

Australian Medical Association
Pre-Budget Submission
2016-17



AMA

Health – the best investment that governments can make

INTRODUCTION



Commonwealth must not retreat from health responsibility

When the Government appointed Sussan Ley as Health Minister in December 2014, it was her job to take the heat out of the then raging co-payment debate – to consult and to keep things calm.

It worked. A month later, on 15 January 2015, the co-payment was gone – dead, buried, cremated. Or so it seemed.

At the time, the AMA called on the Government to shift its health priorities to chronic disease management, public hospital funding, Commonwealth/State relations, prevention, and medical training.

We stressed to the Government and the community that there was no health funding crisis facing Australia, as claimed by the Government and some commentators.

The foundations of the health system were sound. Health spending was not out of control. Our health system was, and is, the envy of the world.

It is not perfect, but the foundations - the balance between public and private, universality, the defined roles for the Commonwealth and the States, and high standards - lead to long life expectancy and good health outcomes, and continue to underpin a healthy nation.

The problem for the Government was that the damage from the 2014-15 Budget would not go away. The quest for significant savings in the health budget had come to a sudden halt with the demise of the co-payment package.

A change of strategy came in the 2015 Budget with the announcement of the Review of the Medicare Benefits Schedule (MBS) and the Primary Health Care Review.

While welcoming the reviews and offering willing AMA participation, we let it be known from the beginning that the AMA would not support a process that was primarily about cost cutting and Budget savings.

Despite assurances from the Minister, all the rhetoric around the reviews has been about removing items, not introducing new items as well, as had been agreed at the outset.

There was unanimity around building a modern MBS that reflects modern medical practice. That unanimity is now frayed.

Last October, the Minister announced a review of the private health insurance sector. This came after months of inappropriate behaviour by some insurers in their negotiations with private hospitals, and questions being raised about the value of many private health policies, with more services being taken off existing exclusion policies.

Meanwhile, the private health insurers (PHIs) continued pushing for a greater role in primary care.

In November, the Government released its-long delayed response to the mental health review. This virtually amounted to the Government allocating funding to Primary Health Networks to be distributed to various care providers and services of their choosing at the local level.

There is still scant detail, and only a small number of PHNs operating at an efficient level, so question marks remain over this strategy, especially given the lack of commitment to a key role for GPs.

The worry is that the mental health approach may be a signal for what is to come with the Primary Health Care Review. The proposed hospital benefit plan in the Reform of the Federation Discussion Paper is also a worrying sign.

In the December MYEFO Statement, the Government announced significant cuts to bulk billing incentives for pathology and imaging. This was completely unexpected, and without consultation. The co-payment had risen from the grave.

So, how is the health landscape looking in 2016?

We have seen active demonising of doctors in the MBS review process, and a clear plan to cut costs.

We have seen a willingness for PHIs to play a more active role in all areas of the health system – despite inappropriate behaviour and lower value products for patients.

We have seen strong indicators of a Government pursuing a US-style managed care system.

And we have seen signs of the Commonwealth retreating from its core responsibilities in funding public hospitals and other health services.

The Government is on a path of funding cuts and shifting costs to patients. This is not good for the Australian health system or the health of Australians.

In this pre-budget submission, the AMA is urging the Government to change tack ... before it is too late.

There is an urgent need to put the focus back on the strong foundations of the health system, foundations that have served well for decades, and which have made the Australian health system one of the best in the world, and the health of Australians among the best in the world.

We need a strong balance between the public and private systems, properly funded public hospitals, strong investment in general practice, and a priority put on prevention.

Above all, we need a health system built on modern health policies, not outdated economic policies designed only to improve the bottom line.



Professor Brian Owler
President

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1**MBS INDEXATION**

Medicare was never designed to cover all the costs of medical services. In 1984-85, Medicare rebates covered 90.3 per cent of medical fees.

But since 1985, annual indexation of Medicare Benefits Schedule (MBS) fees has been below the market indices that have a direct impact on the cost of providing medical services – the Labour Price Index and the Consumer Price Index.

Today, there is a glaring gap between the Medicare rebate and the cost of providing medical services. In 2014-15, Medicare rebates covered 78 per cent of medical fees.

The decision by the Government to not index the MBS for four years from 1 June 2014 until 1 June 2018 will further increase the gap between patients' Medicare rebates and medical fees. There will be a compounding effect forever more, on top of the Government's estimated savings of \$1.8 billion over the four years of the freeze.

