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National Primary Health Care Strategy
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Dear Sir/Madam

**Re: Towards a National Primary Health Care Strategy
A Discussion Paper from the Australian Government**

I am writing in relation to *Towards a National Primary Health Care Strategy - A Discussion Paper from the Australian Government* ('the discussion paper') that was released by the Government in October last year.

The AMA welcomes the Government's commitment to the development of a national primary health care strategy. There is no doubt that a strong primary health care system delivers high quality, equitable and cost effective health care outcomes for the whole community.

The AMA, like many other stakeholders, is unclear about how the proposed national primary health care strategy aligns with other review processes currently taking place, for example, the draft recommendations in the National Health and Hospitals Reform Commission (NH&HRC) interim report released on 16 February 2009.

The NH&HRC report makes a significant number of recommendations in relation to primary health care delivery and appears to pre-empt much of what might be contained in a primary care strategy document. The AMA would welcome further advice as to how existing review processes will come together in an integrated and coherent way.

The AMA recognises the need for primary health care reform in Australia and in this regard has prepared a comprehensive blueprint to improve the delivery of primary health care services in Australia, *General Practice in Primary Care: Responding to Patient Needs*. A copy of this blueprint is attached and it forms the fundamental part of the AMA's submission to the discussion paper.

General practice is the cornerstone of high quality and affordable primary health care delivery in Australia. GPs provide all the care needed for 90% of the problems they encounter and do so at a relatively modest cost to the public purse.

The Australian community values the role GPs play in their health care. 80% of people visit a GP at least once per year and evidence shows that Australians spend more time with their GP than in most comparable countries. Australians report high trust in doctors, particularly general practitioners. Patients also report high levels of satisfaction with, and access to, GP care.

General practice is tackling key health issues such as complex and chronic disease. Between 1998–99 and 2006–07, there were statistically significant increases in the treatment rates by GPs of chronic disease including hypertension, diabetes, lipid disorders and oesophageal disease.

In the face of workforce pressures and the growing burden of complex and chronic disease, GPs have embraced team-based care to give patients better access to other primary health care services after diagnosis and assessment and the consideration of an appropriate management plan.

More than 60% of general practices have a practice nurse and GPs regularly refer patients to other primary health care services such as psychologists, specialised nurses, physiotherapists, dietitians and occupational therapists.

Australia needs to build on these achievements. Reforms to primary health care delivery must be evidence based and measured against the following key criteria:

- the quality of care provided is of the highest possible standard and does not increase the risk of adverse health outcomes,
- coordinated and comprehensive health care is provided,
- the health system continues to be efficient and effective for patients, and
- the overall health system continues to be cost effective for the community as a whole.

These criteria are consistent with many of the principles outlined in the discussion paper.

A GP led model of primary care delivery that involves other medical specialists, practice nurses, specialised nurses, allied and other health professionals working in teams will deliver the best outcome for patients. There is no substantive evidence that shows that non-medical health professionals working independently of GPs can deliver the same quality health care outcomes as the team-based model of primary health care delivery that is supported by the AMA and is currently established in Australia.

The available evidence shows that the substitution of other health professionals for doctors can actually increase the costs of primary care delivery through longer consultations, higher patient recall rates and the increased use of tests and investigations.

In shaping future strategies for primary health care delivery, the role of medical specialists other than general practitioners cannot be ignored. Physicians, for example, have a unique position in the health system. They play an important role in primary care by keeping people from unnecessary presentations at hospital, keeping patients off hospital waiting lists, preventing readmissions, and caring for patients in the community and ambulatory settings.

Physicians provide specialist care for those with complex or multi-system disease, and provide specialist care for the elderly, a very important role given our ageing population and the growing burden of chronic disease. The scale of these emerging health problems cannot be managed effectively by specialists working in isolation from GP led primary care services.

While much of the discussion around multi-disciplinary care focuses on how to better support the involvement of nurses and allied health professionals, there is no doubt that access to specialist care is a key part of patient centred primary health care delivery. In this regard, reforms to primary health care delivery must involve efforts to strengthen and integrate generalist physician care and other cognitive specialties with primary medical care.

The AMA believes that the Commonwealth needs to recognise the important value of generalism and ensure that future funding arrangements support and provide better access to generalist physician care as part of a comprehensive primary care strategy.

The AMA would caution against placing benchmarks and performance pay systems and structures above the need for more resources for direct patient care. Performance reporting must be set at the system wide level and be used as an indication of the need for more funding and resources and not be used to impose penalties when benchmarks are not achieved. Performance indicators must not encourage perverse incentives that could detrimentally affect patient care.

It is widely recognised that e-health has the potential to significantly improve patient care. A robust e-health infrastructure would support better care coordination and provide more timely access to available technologies that can deliver better patient outcomes.

General practice has taken the initiative and embraced e-health - with some Government assistance. However, there is still have a long way to go. In addition, governments have essentially ignored the need to support e-health infrastructure in other areas of specialist medical practice. True patient centred care requires a comprehensive approach to the development a robust e-health system that supports all aspects of patient care.

There are significant shortcomings in primary care research nationally and internationally. As the attached material highlights, greater funding for research will help improve clinical practice and the delivery of primary care services. With appropriate support, there is significant potential for general practice to take the lead in this area through the conduct of practice based research that is relevant to the needs of GPs and focused on areas that will deliver results that can be implemented at the practice level.

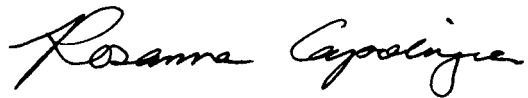
In relation to preventative health care, general practice delivers primary and secondary prevention. This means screening for disease risk (eg, cardio-vascular disease, diabetes, cancers, etc), and engaging patients in preventative strategies to reduce development of disease. In addition, the GP's close management of patients with disease and the practice of secondary prevention reduce complication rates, disability, morbidity and mortality.

The AMA has prepared an extensive submission to the Preventative Health Care Taskforce that is highly relevant to many of the questions outlined in the discussion paper. A copy of this is also attached and also forms part of the AMA's submission on the discussion paper. This submission outlines a number of strategies to better support preventative care including

- the appropriate recognition of preventative health care activities within existing the existing MBS rebate structure;
- provision of patient rebates through the MBS for practice nurses to conduct brief preventative health interventions for and on behalf of the patient's doctor;
- provision of patient rebates through the MBS for group educational and preventative health sessions provided by medical practices;
- pro-active measures to inform and encourage 'primary prevention' target groups (eg., adolescents, young people) to access local doctors;
- practice-based grant programs for development of whole-of-practice prevention measures and programs;
- involvement of doctors (through the AMA) in the development and follow-up of public awareness campaigns.

Australia has a world-class health system, underpinned by an excellent primary health care system that is the envy of many other countries. The key to the success of primary health care delivery is the provision of comprehensive, continuous and coordinated patient centred care by general practitioners. The AMA urges the Government to build on this platform by adopting the strategies and recommendations outlined in the attached materials.

Yours sincerely

A handwritten signature in black ink, reading "Rosanna Capolingua". The signature is written in a cursive, flowing style.

Dr Rosanna Capolingua
President

Attachments: *General Practice in Primary Care: Responding to Patient Needs*
AMA Submission to the Preventative Health Taskforce Discussion Paper:
Australia The Healthiest Country

GENERAL PRACTICE IN PRIMARY CARE: RESPONDING TO PATIENT NEEDS



An AMA blueprint for the delivery of primary health care services in Australia



FOREWORD



International studies prove what general practitioners have known for generations – a strong GP-led primary health care system keeps people well and saves lives.

The studies also show that a strong GP-based system not only improves the health of our patients, but is

also a very efficient means of utilising scarce health dollars. It delivers substantial bang for the health buck.

Still further studies show that the high quality of general practice in Australia also serves to reduce health inequalities across the system.

Despite the proven case that GP-based primary health care improves health and delivers care efficiently and equitably, the community is not always well informed about the important role that general practice plays in primary health care.

This AMA blueprint *General Practice in Primary Care: Responding to Patient Needs* is designed to help the community, policy makers and health care professionals better understand the power of a GP-led primary health care system.

It outlines a number of important facts and also counters a number of myths that have been encouraged to bloom in the health debate.

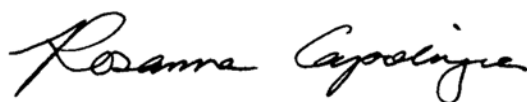
Salient facts include that:

- GPs provide all the care needed for 90% of the problems they encounter,
- GPs account for less than one tenth of per capita expenditure on health,
- GPs champion a team-based approach to patient care, routinely utilising the skills and knowledge of colleagues in the allied health professions. More than 60% of GPs have a practice nurse,

- the current GP shortage is a direct result of deliberate government policy. Australians should not be forced to accept a lower standard of care because of bad policy compounding bad policy,
- many years of intensive study, specific training and experience underpins the breadth of skills and knowledge that give to patients the holistic care that general practice provides. There are no short cuts,
- government red tape now forces GPs to spend up to 25% of their time completing paperwork,
- GPs fully support a system that provides patient rebates to reflect the longer consultations that patients require, as well as supporting acute care. The system must always allow doctors to deliver quality care based on the needs of the patient, not on limits, rationing or caps to care imposed by government.

Importantly, the blueprint also outlines steps that need to be taken to maintain and improve access to high quality primary health care for all Australians. The policy rejects the contention that we must accept lower standards of health care to make them affordable. It embraces reform and recognises the need for sustainable levels of health care funding, but puts patients' needs ahead of cost cutting.

This fundamental focus on our patients lies at the heart of this blueprint and at the heart of every GP practice.



Dr Rosanna Capolingua
AMA President
October 2008

GENERAL PRACTICE IN PRIMARY CARE: RESPONDING TO PATIENT NEEDS

AN AMA BLUEPRINT FOR THE DELIVERY OF
PRIMARY HEALTH CARE SERVICES IN AUSTRALIA



Primary health care is very important for the health of our communities

International studies show that the strength of a country's primary health care system is directly associated with improved population health outcomes for all-cause mortality, all-cause premature mortality and cause-specific premature mortality from major respiratory and cardiovascular diseases ¹.

Increased availability of primary health care is associated with higher patient satisfaction and reduced aggregate health care spending ².

There is evidence for an association between health care systems that are organised around a strong

primary care sector and reduced health inequalities³. Because it reaches so much of the population, general practice has an opportunity to address health inequities by improving access to quality care.

The AMA has prepared this blueprint to help inform the community of the steps that need to be taken to improve access to high quality primary health care services for all Australians. It outlines proposals that are viable, cost-effective and safe. It also attempts to dispel some of the myths about the state of the Australian primary health care system.

Australia has a world-class health care system

According to World Health Organization (WHO) data published in 2007 in respect of the year 2005, Australian males enjoyed a life expectancy of 79.0 years, the second highest of all the OECD countries, and females 83.7 years, the fourth highest of all the OECD countries⁴.

In relation to age-specific death rates in Australia, the death rate for males in 2005 compared to 1961 has more than halved for every age from 40 to 79 and, in respect of females, it has halved for every age from 0 to 84 years. Deaths per 100,000 population from circulatory diseases among males in 2005 were 26.8% of the rate in 1961 and for females, they were 27.3%. For genitourinary diseases, the figures were 27.8% and 56.5% respectively⁵.

