefits Schedule (MBS) item numbers for attendance at aged care facilities will improve access to medical services in these facilities. Providing dedicated clinical treatment rooms with proper equipment and IT support for GPs attending patients at aged care facilities can also be addressed.
- How done?** Introduce MBS items for attendance of patients in aged care facilities to reflect innovations that exist in other areas of the MBS to foster high quality team based care. The new items would give GPs the capacity to delegate some tasks to their practice nurses and other clinical staff and they would also reflect the complexity and the significant amount of clinically relevant non face-to-face time involved in providing medical care to residents of aged care facilities. Fund the introduction of technology to put improved clinical management and prescribing systems in aged care facilities.
- The cost:** \$100m per annum (estimated) for MBS item restructuring, subject to more detailed cost and structure modelling that should be undertaken by the Department of Health and Ageing in consultation with the profession. Existing aged care GP initiatives should be reviewed. Those found to be under-performing should be shut down and funds redirected to MBS item restructuring.
- \$40m per annum for improved clinical management and prescribing systems.
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Dementia

The need: Dementia needs are part and parcel of aged care services and health care for the aged (the previous two items). The life impact and cost envelope justifies special mention. Dementia is one of the leading causes of disability and it places considerable stress on family carers. Current forecasts are that, by 2050, there will be over 730,000 people with dementia, representing 11% of all people aged 65 and over.

The opportunity: Opportunities abound in this area. Action can be taken to best support GP in achieving best management of dementia, to invoke the changes in lifestyle which can reduce the risk of dementia and delay onset, to put more resources into community care and to improve social inclusion. The AMA welcomes and supports the Government's commitment to improve the transition between hospital and care in the community and residential care.

How done? The AMA is calling for:

- The inclusion of cognitive function tests in the MBS and other changes in the MBS to support high quality care including preventative care;
- Expanded funding for community care;
- Social inclusion initiatives; and
- A nationally consistent and effective system of advance care planning.

Cost: \$5m per annum.

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Primary Prevention

The need: Each year Australia experiences significant costs as a result of the rising prevalence of chronic diseases and conditions. In many cases these conditions have causes that are avoidable. This would suggest that an efficient allocation of health resources should significantly incorporate health prevention.

The opportunity: The government has given a commitment to embrace prevention as a core part of its health agenda. That commitment, however, must be a genuine and enduring one that engages individuals and communities to support good decision-making in relation to tobacco, alcohol, food and exercise.

How done? The AMA calls for:

- Tighter regulation of 'junk food' marketing and advertising practices, particularly during children's viewing times;
- A collaboration between government and industry to improve nutrition information and labeling on food products so Australian families can make healthy and informed choices about what they eat;
- A doubling in the proposed allocation of \$3.5m over 4 years to a *National Preventative Health Care Strategy*, with a particular focus on 'whole of government' approaches to addressing risk factors for chronic disease;
- The bolstering of research on preventive interventions and outcomes, and data collection on population trends regarding risk factors for, and determinants of, chronic diseases;
- Support for an expanded role for doctors in providing prevention advice and referral pathways for patients at risk of chronic conditions; and
- The piloting, funding and evaluation of community-based initiatives to reduce chronic disease risks, and to increase the evidence-base for best-practice interventions.

Cost: \$10m per annum (estimate).

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Smoking

- The need:** Smoking is currently the biggest preventable cause of death and disease in Australia. It is a major risk factor for coronary heart disease, stroke, peripheral vascular disease and cancer, among other conditions. The resulting social and economic costs of tobacco use are substantial.
- The opportunity:** The evidence strongly indicates that interventions to reduce tobacco use are some of the most cost-effective public health investments. The government has undertaken to re-invigorate the *National Tobacco Strategy* and this provides the opportunity for it to show national leadership by taking greater responsibility in this key area.
- How done?** An effective strategy for addressing the harms of tobacco use will incorporate measures involving demand-reduction, supply control and the protection of non-smokers. The AMA is calling for:
- Cessation of the duty free exemption for tobacco products;
 - Real increases in tobacco taxes to deter consumption;
 - A ban on the importation of confectionary and fruit flavoured cigarettes;
 - A ban on political parties accepting donations and sponsorships from tobacco companies;
 - A global provision to change all CPI indexation arrangements to a special series of the CPI excluding tobacco, so that people are not compensated through indexation arrangements for increases in tobacco taxes; and
 - Effective use of the proposed \$15m commitment to the *National Tobacco Strategy* to support evidence-based interventions to help smokers quit (including measures to reduce children's exposure to smoking in films and on television).
- Cost:** Net cost savings likely were the Government to implement both the increase in the tobacco tax and the removal of the duty free exemption.
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Alcohol

- The need:** Excess alcohol consumption is an issue of significance in public health. It is associated with diseases of the nervous system, heart, liver and other organs and contributes to car and work-related accidents. The social impact is also very significant, with alcohol contributing to family breakdowns, violence, unemployment and alcohol-related offences.
- The opportunity:** As with tobacco, this is an issue where the Commonwealth Government has an opportunity to show true national leadership and develop a strong and sustained commitment to reducing the harms associated with alcohol consumption.
- How done?** The AMA is committed to achieving a reduction in the incidence of hazardous and harmful levels of alcohol consumption and calls for:
- Alcohol taxes to be based on the total volume of alcohol;
 - Prominent labelling and better consumer information on the health and social risks of inappropriate levels of alcohol consumption;
 - Stricter control on the marketing of alcohol to teenagers; and
 - Wider reaching public education campaigns regarding the dangers of binge drinking.
- Cost:** There may be a small impact only on Budget outlays depending upon whether the restructure of alcohol taxes generates more or less revenue.
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