AMA POSITION

The Medicare arrangements must ensure that the sickest patients have financial support to meet their health care costs. The Government must:

- **immediately index MBS patient rebates; and**
- **lift future indexation of patient rebates to levels that are higher and are set more realistically, to achieve a slowdown in patient out-of-pocket medical expenses.**

2

PUBLIC HOSPITALS

Public hospitals are facing a funding crisis that has been created by the political process and political decisions.

The 2014-15 Budget decision by the Commonwealth Government to restrict growth in its funding of public hospitals to indexation and population growth from 1 July 2017 has been estimated to limit growth to 1.7 per cent in real terms over the next eight years.

This has forced a political debate on taxation so that State and Territory governments can meet the shortfall.

The Consumer Price Index measures changes in the prices faced by households only, and is not an appropriate measure of increases in hospital costs. Increasing funding on the basis of population growth does not address cost increases associated with changing demographics of populations in State and Territories.

AMA POSITION

Commonwealth funding for public hospitals must at a minimum include adequate provision for population growth and demographic change, and provision for annual indexation at a rate that is relevant and appropriate to the health goods and services costs incurred by hospitals.

3**FEDERATION REFORM**

The health reform options released by Government as part of the Reform of the Federation process are insufficiently defined to assess their likely impact on healthcare delivery and healthcare providers.

At the same time, the reviews of the MBS and private health insurance are being undertaken in the absence of any vision for Australia's healthcare system, and are shaping up to position the Commonwealth to withdraw from being a direct payer of services.

AMA POSITION

Commonwealth, State and Territory Governments should develop improved health reform options in collaboration with the AMA and other health stakeholders that:

- **focus on the achievement of a better health system with sufficient resources before considering the best split of roles and responsibilities between different levels of government;**
- **explicitly address the role of the private sector and private healthcare providers in the delivery of healthcare, including delivery of publicly funded healthcare;**
- **ensure equity of access to health services across the States and Territories of Australia;**
- **recognise that the funding and provision of healthcare will always involve Commonwealth and State/Territory Governments to some degree, given that policies and performance in one sector, such as primary care, have direct impacts on other sectors, such as acute care; and**
- **give priority to developing effective mechanisms for coordination and cooperation across governments in consultation with health stakeholders including the AMA.**

4**EFFICIENT MEDICARE CLAIMING**

As the gap between Medicare rebates and medical fees widens, particularly with the Government's four-year indexation freeze on Medicare rebates and the removal of bulk billing incentives for pathology and diagnostic imaging services, more services will be patient billed, and patients will have to pay the full cost of their medical care upfront.

The immediate financial impact of this can be lessened if patients could pay only the gap at the time of the service, and have their Medicare rebate paid directly to the provider of the medical service.

The Medicare Online system supports bulk bill and patient claiming, with practice management software allowing medical practices to lodge patient claims via a secure internet connection for the rebate to be paid into the patient's bank account.

The Electronic Claim Lodgement and Information Processing Service Environment (ECLIPSE) is an extension of Medicare Online claiming, which lets private hospital patients pay only the gap.

All that is needed is a legislative change to allow Medicare rebates for all patient billed services to be paid directly to the provider.

AMA POSITION

Patients should be given the right to assign their Medicare benefit direct to the service provider regardless of the existence or not of a patient gap.

5**INDIGENOUS HEALTH**

The gap in health and life expectancy between Aboriginal and Torres Strait Islander people and other Australians is still considerable, despite the commitment to closing the gap.

The AMA recognises the early progress that is being made to close the gap, particularly in reducing early childhood mortality rates, and in addressing major risk factors for chronic disease, such as smoking. However, to maintain this momentum for the long term, the Government must improve resourcing for culturally appropriate primary health care for Aboriginal and Torres Strait Islander people, and the health workforce.

Despite recent health gains for Aboriginal and Torres Strait Islander people, progress is slow and much more needs to be done. A life expectancy gap of around ten years remains between Aboriginal and Torres Strait Islander people and other Australians, with recent data suggesting that Indigenous people experience stubbornly high levels of treatable and preventable conditions, high levels of chronic conditions at comparatively young ages, high levels of undetected and untreated chronic conditions, and higher rates of co-morbidity in chronic disease. This is completely unacceptable.