Australia has an excellent primary health care system that is the envy of many other countries. It is crucial for all Australians to value their own health and the importance of good health across the community. The key to the success of primary

health care delivery in Australia is provision of comprehensive, continuous and coordinated patient-centred care by general practitioners. According to a joint Australian Institute of Health and Welfare/University of Sydney report released in October 2008, general practice provides all the care needed for more than 90% of all health problems that GPs encounter⁶.

It is widely acknowledged that Australia's GP-led model of primary health care services delivers affordable high quality health care outcomes. The Commonwealth Government spent \$250 per person on general practice in 2005-06 through Medicare, non-Medicare funding, expenditure by the Department of Veterans' Affairs and other funding programs⁷.

In the same year, the AMA estimates that the total of Commonwealth and State/Territory Government per capita expenditure on health care was \$2,844. On any measure, general practice consumes a relatively small proportion of overall government expenditure on health care. There is evidence that improved investment in primary health care services will reap significant benefits for the Australian community.

The Australian community values the role GPs play in their health care. 80% of people visit a GP at least once per year and evidence shows that Australians spend more time with their GP than in most comparable countries. Australians report high trust in doctors, particularly general practitioners⁸. Patients also report high levels of satisfaction with, and access to, GP care⁹.

Emerging pressures

Changing health care needs of the community

There is no doubt that the health care needs of the community are changing. The population is ageing and the burden of complex and chronic disease is growing. While GPs still play a key role in the management of acute conditions, more than one-third of problems now managed by GPs are classified as chronic. The most common of these are hypertension, diabetes, depressive illness, lipid disorders, osteoarthritis, oesophageal disease and

asthma¹⁰. In practice, this means that many patients of GPs have multiple illnesses. This has significant implications for the workload in general practice and how a patient's care is managed and delivered.

Workforce

In 1993, 830 doctors entered the GP training program¹¹. In 1996, the Commonwealth Government decided to limit the number of training places to 400 places per annum. This was a deliberate decision that was designed to keep health care expenditure down and address a perceived oversupply of GPs. The number of GP training places was subsequently increased to 450 places per annum in 2001 and 600 places per annum in 2004.

Australia is training fewer GPs than it did 15 years ago. It should come as no surprise to the community that patients in different parts of the country are having problems with access to GPs. The landmark 2002 report commissioned by the AMA, *GP Workforce: An Analysis of the Widening Gap between Community Need and the Availability of GP Services*, was instrumental in highlighting this issue and overturning the widely held belief that Australia had more GPs than it needed.

Responding to change

General practice is tackling key health issues such as complex and chronic disease. Between 1998-99 and 2006-07, there were statistically significant increases in the treatment rates by GPs of chronic disease including hypertension, diabetes, lipid disorders and oesophageal disease¹².

In the face of workforce pressures and the growing burden of complex and chronic disease, GPs have embraced team-based care to give patients better access to other primary health care services after diagnosis and assessment and the consideration of an appropriate management plan. More than 60% of general practices have a practice nurse and GPs regularly refer patients to other primary health care services such as psychologists, specialised nurses, physiotherapists, dietitians and occupational therapists.

Australia needs to build on these achievements.

GP-led primary care is the best model of patient-centred care

GPs are the highest trained general health professional with a minimum of 10 to 15 years training. A GP's skills encompass: prevention, pre-symptomatic detection of disease, early diagnosis, diagnosis of established disease, management of disease, management of disease complications, rehabilitation, terminal care and counselling. GPs are specifically trained for and skilled in comprehensive first contact and continuing care for persons with any undiagnosed sign, symptom or health concern.

GPs are trained to manage patients with multiple illnesses, which is becoming more and more important as the population ages. 55% of people aged 65-84 years of age have 5 or more long-term conditions¹³.

Patient-centred care delivery considers the needs of the whole patient. True patient-centred care can only be delivered within a framework that enshrines a medical diagnosis and assessment. In the GP-led model of primary health care delivery a patient's care needs are fully assessed. A patient's care is then organised around these needs. The specialised training of GPs is vital to the evolving primary care system.

Other health professionals may be able to make a limited diagnosis of a specific illness or injury, but they are not trained in the total health care of the whole person. There is an increased risk of missed diagnosis and misdiagnosis, and delay in accessing appropriate treatment. Other health care professionals are trained in specific areas with specific levels of knowledge and experience and are not able to make a holistic assessment of the patient. Medical knowledge is growing at a furious rate and it is more important than ever to make sure that the primary health care system enshrines access to a holistic medical assessment and diagnosis.

The right assessment and diagnosis guide a patient's journey through the health system. Patient advocacy is a core role of the modern GP. GPs will open the right doors in the health system once they have

assessed and/or diagnosed a patient's condition. This ensures that the patients' journey is efficient for them, clinically effective and cost-efficient. GPs, based on their medical expertise and skill, will determine the clinical management of the patient, the investigations required and when to refer the patient to a specialist or another health provider. This is the key to patient centred primary health care.

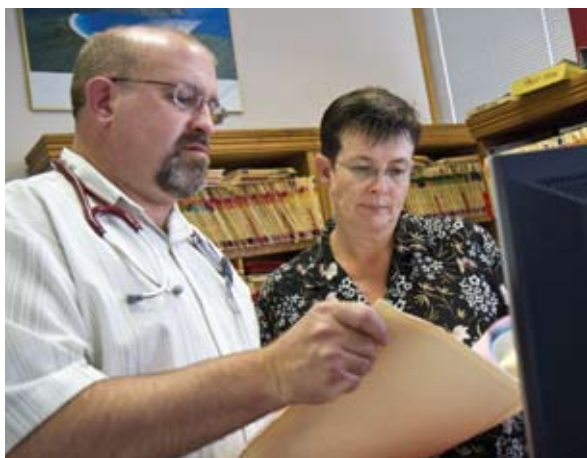
Reforming primary health care in Australia

The Commonwealth Government has announced that it will develop a national primary health care strategy. According to the Commonwealth Government's announcement, the strategy will give priority to:

- better rewarding prevention,
- promoting evidence-based management of chronic disease,
- supporting patients with chronic disease to manage their condition,
- supporting the role GPs play in the health care team,
- addressing the growing need for access to other health professionals, including practice nurses and allied health professionals such as physiotherapists and dietitians, and
- encouraging a greater focus on multidisciplinary team-based care.

The AMA supports these broad policy objectives and is committed to working with the Commonwealth and other stakeholders to ensure patients continue to have access to high quality primary health care services. Reforms must be measured against the following key criteria:

- the quality of care provided is of the highest possible standard and does not increase the risk of adverse health outcomes,
- coordinated and comprehensive health care is provided,



- the health system continues to be efficient and effective for patients, and
- the overall health system continues to be cost-effective for the community as a whole.

Australia must retain the GP-led model of primary health care delivery

Research supporting the substitution of nurses and other health care professions for GPs is limited. Most studies have:

- included only small numbers of nurses,
- had patient samples that have generally been too small to detect rare but potentially serious health outcomes such as missed diagnosis, and
- rigorously evaluated only a narrow range of nursing roles¹⁴.

It is unlikely that the substitution of nurses and other health professionals for doctors will save the health system any money. Studies show that, while there may be potential savings with respect to salaries, this is often offset by longer consultations, higher patient recall rates and the increased use of tests and investigations¹⁵.

The substitution of nurses for doctors does not appear to give patients quicker access to primary care services. Research into the impact of NHS walk-in centres in the UK, which are primarily nurse-led, found no evidence that walk-in centres

shortened waiting times for access to primary care¹⁶.

In 2006, the House of Representatives Standing Committee on Health and Ageing published *The Blame Game – Report on the Inquiry into Health Funding*. The Committee noted that there was broad support for a move towards a wellness model in service delivery – which is often used to promote the substitution of nurses and other health care professionals for GPs.

The Committee deliberated on the role of other health care professionals and concluded that, while it supported the move towards a health system based on a wellness model, decisions about the appropriateness of different types of health care were best made by medical practitioners and their patients¹⁷.

The Commonwealth Government would be doing the community an enormous disservice if, after having pursued a deliberate policy to suppress the intake in the GP training program, it then decided that Australia must move away from a GP-led model of primary health care because of GP shortages that were a product of the Government's own making. The community deserves better than that.

GPs leading teams that include nurses and allied health professionals will deliver the best outcome for patients. There is no substantive evidence that shows that nurses and allied health professionals working independently of GPs can deliver the same quality health care outcomes as the team-based model of primary health care delivery that is supported by the AMA and is currently established in Australia.

General practice as the foundation of comprehensive and coordinated primary health care services

Evidence exists to show that improved access to primary care physicians (ie, GPs) and their expertise in clinical assessment and coordination has significant benefits. According to the World Health Organization, these benefits include less hospitalisation, less utilisation of specialist and emergency centres and less chance of being exposed to inappropriate health outcomes¹⁸.

In Australia, general practice is the foundation of primary care, providing continuing, comprehensive and coordinated primary health care to the vast majority of Australians. In contrast, the fragmentation of care can result in inefficiencies and higher costs, and can pose other risks. Task substitution in Australian general practice needs to be discussed in the context of supporting the core attributes of general practice, including its continuity, comprehensiveness and its role in coordination¹⁹. Otherwise, changes involving task substitution may deprive patients of the valuable contribution of general practice to their care.

Strengthening the primary health care workforce

It is clear that, to improve access to primary health care services, the GP workforce needs to keep pace with the growth in demand for primary care services. In 2005, the former Australian Medical Workforce Advisory Committee recommended the number of GP workforce entrants should be in the range of 1,105 to 1,200 per year from 2007 onwards. Clearly, more training places in general practice are needed for medical students, prevocational doctors and GP registrars. The Commonwealth will need to invest significant resources into GP teaching incentives, the Prevocational GP Placements Program and the Australian General Practice Training Program.

Now is the ideal time to start this process. The number of medical school places in Australia is expanding rapidly and by 2012 there will be almost 3,000 domestic medical school graduates each year. This will be a fertile recruiting ground for general practice - provided the Government demonstrates its ongoing commitment and delivers the resources and infrastructure needed to expand and enhance training opportunities in general practice.

The delivery of general practice services in Australia is also heavily reliant on the contribution made by international medical graduates, particularly in outer-metropolitan, regional, rural and remote Australia. Despite their valuable contribution, many of these doctors do not receive any induction to the Australian health care system and are given little community support. They often work in challenging

environments where access to professional support and up-skilling is very limited. Providing these doctors with more support will enhance their contribution to patient care and will also encourage many of them to seek a permanent place in the Australian general practice workforce.

Workforce shortages are not limited to general practice. Shortages in other health professions are in some cases even more acute. The Australian Health Workforce Advisory Committee has estimated there will be a shortfall of between 10,000 and 13,000 nurses in 2010²⁰. The former Department of Employment and Workplace Relations identified shortages in a number of occupations, including occupational therapists, physiotherapists, pharmacists and podiatrists²¹.

While reform has an important role to play, Australia cannot lose sight of the need to build the capacity of the primary health care system. If Australia does not train enough doctors, nurses and other health professionals, then reform will fail.

Helping address the burden of complex and chronic disease, multiple illnesses and supporting preventative health care

Reforming the Medicare Benefits Schedule

Patients will get the best quality care when decisions about their health care are made according to their clinical need. To effectively tackle chronic disease, GP items in the Medicare Benefits Schedule (MBS) need to be simplified and designed to encourage longer consultations and better support GPs to engage in preventative health care. Unless patients with complex and chronic disease are given a rebate that allows them to spend time with their GP, they may not be able to afford the treatment they need.

The Commonwealth MBS now resembles a patchwork quilt. Since 1999 the number of GP consultation items in the MBS has grown from 41 to 188. This has been the result of identifying patient rebates for specific descriptors of care. The structure of GP consultation items in the MBS is



crying out for genuine reform.

Various attempts have been made to introduce new items that are intended to direct a patient rebate for chronic disease or preventative health care, (eg, a health check). The evidence shows that, if GPs are able to spend more time with each patient, they keep people healthier and reduce the burden on other parts of the health system. Patients need to be able to obtain a rebate that enables them to spend more time in their general practice consultation.

The policy direction towards chronic disease management and preventative care is welcome, but the changes in the MBS that reflect this have been burdened with additional paperwork requirements as well as extraordinarily tight rules regarding the use of relevant consultation items.

Reforms must enable GPs to deliver the best possible care for their patients and release them from unnecessary protocols and paperwork. The

recent initiative to streamline the authority system of prescriptions is a good example of how government can trust GPs to make the right decisions about a patient's health care without risk to the government's fiscal position. Restructuring the MBS can deliver efficiencies that will benefit government and patients and enable delivery of more face to face care by doctors.

Reform of the MBS must address the need for patient rebates to be properly indexed so that they keep up with the rising costs of health care. Failure to properly index patient rebates simply means that over time the costs of health care are transferred from the Commonwealth to the patient. The Commonwealth must also continue to support patients through the maintenance of a strong Medicare Safety Net. The Safety Net helps to alleviate the financial pressures faced by many Australians in accessing medical services. The Safety Net has been a very positive initiative for patient access to medical services and has been warmly embraced by the population.

Supporting the involvement of GP practice nurses and allied health professionals in delivering enhanced, GP-coordinated team-based patient care

The AMA supports an overarching model of primary health care delivery where GPs diagnose, assess and determine a patient's care needs and subsequently coordinate the delivery of care. This model works effectively in relation to acute or short-term medical care, complex and chronic disease and preventative medicine.

GP practice nurses and allied health professionals are a vital component of the care of patients, working as part of a primary health care team with overarching clinical management responsibility and coordination of care led by the GP. They have specific skills that can enhance patient care. The AMA believes that training places for nurses should be expanded and a number of specific measures taken to further support the involvement of nurses and allied health professionals in the care of patients.

GP practice nurse incentives should be extended to all practices. Currently, these can be accessed by general practices in a limited number of urban areas as well as in rural and remote Australia. Many metropolitan areas are ineligible for these incentives – even though they can help improve access to care. Any review of this Practice Incentive Payment should retain appropriate loadings for rural and remote practices while expanding support for all metropolitan practices to engage GP practice nurses.

The AMA believes that GP practice nurses could be better utilised to assist in areas such as the effective management of obesity, blood pressure and diabetes, as well as assist in the management of complex and chronic disease and screening (using GP-developed protocols). While GPs already delegate a broad range of work to GP practice nurses, Medicare funding arrangements mean that patients do not receive a rebate for most of these services, even though they are delivered on behalf of the GP. Currently, a patient receives a rebate only for routine immunisation, wound care, pap smears and a limited number of preventative health activities provided by the practice nurse. The MBS needs to recognise the full scope of work that GPs can delegate to their practice nurses. Funding arrangements should support GPs to delegate work based on the GP's judgement of the skills and expertise of the practice nurse.

The utilisation of the GP practice nurse will enable GPs to see more patients and provide patients with greater access to care.

Medical practitioners, of course including GPs, have always worked with allied health providers in providing patients with the best care for their needs. This has been a team-based approach to patient care. Patients have always accessed allied health providers directly when they have felt the need.

The AMA acknowledges that patients with chronic disease who need ongoing care by allied health providers also need support when accessing that care. Ensuring that patients get access to appropriate care from other health providers following an assessment of their clinical needs by their GP is part of best practice management of chronic disease aimed at improving patient outcomes. The current arrangement for patients to access a Medicare rebate for care delivered by allied



health providers is consistent with this model and is based on this cost effective and clinically efficient principle.

The AMA supports the introduction of improved and streamlined GP referral arrangements for patients to enable them to access rebates for services by allied health providers. This would assist patients in accessing the skills of nurses and allied health professionals as part of appropriate care.

Referral to the necessary expertise of an allied health provider and the number of allied health services a patient receives should be based on the clinical need of the patient, rather than prescriptive government guidelines that are linked to specific conditions or types of illness and limit the potential occasions of service. For example, a patient with chronic diabetes will need ongoing foot care by a podiatrist for life. In contrast, a patient recovering from a stroke will need physiotherapy and occupational therapy for varying time periods depending on recovery. A child will need the expertise of a speech pathologist for a number of years. Clinical review by a doctor is essential to monitor disease processes, progress and holistic evaluation and identify any additional need of the patient for more allied health care.

To support the delivery of team-based primary health care services, the Commonwealth is looking at schemes that will help patients meet the costs of these services. There are a range of possible options that should be considered and discussed, including the provision of redeemable vouchers to patients and the development of GP coordinated chronic care packages (uncapped).

Providing patients with the financial support they need to access GP-coordinated primary health care services

The system of Medicare in Australia provides patients with a rebate for GP services. This has worked well (see previous references to health outcomes and access to GP care in Australia). This allows precious health funding to follow the patients. This gives patients the choice of doctor and location of service as well as flexibility in respect of the number of times they see their doctor. This is a truly patient-centred care model – which patients value. When funds follow the patients it means that they can access the care they require based on medical diagnosis and determination of clinical need.

Patients have a tendency to attend the same GP or the same practice for convenience and familiarity. Medical records shared across doctors in a practice enable continuity of care. In addition, under the current Medicare system, patients have the right to choose to attend another GP or another practice when they feel the need, and still have access to a patient rebate for that service.

Suggestions have been made that patients should be registered with a practice to enhance continuity of care.

Patient registration is not required for continuity of care and it would ultimately remove the patient's right of choice within the principle of universality of Medicare.

Patient registration would lead to waiting lists for patients to access their allocated general practice without the freedom to seek an episode of care elsewhere.

The AMA believes that patient registration also ultimately implies that funds would be allocated to the practice to provide service to patients. The money will no longer follow the patient but be determined by government and allocated to the fund holder. This interferes with the doctor-patient relationship. The GP can no longer make determinations for patients based on their clinical needs, but must take into account the funds that have been allocated. This

introduces rationing of care. Patients will not have access to the care they need, and/or have waiting lists for accessing services depending on fund availability. This has implications for patients and their health outcomes.

Other countries have adopted funding arrangements that place artificial caps on the funding of GP services – either in a general practice or a broader geographic area. These caps impact on patients because they potentially mean that GPs must make difficult decisions to ration access to care. The inevitable result is that patients must wait longer to access the treatment that they need.

The AMA does not support funding models that create rationing and limitations on access to care by patients.

Currently, there is much discussion about developing a health system that is centred around the patient. The Medicare patient rebate is funding which follows the patient and is patient-centred. Funding arrangements must ensure that patients can access the care they need in accordance with the clinical assessment made by their medical practitioner.

Giving GPs the support and infrastructure they need to deliver high quality patient care

Top-down bureaucratic solutions to address problems in the delivery of health care are rarely effective. Good quality care is delivered when governments create a supportive environment that allows GPs and other primary health care providers to effectively meet the health care needs of local communities. To improve the overall delivery of primary care services, government policy must be directed towards:

- supporting GPs by giving them appropriate access to the best available diagnostic tests including the option to refer patients for a Medicare-funded MRI scan,
- support for the introduction of point-of-care pathology testing,
- supporting the adoption of information technology, including high speed broadband

- the development of information systems that support the coordination of care with other health professionals and the public hospital system, and
- infrastructure for training GPs in the community.

The AMA recognises that the expansion of existing models of multi-disciplinary practices may help improve access to health care services. General practice has undergone significant change over the last 20 years and there has been considerable amalgamation of GP practices during this time.

The Government can further assist this adjustment process by creating a framework that allows practices to invest in the delivery of services in response to local community needs. The AMA believes that a proportion of the Commonwealth's Health and Hospitals Fund should be specifically allocated to allow general practices to apply for funding grants that would support them to enhance the services they can offer to the local community.

Ensuring equitable access to primary health care services

All Australians should have equitable access to primary health care services. A more equitable distribution of the primary health care workforce can only be achieved when the right incentives are in place and there is access to professional support as well as essential community services for the families of health professionals working in these areas.

The AMA has proposed, in conjunction with the Rural Doctors Association of Australia, a two-tier incentive program to recruit and retain doctors in regional, rural and remote Australia. The first tier is designed to encourage more doctors to work in rural areas, including GPs, other specialists and registrars. It takes into account the greater isolation involved with rural practice.

The second tier is aimed at boosting the number of doctors in rural areas with essential obstetrics, surgical, anaesthetic or emergency skills. Rural areas need doctors with strong skills in these areas to ensure that communities have access to appropriate local services including on-call emergency services.



The AMA also recognises that some rural and remote communities will be unable to sustain a local GP. Other health professionals working in these areas such as remote area nurses can deliver good quality care provided they are supported by IT and obligatory decision-making protocols are in place – including remote access to advice and support from a medical practitioner.

In some rural and remote communities it may not be possible for patients to access a GP in order to have a prescription written. In these circumstances, appropriate GP-supervised arrangements must be developed to allow patients to have access to the medications that they need in a reasonable clinical timeframe.

Geography is not the only influence on the community's access to primary health care services. Older people in residential aged care facilities (RACFs) need better support to access GP care. While previous investment in infrastructure is welcome, there has been insufficient policy attention paid to ensuring that aged care residents get access to medical services delivered by GPs and other medical practitioners.

Aged care accreditation standards need to include requirements that ensure residents of aged care facilities have appropriate access to medical care. This would ensure that RACFs worked closely with GPs and other medical practitioners to make sure that residents receive the quality of care that they need.

Australia must also work more effectively to close the gap in life expectancy between Indigenous and non-Indigenous Australians. We can make significant progress towards this goal by strengthening primary health care services. In relation to primary health care services, the AMA believes that there should be:

- an immediate investment of around \$500 million a year to expand primary health care services in indigenous communities,
- a commitment to increasing the number of health professionals from Indigenous backgrounds, and
- a requirement for mainstream services to focus current resources to improve health outcomes for Indigenous peoples including by expanding outreach and home visiting programs.

Cutting paperwork so that GPs can spend more time with their patients

By the time a doctors can practise independently as GPs it will have been around 10 to 15 years since they entered medical school.

Instead of maximising this investment by allowing GPs to devote most of their time to clinical practice, government programs and regulations often tie GPs up in paperwork. Some surveys have estimated that GPs can spend anywhere up to 25% of their time completing paperwork. This is a shameful waste of GPs' time and it denies patients access to care.