It is also not credible that Australia, one of the world's wealthiest nations, cannot address health and social justice issues affecting just three per cent of its citizens. The Government must deliver effective, high quality, appropriate and affordable health care for Aboriginal and Torres Strait Islander people, and develop and implement tangible strategies to address social inequalities and determinants of health. Without this, the health gap between Indigenous and non-Indigenous Australians will remain wide and intractable.

AMA POSITION

The Government must strengthen its investment in Aboriginal and Torres Strait Islander health. This must include:

- **correcting the under-funding of Aboriginal and Torres Strait Islander health services;**
- **establishing new or strengthening existing programs to address preventable health conditions that are known to have a significant impact on the health of Aboriginal and Torres Strait Islander people such as cardiovascular diseases (including rheumatic fever and rheumatic heart disease), diabetes, kidney disease, and blindness;**
- **increasing investment in Aboriginal and Torres Strait Islander community controlled health organisations. Such investment must support services to build their capacity and be sustainable over the long term;**

INDIGENOUS HEALTH

- **developing systemic linkages between Aboriginal and Torres Strait Islander community controlled health organisations and mainstream health services to ensure high quality and culturally safe continuity of care;**
- **identifying areas of poor health and inadequate services for Aboriginal and Torres Strait Islander people and direct funding according to need;**
- **instituting funded, national training programs to support more Aboriginal and Torres Strait Islander people to become health professionals to address the shortfall of Indigenous people in the health workforce;**
- **implementing measures to increase Aboriginal and Torres Strait Islander people's access to primary health care and medical specialist services;**
- **adopting a justice reinvestment approach to health by funding services to divert Aboriginal and Torres Strait Islander people from prison, given the strong link between health and incarceration; and**
- **appropriately resource the National Aboriginal and Torres Strait Islander Health Plan to ensure that actions are met within specified timeframes.**

6**MEDICAL WORKFORCE AND TRAINING**

Successive Federal governments have moved to significantly increase the number of medical school places in response to past workforce shortages.

Increasing the number of medical school places is only one step towards training sufficient doctors to meet health delivery requirements. Following medical school, doctors must still complete many years of postgraduate training before they can enter independent practice. This includes a mandatory internship, a period of prevocational training, and then specialist training in general practice and other medical specialties. Data from the former Health Workforce Australia shows that Australia has sufficient numbers of medical graduates, and we do not need new medical schools or any new medical school places. Instead, we must now focus on ensuring that our future medical workforce matches community need by adopting policies to support improved workforce distribution, as well as increasing the number of postgraduate medical training places, particularly in under-supplied specialty areas.

AMA POSITION

To ensure that the medical workforce meets future community need, the Government must:

- **require the National Medical Training and Advisory Network to complete workforce modelling across all medical specialties by the end of 2018;**
- **establish a Community Residency Program to provide prevocational doctors with access to three month general practice placements, particularly in rural areas;**
- **increase the GP training program intake to 1700 places a year by 2018; and**
- **further expand the Specialist Training Program so that it provides 1400 places per annum by 2018, with priority given to training places in rural settings, specialties that are under-supplied as well as generalist roles.**

7

CHRONIC DISEASE

GPs are increasingly treating older patients with more complex needs. The management of chronic and complex disease is a key part of general practice, comprising more than a third of all problems managed. Ensuring patients can access high quality GP care can help keep them out of hospital and help them to enjoy a better quality of life.

A stronger general practice is the key to better health outcomes for patients with chronic and complex disease. While Australia has moved to implement more structured arrangements through Medicare to tackle chronic and complex disease, these arrangements involve too much red tape and adopt a one size fits all model.

AMA POSITION

Reforming Medicare Chronic Disease Management (CDM) items

Current Medicare Benefits Schedule (MBS) arrangements for CDM items are administratively burdensome, do not accord with accepted clinical practice and do not effectively reward or encourage longitudinal care. Provided overall funding is maintained, CDM items could be more effective if restructured to:

- strengthen the role and definition of a patient's usual GP;
- tackle the complex requirements specified in the items so that they reflect modern clinical practice and involve less red tape;
- streamline requirements for referral to allied health services; and
- ensure that the structure of the relevant MBS items encourage longitudinal high quality and appropriate care.

This approach ensures that patients with low to moderate chronic and complex disease would continue to be supported with access to structured care as well as allied health services.

CHRONIC DISEASE

More support for patients with higher levels of clinical need

For those patients with chronic and complex disease who have higher levels of clinical need and are at greater risk of hospitalisation, more pro-active and coordinated funding models are needed.