The Government should establish a benchmark for paperwork in relation to overall compliance with government programs and regulations – which should be set no higher than 5% of a GP's overall time. When the Government considers new regulations or program requirements, it should be required to review existing regulations and requirements so that a corresponding compliance burden is relieved.

Taking the burden off our public hospital system

A strong primary health care system can relieve pressure on hospitals in areas such as mental health and the treatment of complex and chronic disease. Hospitals can also work more closely with GPs to ensure that patients can return to the community as quickly as possible. Better discharge arrangements,

backed with the ongoing management of care by GPs, can get people back in their homes with a lower risk of readmission to hospital.

However, a stronger primary health care system is unlikely to make a significant difference to the workload in emergency departments, reduce patient waiting times or relieve the need for more hospital beds. GP-type presentations in emergency departments consume less than 1% of resources.

The ultimate key to improving waiting times in public hospitals is the provision of more beds so that hospitals can achieve a bed occupancy rate of 85%. This includes the operational capacity to take care of the patients in those beds – doctors, nurses, support staff and equipment. This will improve patient safety and allow hospitals to operate with much greater efficiency.

Consideration also needs to be given to a greater role for GPs in the public hospital system. Creating more opportunities for GPs to work as visiting medical officers and in GP liaison roles could help improve the efficiency of the public hospital system as well as provide GPs with opportunities to maintain and enhance key skills.

Major public health initiatives

General practice plays a key role in the roll-out of specific public health programs. For example, childhood immunisation rates in Australia are at record levels. This has been achieved by ensuring that the right financial arrangements are in place to support the Government's objectives.

Taking immunisation as an example, general practice can play an even bigger role. The AMA would support the expansion of general practice immunisation incentives to encompass a broader range of vaccines and patient groups. By government support for GPs to undertake more of this work, the reach of programs would be expanded and more patients would benefit through having immunisations monitored by their GP.

GPs not only play a significant role in administering certain public health programs: they also have a strong role in raising awareness among patients about public health concerns and identifying those at

risk. There must be appropriate links between public health programs and general practice.

General practice delivers primary and secondary prevention. This means screening for disease risk, eg, cardio-vascular disease, diabetes, cancers, etc, and engaging patients in preventative strategies to reduce development of disease. In addition, the GP's close management of patients with disease and the practice of secondary prevention reduce complication rates, disability, morbidity and mortality.

Screening for a range of chronic and infectious disease is a major part of general practice. This includes major public health concerns such as sexually transmitted infections, cancers (eg, cervical, breast, colorectal and prostate), heart disease and mental illness.

Many of these conditions require sensitive handling and patients have confidence in the advice provided by their GP. This means there are substantial opportunities for GPs to further increase awareness among their patients about disease risks, the development and management of chronic conditions and the problems of substance use. Professional advice from a GP has been shown to be effective in motivating people to initiate appropriate behavioural and lifestyle changes.

It is important to effectively use GPs to tackle public health concerns. This can best be achieved by further strengthening the training and support provided to GPs to ensure that they can play their role in broader public health campaigns, and establishing appropriate referral pathways that can be used by GPs to refer their patients to relevant community services and other health providers with specific expertise in these areas.

Research into best practice primary care delivery

There are shortcomings in primary health care research nationally and internationally, in terms of both quality and quantity. A survey of public expenditure on primary care research in Australia, New Zealand, the United Kingdom and the Netherlands, found that the average was less than

\$1.50 per capita per annum, in contrast to the international average expenditure on health and medical research of \$28 per capita per annum²².

The National Health and Medical Research Council has often been the subject of criticism for its low level of funding for research into health services. Australia needs to lift its expenditure on primary health care research progressively over time. More research will help improve clinical practice and provide an evidence base to improve the delivery of primary care services.

Over time, through appropriate research, it may be possible to develop accountability benchmarks that could improve patient care – provided these benchmarks focus on getting the best outcome for the patient, not simply meeting certain targets for service delivery.

Social support and infrastructure

Delivering improved health care outcomes is not just about building a sustainable model of primary health care services. Though GPs provide world-class primary care services, social infrastructure and support are also vital to ensuring high quality health care outcomes – particularly for disadvantaged groups.

A fair safety net, accommodation, effective transport links, education and community support services all have a positive impact on people's health. Though the Government's focus on improving primary health care delivery is welcome, it must also acknowledge its responsibility to invest in the social determinants of health – in particular, education, housing, physical infrastructure and economic development.

RECOMMENDATIONS

The AMA acknowledges that change and innovation in primary health care is important for the delivery of sustainable, high quality services to patients. GPs will continue to lead the way and this blueprint demonstrates the AMA's commitment to implementing appropriate reforms that deliver benefits for patients. In summary, this blueprint recommends that:

1. Primary care reforms must build on the existing GP led model of primary health care, which is a proven model that delivers high quality, cost-effective outcomes for patients.
2. Primary care reforms must ensure patients continue to have a right to a diagnosis by a medical practitioner.
3. While reform is important, it must not come at the expense of building the capacity of the general practice workforce. The Commonwealth must support additional training places in general practice for:
 - i. medical students,
 - ii. prevocational doctors, and
 - iii. general practice registrars.
4. International medical graduates should be provided with more professional support including access to relevant training programs and mentoring. They and their families should also be given access to basic services that are currently denied to them including Medicare and public education.
5. The Commonwealth should work with the medical profession to reform GP consultation items in Medicare Benefits Schedule so that:
 - i. it supports longer patient consultations and supports GPs to engage in more preventative health care activities,
 - ii. the paperwork associated with chronic disease and preventative health items is significantly reduced, and
 - iii. a more appropriate indexation formula is applied to patient rebates so that they keep up with the rising costs of health care delivery.
6. Within the GP coordinated model, reforms need to give support to the greater involvement of nurses and allied health professionals in the care of patients. This can be achieved by:
 - i. making GP practice nurse incentives available to all practices,
 - ii. expanding Medicare funding to support a broader range of work undertaken by GP practice nurses in areas such as the management of obesity, blood pressure, diabetes, complex and chronic disease and preventative screening,
 - iii. introducing streamlined arrangements that allow GPs to refer patients to other primary care services, based on an appropriate assessment of clinical need rather than prescriptive Government guidelines that currently limit access to such services,
 - iv. providing an appropriate funding mechanism to support patients to access GP-referred primary care services. Options could include redeemable vouchers for patients and the development of GP-coordinated chronic care packages (uncapped)', and
 - v. increasing the available number of nurse training places.
7. Government policy should be directed towards:
 - i. supporting GPs by giving them appropriate access to the best available diagnostic tests including the option to refer patients for a Medicare funded MRI scan,
 - ii. the introduction of point of care pathology testing,

- iii. supporting the adoption of information technology in primary care, including high speed broadband,
 - iv. developing information systems that support the coordination of care with other health professionals and the public hospital system, and
 - v. more infrastructure for training GPs in the community.
8. A proportion of the Commonwealth's Health and Hospitals Fund should be specifically allocated to allow general practices to apply for funding grants that would support them to enhance the services they can offer to the local community. This will support the further development of infrastructure and expansion of existing models of multi disciplinary practices, which may help improve access to primary health care services.
9. The Commonwealth should fund a robust package of incentives to support the recruitment and retention of doctors in regional, rural and remote Australia – taking into account the isolation associated with practising in these areas as well as the need for doctors with relevant advanced skills.
10. In areas where it is not possible to sustain a local GP, properly-funded and appropriate support must be in place to ensure that other health professionals working in these areas such as remote area nurses can deliver good quality care. This includes IT and obligatory decision-making protocols that ensure remote access to advice and support from a medical practitioner is available.
11. In those rural and remote communities where it is not be possible for patients to access a GP in order to have a prescription written, properly funded, appropriate GP-supervised arrangements must be developed to allow patients to have access to the medications that they need in a reasonable clinical timeframe.
12. Aged care accreditation standards need to include requirements that ensure residents of aged care facilities have appropriate access to medical care by GPs and other medical practitioners. This would ensure that RACFs worked closely with GPs to make sure that residents receive the quality of medical care that they need.
13. Australia must work more effectively to close the gap in life expectancy between Indigenous and non-Indigenous Australians. We can make significant progress towards this goal by strengthening primary health care services. In relation to primary health care services, the AMA believes that there should be:
 - i. an immediate investment of around \$500 million a year towards building effective primary care services for Indigenous Australians,
 - ii. a commitment to increasing the number of health professionals from Indigenous backgrounds, and
 - iii. a requirement for mainstream services to focus current resources to improve health outcomes for Indigenous peoples.
14. The Government should establish a benchmark for paperwork in relation to overall compliance with government programs and regulations – which should be set no higher than 5% of a GP's overall time. When the Government considers new regulations or program requirements, it should be required to review existing regulations and requirements so that a corresponding compliance burden is relieved to ensure that the majority of doctors' time is spent on face-to-face patient care.
15. The role general practice can play in the roll-out of specific public health programs needs to be much better recognised. Professional advice from a GP has been shown to be effective in motivating people to initiate appropriate behavioural and lifestyle changes. To support

GPs to do more in this area, the following needs to be in place:

- i. appropriate funding arrangements that support the Government's objectives in areas such as immunisation,
 - ii. further strengthening the training and support provided to GPs,
 - iii. appropriate referral pathways that can be used by GPs to refer their patients to relevant community services and other health providers with specific expertise in these areas, and
 - iv. appropriate links between public health programs and general practice.
16. The Commonwealth needs to lift its expenditure on primary health care research progressively over time. More research will help improve clinical practice and provide an evidence base to improve the delivery of primary care services. Through appropriate research it may be possible to develop accountability benchmarks for primary health care services that could improve patient care – provided these benchmarks focus on getting the best outcome for the patient, not simply meeting certain targets for service delivery.

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AMA

AMA Submission: Preventative Health Taskforce
Australia The Healthiest Country

December 2008

Introduction

As the peak professional organisation representing medical practitioners in Australia, the AMA welcomes the opportunity to respond to the options for prevention of obesity, smoking and harmful alcohol use that are explored in the National Preventative Health Taskforce discussion paper – *Australia: The Healthiest Country by 2020*.

Medical practitioners engage in high quality health prevention and preventative medicine every time they consult with their patients. Prevention is an integral part of medical care, and has been since the advent of modern medicine. The AMA's response to the Taskforce is therefore informed by a deep understanding of the factors that will contribute to successful health prevention, at both an individual level, community and national level.

Doctors are also at the front line of acute care and treatment, addressing urgent medical needs in a health system with finite resources. The AMA recognises the place of prevention in Australia's health system. It also recognises the importance of a strong commitment to the resourcing of acute care and treatment. The Taskforce proposes a decade long investment in the prevention of obesity, alcohol misuse and smoking. While this is important, this must not come at the expense of treatment and acute care needs. The AMA believes that when the issue is the allocation of scarce health resources, the Taskforce's proposed 10 year investment in prevention must be a balanced one.

The Taskforce considers proposals for prevention at a population-based level and at the level of individual interactions in primary care settings. This submission comments on both, with a particular focus on the latter. The AMA is heartened that a great many of the population-level preventative measures that the Taskforce endorses are ones that have been advocated by the AMA for some time. There are still some gaps, however, and this submission includes recommendations as to how they should be addressed.

The AMA's response to the Taskforce begins with the role of doctors in health prevention, and takes two facts as its starting point:

- (i) health prevention and preventative medicine are already integrated into the medical care provided by doctors, and
- (ii) among the health professionals and service providers that may contribute to health prevention in the primary care context, doctors make a central and unique contribution.

Against this background, the AMA believes that the key issue for the Taskforce is how best to support doctors in their preventative efforts in the target areas of smoking, obesity and alcohol misuse.

The AMA fully supports the aspirations expressed in *Australia: The Healthiest Country by 2020*. Achieving them will demand a careful resource balance between prevention and care. However the balance is struck, the medical profession will be central to the solution.

Prevention in Medical Practice

The AMA believes that a comprehensive and effective national prevention strategy should place particular importance on medical practice. Doctors are multi-skilled and highly trained professionals. For example, general practitioners are the most highly trained general health professional, with a minimum of 10 to 15 years training, and have expertise in managing patients with multiple conditions. Doctors command a high level of respect and credibility in the eyes of their patients and the public, and provide high level health and medical care to all groups in society. About 88% of all Australians visit a general practitioner at least once a year,¹ giving doctors significant opportunities to address the health risks and medical problems of a very large proportion of the Australian population.

Doctors provide long-term and continuous care to many of their patients, and “often . . . develop an ongoing relationship and rapport . . . which can lead to an increased sense of respect and trust.”² They are not only aware of their patients’ medical conditions and concerns, but also very often the circumstances of their lives, and that of their families. These factors all contribute to making doctors pre-eminent in identifying the presence of risks to individuals’ health, and the particular factors in their lives that contributing to those risks.

Prevention and Doctor-Patient Consultations

Doctors already engage in preventative medicine. An estimated 29.7% of all clinical treatments provided by general practitioners (GPs) in 2007-08 involved types of health advice, education and counselling that could be considered preventative.³ In each year from 2000 to 2006, nearly 10 million patient encounters involved general practitioner advice and counselling on nutrition, weight and exercise, smoking, lifestyle and alcohol issues.⁴

Doctors, particularly GPs, routinely incorporate prevention into their patient consultations as part of providing comprehensive ‘whole-of-patient’ health and medical care. As a matter of course, doctors will actively screen and be constantly alert to risk factors for chronic conditions. Doctors recognise the importance of providing patients with timely information and advice when risk factors emerge or become apparent. Brief interventions by doctors are among the top five most cost-effective interventions for reducing the harms to young people of alcohol misuse.⁵ Similarly, doctor interventions for smoking are also widely acknowledged as effective.⁶ Doctors also have a sound understanding of when to refer, or recommend further action to their patients, to address risks early.

There is not always a sharp line between primary and secondary prevention, particularly with advice and counselling in relation to smoking, alcohol, exercise and diet.⁷ With regard to these

¹ *General Practice Activity in Australia 2007-08*. C. Bayram. H. Britt, et. al., AIHW, 2008.

² *Alcohol and Other Drug Brief Interventions in Primary Care*, Turning Point Alcohol and Drug Centre, 2008.

³ *General Practice Activity in Australia 2007-08*. C. Bayram. H. Britt, et. al., AIHW, 2008.

⁴ “Preventive Activities in General Practice”, Helena Britt, *GP Review* May 2007.

⁵ *Identifying cost-effective interventions to reduce the burden of harm associated with alcohol misuse in Australia*. Doran, C., Vos, T, et. al., Alcohol Education and Rehabilitation Foundation, 2008

⁶ *Putting prevention into practice. Guidelines for the implementation of prevention in the general practice setting*. Royal Australian College of General Practitioners, 2006.

⁷ “Preventive Activities in General Practice”, Helena Britt, *GP Review* May 2007.

behavioural risks, doctors mostly practise secondary prevention, ie., early intervention to stop emerging problems or harms from becoming worse. Through screening or observation, doctors become aware of the early signs in their individual patients of problematic drinking, or more frequent tobacco use, or excess weight, and they then determine what action or intervention will best help to turn things around early, before they become worse.⁸ Depending on the individual involved and the doctor's judgement, the intervention could take a range of forms – provision of information, advice, motivational counselling, advice on behaviour-management techniques or referral to other medical specialists or allied health professionals.

Doctors mostly engage in secondary prevention because they generally deal with people who already have health problems or concerns, and who may be exhibiting alcohol, smoking or weight risk factors. However doctors can engage in primary prevention regarding these risks during a normal consultation, or a health check, or when people are seeking advice about family members. It may be medically appropriate for a doctor, for example, to advise a pregnant non-drinker and non-smoker not to start drinking or smoking. And it may be appropriate for a doctor to provide this advice to a patient whom the doctor believes is at risk of initiating tobacco use, or excessive or binge drinking, etc..

RECOMMENDATION 1

Any strategic consideration of the place of prevention in the primary care setting must begin with recognition of the following facts:

- Doctors have a central place in the primary care setting;
- Doctors already routinely integrate prevention into their patient consultations, and doctors are integral to prevention in the health system, particularly secondary prevention.

Supporting the Role of Doctors in Prevention

The AMA believes that the key issue regarding primary care in a National Prevention Strategy will not be how doctors can or should adopt new roles or attitudes to prevention. It will be how the role that doctors already play in prevention can be better supported and further strengthened. This applies to the interventions that doctors undertake in consultations. But also, outside the doctor-patient consultation context, there are opportunities for doctors to play an enhanced role in primary prevention regarding smoking, harmful drinking and obesity.

Supporting Doctor-Patient Prevention

The proportion of patients attending general practice who exhibit smoking, alcohol and weight risk factors is significant. During 2007-08, an estimated 19.3% of the GP patient population were daily smokers (with prevalence highest in younger adult patients); 29.3% of GP patients were at-risk drinkers; and 23.5% were obese and 35.3% overweight.⁹ The patient population rates for at-risk drinking have remained the same over the last 10 years, and rates for smoking have decreased.

⁸ For a characterisation of secondary and other forms of prevention in relation to alcohol, tobacco and other drug use, see *Prevention, Alcohol and Other Drugs* Council of Australia, 2003.

⁹ *General Practice Activity in Australia 2007-08*. C. Bayram. H. Britt, et. al., AIHW, 2008.

However, the proportion of people attending GPs who are either overweight or obese has increased significantly since 1998-99.¹⁰

In 2007-08, an estimated 7% of patient encounters with GPs involved advice and counselling specific to smoking, weight or alcohol.¹¹ Given the proportions of the GP patient population noted above that are subject to these risk factors, there are still opportunities to strengthen doctors' provision of prevention specifically relating to smoking, obesity and harmful alcohol use. This is particularly so in the case of overweight and obesity, given significant increases in the proportion of patients who are overweight and obese.¹²

Maximising the role of doctor-patient prevention will be a matter of:

1. minimising the impediments to prevention that can arise in the complex circumstances of modern medical practice;
2. more support and information on best practice strategies, and
3. ensuring that the time required to undertake this work is available, enabled and properly recognised.

Minimising the barriers and impediments to doctor patient prevention

The AMA believes that doctors could significantly enhance their contribution to effective doctor-patient prevention if the following factors were addressed:

There is limited information available to doctors about best practice preventative interventions for smoking, alcohol, and obesity. Targeted screening and 'brief interventions' involving awareness raising and motivational advice and referral, are generally regarded as appropriate early intervention measures for doctor consultations.

There is a credible evidence-base concerning the forms of brief intervention that work in smoking cessation, and how well.¹³ Very brief advice from a GP to quit results in a 2-3% increase in quitters after one year, and this can be increased with active follow-up. The evidence-base for the effectiveness of brief interventions for hazardous alcohol consumption is less well-established, but nonetheless credible. There is evidence that a five minute session of advice about hazardous drinking can produce a significant reduction in alcohol consumption after 9 months (and as great a reduction as longer sessions) with longer term effectiveness sustained through follow-up sessions and continued reinforcement.¹⁴ The evidence-base relating to effective GP obesity interventions is more limited. There is some evidence of short-term effectiveness of brief GP advice (coupled with literature resources) in patients' weight reduction,¹⁵ and indications that GP advice and monitoring of exercise regimes can have some effect.¹⁶ In view of the increasing proportion of the

¹⁰ From 32.8% (1998-99) to 35.4% (2007-08) for overweight, and from 18.3% to 23.9% for obesity. *General Practice Activity in Australia 1998-99 to 2007-08: 10 Year Data Tables*. H. Britt, G. Miller, et. al., AIHW 2008

¹¹ Not necessarily as the main problem or reason for the encounter. *General Practice Activity in Australia 2007-08*. C. Bayram. H. Britt, et. al., AIHW, 2008.

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¹⁴ "The long-term effectiveness of brief interventions for unsafe alcohol consumption: a 10-year follow-up", Wutzke, S., et. al., *Addiction* 97(6), 2002 pp. 665-675.

¹⁵ *Literature Review to Reduce the Burden of Harms from Poor Nutrition, Tobacco Smoking, Physical Inactivity and Alcohol Misuse*, Dalziel, K, et. al., 2006 Centre for Health Economics, Monash University.

¹⁶ See for example, 'Half of patients given exercise prescriptions are more active', *British Medical Journal* 337, 2008.

patient population with excess weight, it is important that the evidence-base for GP obesity interventions is developed, and best practice models are promoted widely across the profession.

The forms of brief intervention that are effective for one risk factor may not be as effective for the others. Nor might the same forms of brief intervention be effective with differing population groups (eg. cultural groups), ages, genders and individual life circumstances (eg., during pregnancy). There is a need for doctors to be updated on an ongoing basis with current evidence and information about these issues.

To be genuinely effective, brief interventions and their associated guidelines and screening protocols, need to be capable of being realistically undertaken in a busy medical practice. Where there is experience, or a perception, on the part of doctors that an intervention or guidelines are impracticable or cannot be readily applied, there will be a reluctance to adopt them.¹⁷ A safeguard against this is to include a ‘reality test process’ when developing any national guidelines regarding interventions, based on input and feedback from practising doctors. The AMA would be happy to facilitate this process through its public health and general practice committees. The uptake of brief interventions can also be enhanced by ‘packaging’ them in a readily accessible and user friendly form for doctors, such as incorporating online reminders and protocols into doctors’ software. Again, a process of ‘road-testing’ these through the AMA before finalising them would help in this regard.

The means by which information about brief interventions is disseminated to doctors is particularly crucial. WHO evidence shows that direct and active approaches to promoting and raising awareness about evidence-based interventions to GPs (such as telephoning, or face to face visits with GPs) were more successful in promoting uptake than indirect and passive approaches such as general mail outs of written information.¹⁸

RECOMMENDATION 2

The uptake and integration of brief interventions into routine medical practice across Australia should be increased through:

- Dissemination of best-practice information to doctors about
 - the most effective forms of brief intervention in a routine clinical setting for each risk factor; and
 - what is effective for different population groups, including prevention ‘target groups’ such as adolescents and youth.
- Significantly increasing the research and evaluation effort to identify brief or other interventions that doctors can apply with good effect in the case of overweight and obesity;
- Involving the AMA, in providing practice-based quality assurance on:
 - the development of prevention guidelines and protocols, to ensure their practicality in a practice context, and

¹⁷ Some studies of clinical guidelines in these risk areas indicate that they are perceived by practitioners as better suited to education and information than to practical application. See, for example, “Diagnosis and management of childhood obesity: A Survey of general practitioners in South West Sydney”, Louise Silversten, et al., *Journal of Paediatrics and Child Health* Vol 44 2008, pp. 622-629.