The Department of Veterans Affairs (DVA) has initiated the Coordinated Veterans Care (CVC) program that provides additional funding support to GPs to provide comprehensive planned and coordinated care to eligible veterans with the support of a practice nurse or community nurse. This program is designed to reduce avoidable hospital admissions and deliver overall savings to the health system.

The AMA supports the development of a broad coordinated care program to tackle chronic and complex disease based on the model of care and funding arrangements developed for the CVC program. The AMA also notes the promotion of the concept of the 'medical home' and recognises that this may have some benefits in the Australian context, provided that general practice retains this role for higher risk patients.

8**PHARMACISTS IN GENERAL PRACTICE**

The costs to the health system associated with overprescribing, medication misuse, adverse drug events (ADEs), and preventable hospital admissions are significant.

A study by Picton and Wright (2013) estimated that rates of patient non-compliance with their medications are as high as 33%, and the Australian Commission on Safety and Quality in Health Care (ACSQHC) estimates there are 230,000 medication related admissions to hospitals annually, costing an estimated \$1.2 billion (Roughead et al, 2013).

Evidence suggests that where pharmacists are integrated within general practices there is greater capacity for interdisciplinary teamwork and the improvement of patient care.

Working in collaboration with GPs in a general practice provides the ideal setting for pharmacists to utilise their complementary skills to ensure the quality use of medicines and the reduction of ADEs in patients. It has also been shown that where there is an integrated pharmacist conducting HMRs the timeliness, uptake and completion of HMRs is increased.

Further, the PINCER trial, conducted in England in 2010, found that pharmacists play a critical role in reducing medication errors in general practice. Study findings demonstrated that pharmacist input and collaboration with GPs reduced the frequency of prescription errors and medicine monitoring errors.

AMA POSITION

The Government should support the employment of non-dispensing pharmacists in general practice through the establishment of a funding model that is structured in the same way as the existing incentive payments provided for nurses working in general practice.

This proposal is backed by an independent analysis from the highly respected Deloitte Access Economics, which shows that the AMA proposal delivers a benefit-cost ratio of 1.56, which means that every \$1 invested in the program generates \$1.56 in savings to the health system.

PHARMACISTS IN GENERAL PRACTICE

The role of the general practice pharmacist would not include dispensing or prescribing medication or issuing repeat prescriptions. The AMA proposes that non-dispensing pharmacists in general practice will focus on medication management, in particular:

- medication management reviews conducted in the practice, an Aboriginal Health Service, the home or a Residential Aged Care Facility (RACF),
- patient medication advice to facilitate increased medication compliance and medication optimisation;
- supporting GP prescribing;
- liaising with outreach services and hospitals when patients with complex medication regimes are discharged from hospital;
- updating GPs on new drugs;
- quality or medication safety audits; and
- developing and managing drug safety monitoring systems.

9**RURAL GP INFRASTRUCTURE GRANTS**

In the 2014-15 Budget, the Government committed \$52.5 million to provide funding for at least 175 rural general practice infrastructure grants of up to \$300,000 each. These grants were promised to assist general practices to expand their facilities with additional consultation rooms and space for teaching medical students and supervising GP registrars.

The roll out of these grants has been plagued by delays and, unlike previous years, limited interest from practices. This appears to have been the result of poor policy design and implementation as well as significant uncertainty over the future of Medicare funding for general practice services, including the Government's unfair freeze on patient rebates.

Previous rounds of infrastructure grant funding have a track record of delivering real results for rural communities, with local practices taking realistic steps to improve patient access to services as well as to support teaching activities. The Australian National Audit Office has also shown that infrastructure funding grants are effective and a good value for money investment.

AMA POSITION

The Government must address delays in the roll out of infrastructure grants as a matter of priority and reassess the program design, including abandoning the requirement for practices to match funding on a dollar for dollar basis. In addition, the Government must commit to funding a further 425 grants over the forward estimates.

10**MEDICAL CARE FOR DEMENTIA, PALLIATIVE CARE AND AGED CARE PATIENTS**

While the issues for people with dementia, those who require palliative care, and older Australians with complex and multiple medical conditions are unique, the needs for medical care and management are relatively similar.

All require the regular attention of doctors, with ongoing management of the patient with the patient's family and carers, mostly outside the doctor's surgery.

Australia's system for funding medical care for these patients is inadequate. It does not appropriately recognise the time that doctors spend assessing patients, organising services, and providing support to the patient's family and carers.

Poor support for medical services in these domains diminishes access and can create unnecessary pressure for, and counter-productive utilisation of, acute services.

Properly funded medical care will help provide Australians with appropriate and quality dementia, palliative and medical care in appropriate settings.

AMA POSITION

Medicare rebates for services provided by doctors and practice nurses must reflect the time and complexity of providing ongoing dementia, palliative and medical care in the community.

Medicare rebates should cover the time that doctors spend:

- **with the patient, assessing and diagnosing their condition and providing medical care;**
- **with the patient's family and carers, to plan and manage the patient's care and treatment; and**
- **organising and coordinating services for the patient.**

11**CLIMATE CHANGE AND HEALTH**

In recent decades, climate change has already contributed to levels of ill health and rising temperatures are likely to increase the risk of heat-related death and illness. Local changes in temperature and rainfall have altered distribution of some water-borne illnesses and disease vectors, and reduced food production for some vulnerable populations.

There is robust evidence that hot weather increases mortality in Australia, with air pollution exacerbating this relationship. These potential changes will impact on the health of Australians, and place increasing and unpredictable demands on Australia's health system.

The direct effects of climate change include injuries and deaths from increased heat stress, floods, fires, drought, and increased frequency of intense storms. Mitigation of climate change can be considered a public health measure, which seeks to prevent its adverse health impacts. Irrespective of climate change, policies to reduce Greenhouse Gas emissions have potentially large public health benefits.

The AMA believes that the consequences of climate change will have serious direct and indirect, observed and projected health impacts both globally and in Australia.

AMA POSITION

The Government should acknowledge and act on Climate Change by addressing the following:

- 1. A National Strategy for Health and Climate Change that brings together regional and national collaboration across all sectors, including a comprehensive and broad reaching adaptation plan to reduce the health impacts of climate change. This National Strategy should incorporate:**
 - **strong communication linkages between hospitals, major medical centres, general practitioners and emergency response agencies, to maximise efficient use of health resources in extreme weather events;**
 - **localised disaster management plans for specific geographical regions that model potential adverse health outcomes in those areas;**
 - **establishment of a National Centre for Disease Control (CDC) to coordinate, manage, and address potential threats; provide surveillance of imported communicable diseases and national health emergencies; coordinate and manage programs for immunisation, sexual health, blood-borne viruses, tuberculosis, leprosy, and other mycobacterial diseases;**
 - **nationally coordinated surveillance measures to prevent exotic disease vectors from becoming established in Australia, with focus on diseases in surrounding locales; and**
 - **development of effective interventions to address mental health issues arising from extreme events, including those involving mass casualties and from longer-term changes, including drought.**

CLIMATE CHANGE AND HEALTH

2. Strategies that focus on improvements in energy and combustion efficiency, and transition to non-combustion energy sources, such as solar, wind and wave, which would mutually reduce emissions of health-harming pollutants and climate-altering GHGs;
3. Designing transport systems that promote active transport and reduce use of motorised vehicles, leading to lower GHG emissions and better health through improved air quality and greater physical activity; and
4. Greater education and awareness of the health impacts of climate change and the public health benefits of mitigation and adaptation.

In relation to climate change and human health, the AMA urges the Government to:

- recognise the latest findings of the Intergovernmental Panel on Climate Change (IPCC), the CSIRO and the Bureau of Meteorology regarding the science of climate change, the role of humans, past observations and future projections;
- acknowledge the serious direct and indirect, observed and projected health impacts of climate change both globally and locally;
- acknowledge the groups vulnerable to, and the inequity in the distribution of the health impacts of climate change both within and between countries;
- endorse the Climate Change Authority (CCA) as the source for an Australian carbon budget and emission reduction targets that constitute Australia's fair share of the global mitigation effort;
- promote the health co-benefits of climate change mitigation and adaptation strategies as a public health opportunity, with significant potential to offset some costs associated with addressing climate change;
- initiate assessments of the costs and benefits of climate mitigation and adaptation policies to incorporate the predicted public health benefits accrued from such policies and the public health costs of unmitigated climate change;
- support greater education within the health and emergency services sector, including medical student education, regarding climate change as a health issue; and
- support investment in renewable energy sources given the associated direct health benefits compared with alternatives and indirect benefits of avoided climate change.

12**PREVENTION**

Investing in preventative health measures can reduce the rate of chronic ill-health and improve the health and well-being of all Australians.