¹⁸ “A multi-country controlled trial of strategies to promote dissemination and implementation of brief alcohol interventions in primary health care: findings of a WHO collaborative study”, Funk, M., Mundt, M, et. al., *Journal of Studies in Alcohol*, 66 (3), 2005.

- the packaging of information and guidance on conducting brief interventions into printed and on-line resources for doctors' use in clinical settings, together with materials (eg., literature) for patient use.

Taking direct and active approaches to promoting and raising awareness among GPs of evidence-based brief interventions.

Doctors may not necessarily have all the skills to apply best-practice interventions effectively. It is one thing to know what works, it is another to know how to make it work, and when. In many cases, doctors are able to accurately identify patients who are at risk, and to initiate interventions. In other cases however, there may be difficulties in doctors identifying smokers¹⁹ as well as early stage hazardous drinking.²⁰ Even when these difficulties don't occur, doctors may often care for patients who become defensive when issues of smoking or alcohol use are raised, or who see the doctor as judgemental.²¹ Similarly, in cases of overweight and obesity, research shows that a significant proportion of overweight people do not see themselves as overweight, and many mothers do not perceive their overweight children to be different from their peers.²² Often, problems that patients have with smoking, drinking and weight management are caused by, or result in, general emotional difficulties and complex life-circumstances. Highly developed skills are required to initiate and provide brief interventions in a way that recognises patients' readiness to change, and negotiates patient sensitivities, perceptions and experiences. Initial medical training may transfer these skills to a certain extent, but further opportunities for skill development need to be available to doctors to help them deal with some of the more complex doctor-patient issues.

RECOMMENDATION 3

The implementation of brief interventions by doctors could be made more effective through:

- Stronger incorporation into medical training of brief intervention skills and techniques, including counselling and screening techniques;
- Ongoing availability to doctors of continuing professional development in this area and availability of advice to doctors on best-practice prevention screening tools, and counselling skills and techniques.

Information about, and linkages to, appropriate referral services in doctors' local areas is not always available for doctors. Referral by a GP to specialist medical practitioners or allied health professionals can have positive impacts on the effectiveness of interventions for smoking, problematic alcohol use, and weight issues. However, the referral options that are available in a local area may not always be apparent to medical practitioners, particularly referral options to

¹⁹ See, for example, "GPs confidence in and barriers to implementing smoking cessation activities: compared to dentists, dental hygienists and pharmacists", *Australian Journal of Primary Health* 12 (3), 2006, pp. 117-125.

²⁰ See for example, "Obstacles to carrying out brief interventions for heavy drinkers in primary health care: a focus group study", Aalto, M, et. al *Drug and Alcohol Review* 22 (2) 2003; "Identification of and guidance for problem drinking by general medical providers: results from a national survey", D'Amico E J, et. al., *Medical Care* 43 (3), 2005.

²¹ For studies reporting these factors, see, for example, 'In-practice management versus Quitline referral for enhancing smoking cessation in general practice: a cluster randomised trial', 2008 *Family Practice*; "Death, depression and defensive expansion: closing down smoking as an issue for discussion in GP consultations", Pilnick A, and Coleman T., *Social Science and Medicine* 62 (10), pp. 2500-2512; "Factors influencing inquiry about patients' alcohol consumption by primary health care physicians: qualitative semi-structured interview study" Aira, M. et al., *Family Practice* 20 (3), 2003, pp. 270-275

²² "Maternal concern and perceptions of overweight in Australian preschool-aged children", Campbell, M. W, et al., *Medical Journal of Australia* Volume 184, (6), 2006, pp. 274-277.

allied health providers such as dieticians, and certain options for physical activity, eg, gym programs suited to certain ages or abilities. Coordination and information exchange between these services and medical practices to facilitate referral may also not be in place.²³

The desired outcome from most forms of brief intervention for smoking, obesity and harmful alcohol use is for the patient to become sufficiently aware and motivated to self-regulate and manage their own behaviour. In seeking to do this, many people are likely to default to popular schemes and programs in the public domain, particularly for dealing with smoking and weight problems. Many of these are transient schemes, but others tend to maintain their currency (for example, the *Weight Watchers* program, the ‘Atkins Diet’, or more recently the ‘Low GI’ diet). Doctors would be in a better position to advise their patients if they had available to them evidence-based assessments of the major publicly available and promoted programs that many patients may resort to for self-management.

RECOMMENDATION 4

The potential of brief interventions to motivate patients to self-manage their risk behaviour would be enhanced if:

- Information was readily available to medical practices about programs, services and therapists in the local area that would be suitable as referral options, and
- Evidence-based evaluations were conducted of the major publicly available programs for self-managing weight, smoking, and alcohol use, and information on the evaluation outcomes was made readily available to medical practitioners.

Some of the population groups that would most benefit from early intervention are under-represented in patient populations. When it comes to smoking and alcohol use, the behaviours adopted in teenage years can influence the habits of later life. Each successive generation of Australian teenagers is starting to drink at an earlier age than the previous one. This increases their likelihood of continuing to drink in later life, including becoming dependent drinkers.²⁴ Adolescents and teenagers are an important group to target for early intervention. Despite this, and the fact that Australian youth regard health as an issue of high priority in their lives,²⁵ they are not highly represented among the patients who access GPs.²⁶ Whatever the explanations for this, targeted efforts are needed to normalise and reinforce the value of routine doctor attendance among teenagers and young adults. Those efforts could include nation-wide public awareness campaigns targeted at young people, reinforcement in the school setting of the importance of regular medical attendance, and the enhancement of existing youth outreach initiatives like the *Youth Friendly Doctor* program and *Dr Yes*.

Measures to raise public awareness around smoking, alcohol and weight can also be instrumental in breaking down psychological barriers that individuals may have to self-awareness of their risk

²³ Poor linkages with referral options and community-based support services has been identified as an impediment to the uptake of brief interventions in general practices for smoking, alcohol, nutrition and physical activity. See “Implementation of a SNAP intervention in two divisions of general practice: a feasibility study”, Harris, M., et al., *Medical Journal of Australia* Vol. 183 (10), 2005.

²⁴ *Young People and Alcohol*. National Centre for Education and Training in the Addictions, 2008.

²⁵ *National Survey of Young Australians 2008* Mission Australia, 2008.

²⁶ Patients aged 15 to 24 years accounted for only 9.5% of encounters with GPs in 2007-08 *General Practice Activity in Australia 2007-08*. C. Bayram, H. Britt, et. al., AIHW, 2008.

behaviour. With regard to alcohol, a culture which normalises excess drinking, together with limited public information about risky drinking levels, can make it easier for individuals to deny that they are engaging in risks to their health. Public awareness campaigns can go some way to addressing these perceptions, and can help ease the way for doctors to provide effective interventions to patients who may be otherwise reluctant to acknowledge their health risks. The “Measure Up” media campaign and the recent media campaigns around youth alcohol abuse are positive in this regard. Both of these campaigns could be improved through better follow-up links with doctors (see the later discussion).

RECOMMENDATION 5

To improve doctors’ access to important groups and individuals for early intervention, more public awareness and outreach measures should be implemented that are targeted to adolescents, young people and other key groups to encourage them to routinely access doctors’ services.

Realistic, flexible and efficient support for doctor-patient preventative health

In the day to day circumstances of modern, busy medical practices, doctors face many competing demands and priorities, particularly the provision of treatment and acute care to patients who are in immediate need. If doctors’ uptake of preventative interventions for smoking, obesity and alcohol misuse is to be maximised, the time required for doctors to undertake this work needs to be available and properly recognised.

There are options within the existing framework of government rebates to patients for medical services. There is no need to establish a specific prevention benefit item in the MBS, nor a prevention add-on item to standard consultations. Instead, supportive rebate arrangements should be guided by the following principles:

- arrangements should support the provision of effective forms of brief intervention for alcohol, smoking or obesity;
- arrangements should recognise, enable and support an appropriate level of time spent with patients, continuity of care and appropriate follow-up;
- arrangements should minimise red tape, administration and transaction costs;
- arrangements should allow medical practitioners the flexibility to use their practice team skill-set in the most effective way;
- arrangements should not result in the unnecessary addition of new Medicare items.

There is no ‘one-size fits all’ prevention consultation that doctors can provide to all their patients. Individuals will differ in the seriousness of their smoking, alcohol or weight risk. They will differ in their motivational state, readiness to change, level of risk awareness and in how receptive they are to advice. All of these factors are relevant to the level of skill and expertise that will be needed to provide an effective intervention. Individual patients will also differ in whether they need follow-up and continuing advice, support and care. The circumstances under which issues around smoking, alcohol and weight arise in a consultation will differ as well. Sometimes these risk issues will be the key patient concern, and will be raised early in a consultation. At other times, they will

be issues that are addressed incidentally and opportunistically in a consultation that is about another matter, perhaps toward the end.

These facts all point to the need for government to take into account the flexibility needed to ensure that interventions are provided in a way that suits individual patients' circumstances. For the doctor, this might mean extending the consultation time when a health risk is disclosed. It may also mean that a doctor, after assessing a patient's needs and motivation, decides that the patient could be referred by the doctor to a skilled practice nurse in the practice team under the doctor's supervision, who can provide an appropriate brief intervention. Or the doctor may recognise that the patient's needs are complex and require highly developed expertise, knowledge and counselling skills. In this case the doctor could decide to provide the appropriate preventative intervention, with possibly one or more follow-up sessions, or refer to another service or appropriate medical specialist.

Appropriate arrangements for recognising doctors' time should not involve latent disincentives or inefficiencies introduced in the guise of government accountability measures (for example, more than the minimal administrative processes, recording requirements, or other red tape).

The AMA believes that doctor-patient preventative interventions for alcohol, smoking and obesity can be delivered within existing, or appropriately amended, MBS fee-for-service items. However, this will require a better reflection of the time and costs involved in standard and long consultations through better indexation of patient rebates through the MBS, and more flexibility in MBS arrangements to allow patients to access a rebate for services provided by practice nurses undertaking preventative interventions within general practice. The MBS currently recognises practice nurses performing activities like immunisation, wound management, assist with health checks, assist with chronic disease management. The MBS should also recognise that they can assist, where appropriate, in providing brief interventions for patients' alcohol, smoking and weight issues, and follow-up, where appropriate.

It is important that medical practices also be supported to undertake preventative health activities in a variety of ways. While practices generally approach prevention in a one-on-one consultation environment, there is scope for practices to do more. Group educational sessions in a medical practice are an efficient way of helping patients to remain healthy, and should be supported by government.

RECOMMENDATION 6

The most appropriate funding arrangements to support patient rebates for the flexible and efficient provision of preventative interventions in medical practice (initial intervention and any follow-up) will consist of:

- Existing standard and long consultation items with improved indexation of patient rebates through the MBS to properly recognise the time spent on preventative health care;
- Improved MBS arrangements to provide patient rebates for practice nurses conducting brief preventative health interventions or follow-up 'for and on behalf of' the patient's doctor; and
- MBS arrangements that provide patient rebates for services provided by medical practices undertaking group educational and preventative health sessions.