Rates of chronic cardiovascular conditions remain high and the number of Australians who are overweight or obese continues to increase. Harmful use of alcohol, illicit drugs, poor food choices and overconsumption, and sedentary behaviour also contribute to cardiovascular conditions and poor health outcomes.

The AMA has strongly supported efforts undertaken by the Commonwealth to reduce smoking rates, however other health prevention initiatives must be supported to address excessive alcohol consumption and related harms such as Fetal Alcohol Spectrum Disorders (FASD), obesity, illicit drug use, and specific gender based health problems.

Successive Commonwealth governments have underinvested in health prevention and early intervention. This is despite the fact that spending upstream on effective prevention and early intervention results in significant downstream cost savings in terms of chronic disease development, its treatment and management, and other costs to the community.

The Government's decision to change arrangements to the Australian National Preventive Health Agency and transfer its functions to the Department of Health, and to terminate the National Partnership Agreement on Preventive Health, has not resulted in any demonstrable efforts to invest in, and address, preventable health issues in Australia.

AMA POSITION

Funding of prevention and early intervention is a sound and fiscally responsible investment in Australia's health system.

The Government must increase investment to properly resource evidence-based approaches to preventive health.

13**METHAMPHETAMINE (ICE)**

Methamphetamine is a synthetic stimulant drug that comes in a number of forms.

In Australia, crystal methamphetamine is currently the favoured form of methamphetamine, followed by the powder form.

Australians who use methamphetamines are reporting more regular and frequent consumption. The incidence of methamphetamine harms, particularly psychosis, increases sharply as a consequence of the quantity consumed.

Methamphetamine psychosis is one of the most damaging health consequences of methamphetamine use.

Acutely, it presents a major safety issue for health care staff and the intoxicated patient and his/her family and friends.

The experience of emergency department physicians is that users represent all walks of life and that smoking or injecting crystal methamphetamine appears to be associated with a significant likelihood of extreme and harmful usage and addiction.

AMA POSITION

The Government must provide:

1. Funding for acute treatment and rehabilitation, including:

- **emergency department staffing should also have a specialist drug liaison officer to engage, support and intervene in patients with acute methamphetamine related illness;**
- **treatment services should reflect the full range of methamphetamine users. This means services providing intensive inpatient support with collaboration between addiction medicine, psychiatric and other specialist oversight, through to less intensive support provided in the community via cognitive, behavioural and motivational interventions; and**
- **all hospitals should have appropriate, rapidly responsive security arrangements and appropriate infrastructure.**

2. Funding for research on methamphetamine use causation, prevention strategies and the best methods of treatment and rehabilitation for methamphetamine dependency;

3. Dedicated health financing to include specific and increased funding for treatment, rehabilitation and support services for drug-addicted patients. Any increase in funding must improve referral systems for methamphetamine affected patients; and

4. A comprehensive and sustained public health education program on the health and social consequences of methamphetamine use is needed to discourage experimentation, normalisation of use and induction of new users.

14

ALCOHOL

The far-reaching impacts of alcohol-related harm is why Australia urgently needs a whole-of-government national strategy to coordinate and drive action to address preventable harms and deaths.

The AMA believes the most effective way to reduce the harms from alcohol, and to address an unhealthy drinking culture and the injuries and deaths caused by the misuse of alcohol, is through a nationally-led strategy of high impact campaigns to change behaviours, backed by effective regulation, and early intervention and treatment.

Following the AMA National Alcohol Summit in 2014, which drew together people from government, community leaders, medical and health experts, police, families of victims, and people who have experienced first-hand myriad harms that arise from alcohol, the AMA has repeatedly called on the federal Government to develop and fund a comprehensive world-leading National Alcohol Strategy.

AMA POSITION

The AMA supports the finalisation of a National Alcohol Strategy that includes:

- **the Federal Government leading a consistent national approach to the supply of, and access to, alcohol;**
- **the development and implementation of effective and sustained advertising and community-led public education campaigns that address the public's understanding of unsafe drinking and the harms of excessive alcohol use. These campaigns should target a range of priority audiences, including young people and pregnant women;**
- **availability of targeted alcohol prevention and treatment services throughout the community, including: GP-led services and referral mechanisms, community-led interventions safe sobering-up facilities, increased availability of addiction medicine specialist services, treatment and detoxification services at all major hospitals, and services for acute alcohol abuse at hospitals with emergency departments;**
- **measures that specifically respond to the particular needs and preferences of Aboriginal and Torres Strait Islander people, and other culturally and linguistically diverse groups known to have higher rates of alcohol consumption;**