Grants for whole-of-practice preventative care

While the right government rebate arrangements will greatly assist in supporting doctors' delivery of prevention, there are other important prevention measures at a whole-of-practice level that also warrant support. Some of these have been mentioned previously. For example, making educational material and resources on alcohol, smoking, and weight issues available for patients' use. Other potentially effective whole-of-practice prevention measures include:

- employment of 'preventative health coordinators' in medical practices to liaise with GPs, allied health providers, and other community-based providers to ensure the coordination of preventative care and pathways for patients;²⁷
- mail or phone-based outreach from medical practices to patients who may be at risk, or scheduled for a consultation to discuss the relevant risk factors;
- provision of on-line screening tools in surgery waiting rooms, for patients to fill out routinely while waiting for appointments.²⁸

In addition, individual medical practices may have specific patient population profiles and needs that would benefit from special practice-level measures (for example, group counselling programs for weight management among an elderly patient population). Grant funding should be available to medical practices for practice-level prevention measures, and for practices to develop special initiatives and programs that are specific to their patients' prevention needs. It is important that this support should involve minimal red-tape and administrative costs, unlike PIP payments.

RECOMMENDATION 7

Grant programmes for general practices should be established to support the development and implementation of whole-of-practice prevention measures and programs. These arrangements should involve a minimum of administrative and transaction costs for doctors and medical practices, and should be as available to smaller rural and regional practices as to others.

Doctors Supporting Primary Prevention Beyond the Consultation Context

There are opportunities outside of the patient consultation context where medical professionals can play an effective role in primary prevention.

Doctors are trusted, and their advice has credibility among the public. This suggests that preventative health messages in public media and education campaigns will be reinforced if provided by doctors or endorsed by a doctors' professional association, such as the AMA. In this way, the public could be assured that the campaigns are evidence-based. Similarly, media and public education campaigns such as the 'Measure Up' campaign or the recent alcohol and young people media advertising campaign, would have greater preventative effect, if part of the message being conveyed is that concerned people should contact their doctor for further advice.

²⁷ *Putting prevention into practice*, Royal Australian College of General Practitioners, 2006. This possible measure is based on the existing clinical coordinator role, and would include other possible activities such as development and implementation of prevention plans, education of practice team members, and patient follow-up.

²⁸ See, for example, "Computerised screening for hazardous drinking in primary care", Kypros Kypri, et al., *The New Zealand Medical Journal* Vol. 118, No 1224, 2005, pp. 1-10.

There are already certain doctor ‘outreach’ initiatives that would be very effective vehicles for primary prevention regarding alcohol, smoking and obesity, were they to be extended. For example, the *Dr Yes* and *Youth Friendly Doctor* programs involve doctors or medical students visiting schools to provide information and advice about a range of health issues relevant to young people, including the risks of alcohol, smoking and weight issues. Other doctors routinely visit locations frequented by at-risk groups who may not regularly visit doctors, such as middle aged men, and provide preventative health information and advice. The preventative benefits and potential of these outreach activities could be enhanced if greater support was available to doctors and doctors’ associations doing this.

RECOMMENDATION 8

- The AMA should be invited to quality assure public education and mass media campaigns regarding alcohol, smoking and obesity risks, with a view to the AMA providing professional endorsement of appropriate evidence-based campaigns;
- Public education and mass media campaigns about these risks should recommend, where appropriate, that further advice be sought from a medical practitioner, and
- A grant program should be developed to encourage and support preventative health outreach activities in the general community conducted by individual doctors, medical practices, or doctors’ professional associations.

Population-based Prevention of Obesity, Smoking and Harmful Alcohol Consumption

The AMA believes that strategic, long-term, and properly resourced population-based approaches to prevention can be effective in bringing about reductions in obesity, smoking and harmful alcohol use.

Obesity Prevention

The epidemic of obesity in Australia is sustained by a complex range of social, economic and personal factors that influence how easily individuals can make healthy choices about their diet and physical activity.²⁹ An effective response to this epidemic must be multifaceted in the ways it makes healthier choices more available to people. The AMA believes³⁰ that combating obesity is a shared social responsibility that must engage stakeholders and agencies across all sectors of society. These stakeholders and agencies include Federal, State and local governments, the corporate sector, non-government organizations, the health sector, food industries, the media, employers, schools, community organizations and individuals.

The AMA advocates a national strategic approach to preventing obesity, in which all levels of government set clear goals and targets, and employ policy, regulatory and fiscal instruments to make healthier choices easier for people. As part of such a strategy, the AMA has proposed:

- targeted regulation of food prices and distribution (including through subsidies), to make healthier food options more available and affordable, and unhealthy ones less available and less affordable;
- regulation of food marketing to ban the promotion of unhealthy foods to children, and to ensure that simple and accurate nutrient information about products is available to consumers;
- reduction in the production and sale of energy dense and nutrient poor food products by the food industry (through eg., reducing the calorie density of food items, responsible display and placement of products in retail outlets, etc.);
- national school-based initiatives, where every school's curriculum, physical environment and community relationships are modelled to promote nutritional literacy, healthy dietary choices and physical activity;
- promotion and support for sole breastfeeding of babies in the first six months of life (unless there are medical reasons against this);

²⁹ *Diet, nutrition and prevention of chronic diseases*. World Health Organisation, Geneva, 2003.

³⁰ AMA 2008, *Position Statement on Obesity*.

- incorporation of measures to promote and facilitate physical activity within urban and infrastructure planning regulations;
- adoption by employers of measures to promote and facilitate healthy options in workplaces, and
- funding of a network of local community-based pilot programmes and initiatives to address obesity.

It is encouraging that the AMA's views have been reflected in the overall strategic approach that the National Preventative Health Taskforce takes, and in the particular measures it proposes. The AMA is especially heartened that COAG, at its meeting in November 2008, has agreed on a Health Prevention National Partnership to fund measures including those proposed by the AMA regarding local community initiatives to address obesity, promotion of healthy options in the workplace, and healthy children initiatives in schools.³¹

The AMA also sees as promising the Preventative Health Taskforce proposals regarding:

- targeted social marketing campaigns;
- expansion of the national nutrition and activity survey, and
- the development of a national food strategy for Australia.

The AMA believes that there are also some key respects in which the approach to obesity prevention proposed by the Taskforce could be strengthened.

Overall goals and specific targets

The Taskforce stipulates determinate goals for alcohol prevention and smoking prevention – reducing the prevalence of harmful drinking by 30%, and the prevalence of daily smoking to 9% or less. The proposed goals for obesity prevention – halting and reversing the rise in overweight and obesity – are less specific. It is also problematic that little is indicated in the way of specific targets and objectives tied to the *particular* measures and interventions that are advocated. For example, the target effect at 2020 on fitness activity from increasing tax breaks (at a certain level) for fitness related products, or levels of behavioural change sought from regulating unhealthy food marketing to children.

RECOMMENDATION 9

Overall goals for obesity prevention should be adopted, and specific obesity-related objectives and targets should be identified for the component measures in an obesity prevention strategy.
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Non-regulatory means of leveraging change

Many of the measures proposed by the Taskforce involve new regulation by government. For example, increasing taxes for energy dense foods, regulating the

³¹ COAG Communique 29 November 2008.

amount of trans fats in foods, and banning the advertising of unhealthy food to children. However, a number of proposed measures do not appear to be regulation-based. For example, ‘encourage school communities to support initiatives to enable healthy eating’, ‘encourage employers and workplaces . . .’, ‘facilitate the adoption of consistent town-planning’, and ‘curb inappropriate advertising’. It is unclear by what non-regulatory means these outcomes are to be induced. There is also no systematic justification provided as to when regulatory measures are appropriate, and when other means of achieving compliance will suffice, or what they may be (eg., government partnerships, voluntary codes, etc.).

RECOMMENDATION 10

An obesity prevention strategy should develop a clear conception of the means by which compliance with its component measures is to be secured.

Assignments of responsibility

The Taskforce provides little indication of what measures and outcomes are to be the responsibility of which level of government (federal, state or local). While this may be subject to negotiation under the emerging National Healthcare Agreements, there is still a need to provide a broad delineation as part of the development of an efficient and well coordinated obesity prevention strategy.³²

RECOMMENDATION 11

An obesity prevention strategy should incorporate a framework for assigning policy responsibilities and activities to different levels of government.

Policy priorities and target groups

Some obesity prevention measures may have a greater claim on resources than others. The AMA believes that where obesity prevention over the longer term is the concern, a significant focus should be on children and youth. It is important that this focus includes an emphasis on obesity during pregnancy, given the heightened risks this involves for both mother and child.

RECOMMENDATION 12

A particular focus should be adopted in an obesity prevention strategy on measures for children and youth, including unborn children and pregnant mothers

³² Some have argued this should be a central aspect of a comprehensive policy framework for obesity reduction. See, for example, Sacks, G., Swinburn, B., and Lawrence, M., 2008, “Obesity policy action framework and analysis grids for a comprehensive policy approach to reducing obesity”, *Obesity Reviews*, September 2008.

Data Collection and Research

To be effective in achieving its goals, an obesity prevention strategy will need to incorporate the regular collection of accurate and representative data about changes in prevalence of obesity, including in specific population groups. Data should also be routinely collected about the operation and outcomes of the strategy's initiatives. Strong research programs will also need to be maintained to ensure the strategy is informed by best practice initiatives.

RECOMMENDATION 13

An obesity prevention strategy should incorporate ongoing data collection on obesity levels and the outcomes of initiatives, and also research regarding best practice measures for obesity reduction.

Prevention of Tobacco Use

The AMA has for many years actively campaigned to bring about lower levels of smoking in Australia and improved protection for non-smokers. The AMA is encouraged that the Taskforce has also endorsed many of the views proposed by the AMA regarding tobacco use. Major among these are:

- banning all forms of promotion of tobacco products, including at the point of sale;
- increasing the taxation on tobacco products;
- prohibiting the duty-free sale of tobacco;
- tightening enforcement of legislation prohibiting tobacco sales to minors;
- restrictions on the depiction of smoking in films;
- support for plain/generic packaging of tobacco products;

The AMA also supports the following proposals made by the Taskforce:

- tighter enforcement of legislation to protect against exposure to second-hand smoke;
- the required licensing of retailers to sell tobacco;
- prohibition of the sale of tobacco products from customer operated vending machines;
- prohibition of smoking in cars carrying children;
- requirement to fully disclose tobacco product constituents, additives and emissions; and
- development of effective media and public education campaigns to reduce smoking.

In addition, there are some further issues, measures and proposals to prevent and reduce tobacco use which the Taskforce may wish to consider.

Focus on primary prevention

Despite its stated intention regarding primary prevention of tobacco use, the Taskforce appears to place a greater emphasis on smoking cessation than on discouraging smoking initiation, and halting the progression from experimental to regular smoking.

RECOMMENDATION 14

A strategy for preventing tobacco use should include a strong focus on discouraging smoking initiation, and halting the progression from experimental to regular smoking.

Overall goals and specific targets

The AMA considers it important that a smoking prevention strategy has determinate overall goals, incorporates measures robust enough to achieve these goals, and specifies targets and objectives for each type of proposed measure. The Taskforce has proposed an overall goal of reducing the prevalence of smoking to 9% of the population or less by 2020. Achieving this goal, however, will require particular and intensive efforts to increase cessation among high prevalence groups. While the overall prevalence of daily smoking may be less than 17%, prevalence is 21% or slightly higher among Australians in their 20s, 30s and 40s³³, and is even higher among certain sub-populations.³⁴ The measures proposed by the Taskforce do not sufficiently target these high prevalence groups.

RECOMMENDATION 15

A strategy for preventing tobacco use should include a strong focus on measures targeted to population sub-groups with particularly high smoking rates.

There are also a range of demand reduction and supply control measures that the AMA believes should form part of a national approach to preventing tobacco use.

Demand reduction

Tobacco promotion

The AMA supports the phasing out of all forms of tobacco promotion. This should include all emerging forms of advertising and promotion (eg., electronic and internet).

RECOMMENDATION 16

The Tobacco Advertising Prohibition Act should be reviewed to address any loopholes regarding emerging forms of advertising and promotion (such as internet advertising).

³³ 2007 National Drug Strategy Household Survey. AIHW 2008.

³⁴ Smoking prevalence of 43% has been reported in the Victorian construction industry. Tony LaMontagne, 2007, *Health Protection & Workplace Health Promotion: A Strategy for Addressing Social Gradients in Smoking and Cessation?* McCaughey Centre: VicHealth Centre for the Promotion of Mental Health & Social Wellbeing School of Population Health, University of Melbourne, http://www.mccaugheycentre.unimelb.edu.au/presentations_library/Lamontagne_VH_Nov07.pdf

It is important that graphic warnings be placed on tobacco products and that they remain effective.

RECOMMENDATION 17

Health warnings appearing on tobacco packaging should be changed regularly, and be integrated with media and education campaigns.

Prevention and youth

A major demand reduction focus in primary prevention should be on young people. Given that more than 90% of Australians who smoke begin as teenagers and new users are as young as 14, 13 and even 12 years of age³⁵, it is essential to develop consistent, comprehensive and effective strategies to discourage the uptake of smoking among children and young adults.

RECOMMENDATION 18

- Children's media literacy, and resilience skills should be strengthened through the provision of media literacy and 'life skills training' at age-appropriate levels in school;
- Targeted demand-reduction strategies should be developed for tertiary educational institutions and in workplaces where the employee population is typically teenagers and young adults.

Tobacco pricing

As suggested previously, the AMA believes that price signals can affect consumer demand.

RECOMMENDATION 19

Taxes should be applied to increase the price of tobacco by 5% each year.

Supply control

Retail Licensing

The degree to which tobacco products are available through retail outlets contributes significantly to tobacco related harms. Potential sales outlets should be reduced.

RECOMMENDATION 20

- There should be a phased reduction in the number of retail outlets, and
- The distribution of tobacco products for promotional purposes, and the sale of tobacco products via the internet and from customer operated vending machines should be prohibited.

³⁵ *National Tobacco Strategy 2004-2009*, p.10 at [http://www.health.gov.au/internet/main/publishing.nsf/Content/E955EA2B5D178432CA256FD30017A522/\\$File/tobccstrat2.pdf](http://www.health.gov.au/internet/main/publishing.nsf/Content/E955EA2B5D178432CA256FD30017A522/$File/tobccstrat2.pdf).

Current regulations make it difficult to prohibit the importation to Australia of specific categories of tobacco product, such as cigarettes with characterising flavours (such as fruit flavours). These flavoured tobacco products have the potential to be attractive to young people.

RECOMMENDATION 21

Regulations should be revised to make it easier to prohibit the importation of tobacco products with characterising flavours.

Information for policy and program development

To ensure that a strategy for preventing tobacco use adopts informed and effective policies and programs, improvements should be made in the collection and analysis of information regarding tobacco use.

RECOMMENDATION 22

- State and Territory-level tobacco sales data should be collected and reported;
- A comprehensive Australian survey which includes information about teenagers should replace the Australian Secondary Schools Alcohol & Drug Survey, and
- Detailed information about tobacco companies' promotional expenditures should be required to be provided to the Australian Government.

The tobacco industry

The costs of tobacco-related harm should not be met entirely by governments and the wider community.

RECOMMENDATION 23

A levy should be imposed on Australian tobacco company profits, and the revenue raised should be used to finance cessation initiatives.

Government support for the tobacco industry should be minimized, as should the potential influence of that industry on political decision-making.

RECOMMENDATION 24

- Government superannuation funds should be prohibited from investing in tobacco companies, and
- Political parties should be prohibited from accepting tobacco company donations in any form.

Prevention of harmful alcohol use

The AMA has for some time advocated a comprehensive set of measures to discourage excessive alcohol consumption, and early onset of drinking, which incorporates:

- volumetric taxation - applying levels of taxation on the sale of alcohol beverages according to the percentage of a beverage's volume that is alcohol;
- legislation and regulation to control the marketing and advertising of alcohol, especially to teenagers and adolescents, and the sponsorship of sporting events by alcohol manufacturers;
- examination of the pricing policies at drinking venues, to ensure that non-alcoholic drinks are not more expensive than alcoholic;
- clear and prominent warnings on alcohol products, and clearly visible 'point of sale' signage in drinking venues showing levels of risky and high risk consumption (translated in terms of standard drinks/glasses);
- carefully devised and targeted media campaigns and school-based education informing of the risks of excessive alcohol consumption;
- examination of the regulations applying to opening hours of licensed premises.

The AMA is heartened to note that the Taskforce has endorsed many of these measures as part of its proposed strategic approach to excess alcohol use. There are further measures that can be undertaken to strengthen that strategic approach.

Managing the physical availability of alcohol

The physical availability of alcohol is an important determinant of alcohol use and misuse.³⁶ For example, increased trading hours for licensed premises have been associated with increased levels of alcohol consumption or alcohol related harm.³⁷ Similarly, there is evidence of a relationship between increases in the numbers of licensed venues and increased levels of violence.³⁸ The AMA believes that the impact of regulations relating to the positioning and opening hours of licensed premises needs to be closely examined. This is particularly so in the context of existing National Competition Policy, which supports competition in the industry which could in turn lead to increases in newly licensed premises and extensions of trading hours.

RECOMMENDATION 25

National Competition Policy should be reviewed to consider the merit of exempting regulations relating to the licensing of premises to supply alcohol.

³⁶ *Alcohol misuse: tackling the UK epidemic*. British Medical Association. 2008

³⁷ *Restrictions on the Sale and Supply of Alcohol: Evidence and Outcomes*. National Drug Research Institute, Curtin University of Technology 2007

³⁸ *Restrictions on the Sale and Supply of Alcohol: Evidence and Outcomes*. National Drug Research Institute, Curtin University of Technology 2007

90% of 18-24 year olds have drinking patterns that place them at high risk of acute harm.³⁹ The AMA believes it is also important to consider options to address the supply of alcohol to consumers under the minimum purchase age. For example, the recently introduced NSW secondary supply law makes it an offence to supply alcohol to minors in a private home without the direct approval of a parent or guardian. There may be other regulatory and non-regulatory means of controlling the supply of alcohol to underage people.

RECOMMENDATION 26

Regulatory and non-regulatory options to control the supply of alcohol to underage people should be explored and evaluated.

Managing the economic availability of alcohol

Taxation is a broad policy instrument that is cost effective and likely to impact on overall consumption levels through influences on product prices.⁴⁰

RECOMMENDATION 27

An effective way to shift consumer preferences to lower alcohol beverages is to ensure that beverage prices reflect alcohol content. This can be achieved through uniform application of 'volumetric' taxation on the sale of alcohol beverages according to the percentage of a beverage's volume that is alcohol.

Improved Enforcement of Current Legislative and Regulatory Measures.

The AMA believes that retailers have a special responsibility to reduce the incidence and consequences of excessive alcohol consumption, particularly 'binge' drinking and the unlawful supply of alcohol to teenagers.

RECOMMENDATION 28

- There should be mandatory responsible service of alcohol programs to facilitate the training of licensees, managers, and industry staff in appropriate serving practices and refusal of services to intoxicated or under-aged customers, and
- Venues should be required to adopt appropriate oversighting and enforcement of responsible service practices.

³⁹ Bonomo YA, Bowes G, Coffey C et al. "Teenage drinking and the onset of alcohol dependence: a cohort study over seven years" *Addict* 99, 2004, pp.1520-8

⁴⁰ Doran C, Vos T, Cobiac L et al. *Identifying cost effective interventions to reduce the burden of harm associated with alcohol misuse in Australia*. Alcohol Education and Rehabilitation Foundation, 2008

Data and evaluation

The AMA believes that there is a clear need for improved availability of data on alcohol consumption and harms. The World Health Organisation has recommended that public health monitoring of alcohol use should include credible estimates of per capita alcohol consumption derived from sales data in addition to well conducted population surveys of drinking patterns.⁴¹ Local level sales data could be used to evaluate the effectiveness of local community initiatives. State level data can be used to evaluate broader strategies such as lockouts, tax increases and community based restrictions.

RECOMMENDATION 29

The collection of alcohol sales data should be significantly improved in order to evaluate programs, monitor behavioural change and determine levels of alcohol related harm.

⁴¹ *International guide for monitoring alcohol consumption related harm*. Geneva: WHO 2000.

Prevention of Obesity, Smoking and Harmful Alcohol Use Among Indigenous People.

A major challenge for a National Preventative Health Strategy will be to address the very significant levels of chronic disease that many Indigenous Australians experience as a result of high levels of smoking, alcohol misuse and obesity.

As a member of the HREOC Steering Committee for Indigenous Health Equality, the AMA holds the view that enduring reductions in the prevalence of these risk factors can only be achieved through sustained improvements in the access of Indigenous people to high quality, comprehensive primary care. Access to medical practitioners is especially important. The observations made earlier in this submission about the significant preventative role played by doctors apply equally in the context of Indigenous health.

In seeking to reduce the prevalence of smoking, alcohol misuse and obesity among Indigenous people, it is important to set appropriate targets. The AMA supports the targets for closing the gap in life expectancy between Indigenous and non-Indigenous Australians that are outlined in *Close the Gap – National Indigenous Health Equality Targets*.⁴² Of particular relevance to alcohol, smoking and weight risks are the following key targets:

- the rate of smoking in Indigenous population be reduced to that of the non-Indigenous population by 2020;
- 90% of Indigenous families to have access to a standard healthy food basket at the cost of less than 25% of their available income, within 10 years;
- the per capita rate of alcohol consumption in the Indigenous population to be reduced to the national average by 2020.

As non-Indigenous prevalence rates for these risks will hopefully reduce over time, these targets for Indigenous outcomes should also.

RECOMMENDATION 30

The National Preventative Health Strategy should incorporate relevant prevention and risk-reduction targets detailed in *Close the Gap – National Indigenous Health Equality Targets*, and should adopt appropriate measures to achieve those targets.

The AMA welcomes the recent COAG agreement to an Indigenous Health National Partnership, which will contribute a total of \$1.6 billion over 4 years for programs including those to reduce smoking rates, improve uptake of MBS funded primary care services and health checks by Indigenous people, expand the primary care workforce, and establish lifestyle modification programs to manage lifestyle risk factors.

⁴² Steering Committee for Indigenous Health Equality, 2008.