ALCOHOL

- development and implementation of statutory regulation of alcohol marketing and promotion, independent of the alcohol and advertising industries, with meaningful sanctions for non-compliance. Particular attention should be paid to sponsorship and promotion in the community and professional sporting industries;
- research, evaluation and data collection to monitor and measure alcohol use and alcohol-related harms, and the effectiveness of different alcohol treatment options. Data collected by government departments and authorities should be readily available to alcohol researchers and program evaluators;
- a review of current alcohol taxation and pricing arrangements and how they can be reformed to discourage harmful drinking; and
- transparent policy development, with sufficient independence to avoid influence from industry.

15

TOBACCO

Tobacco smoking is the largest single preventable cause of death and disease in Australia.

Smoking contributes to more deaths and hospitalisations than alcohol and illicit drug use combined.

Smoking is a major risk factor for coronary heart disease, stroke, peripheral vascular disease, respiratory disease and cancer, accounting for 20-30 per cent of cancer cases.

Smoking rates in Australia have declined over the past few decades, but 16 per cent, or 2.8 million people in Australia, continue to smoke.

Tobacco smoking is contributor to ill-health, it is responsible for 8 per cent of the burden of the burden of disease in Australia.

Each year 15,000 Australians die as a result of tobacco smoking. A large scale Australian study recently found that two in three smokers (1.8 million people) will die as a result of their smoking.

AMA POSITION

The Government must provide:

- **monitoring and policing of the marketing and promotion practices associated with E-cigarettes, and that E-cigarettes should not be sold to anyone aged under 18 years;**
- **ongoing public education and awareness campaigns that seek to deter all people from smoking cigarettes. This national campaign should be complemented by more targeted campaigns for groups that require more specific messages, such as young people, and other groups which are known to have higher rates of smoking. Campaigns should aim to prevent uptake and increase quit attempts;**
- **funding to support the various jurisdictions to pursue more smoke-free environments, recognising that nationally consistent legislation around smoke-free environments are in everyone's best interest. All Australians deserve an opportunity to dine, socialise and work in completely smoke-free situations;**
- **continued targeted research into the most effective methods of smoking cessation, including combinations of cessation approaches. This should include distinct focus on those groups known to have higher rates of smoking;**
- **appropriate funding for doctors who take the time to support their patients through the process of smoking cessation. Such funding recognises that patients require tailored advice, and may require ongoing support to reinforce their decision to quit smoking; and**
- **continued funding for international litigation to fight efforts to undermine Australia's world leading tobacco control measures, including Plain Tobacco Packaging.**

16**OBESITY**

The AMA wants to see a greater emphasis on addressing the growing problem of obesity, especially in children.

Combating obesity demands a whole-of-society approach, requiring collaboration between all levels of government, the non-government sector, the health and food industries, the media, employers, schools and community organisations health and education professionals.

Nutrition too is a serious public health issue for the Australian population, especially for young children and adolescents.

Appropriate nutrition is key to the prevention of malnutrition, overweight and obesity, and is urgently required from health, social and economic perspectives.

The AMA concurs with the WHO position that the school environment is one of the most obvious venues for child and adolescent education on nutrition. It is increasingly recognised that food consumption prior to and during school hours will affect a student's ability to concentrate and learn – hence there are additional reasons for schools to get the nutritional environment right.

If the current levels of overweight and obesity, particularly in children and young people, is not addressed, the AMA believes there will be inherent long term negative economic and social implications for Australian society.

AMA POSITION**The Government must provide:**

- **the development of a national obesity prevention strategy that recognises obesity is a complex problem that has to be addressed through a broad range of measures;**
- **prohibition on the marketing and promotion of junk food and sugary drinks to children, particularly in children's television viewing times, as marketing affects children's consumption and diet related behaviour;**
- **the investigation and funding of a program to improve the nutritional status and nutritional literacy of Aboriginal or Torres Strait Islander women who are assessed to be at risk;**
- **review and promotion of national breastfeeding guidelines;**
- **the use of price signals to encourage consumers to make healthier food and beverage choices; and**
- **continued support of Health Star Rating labelling to improve consumer food choices and to encourage food reformulation, where practical.**

17

PHYSICAL ACTIVITY

Physical inactivity costs the health budget an estimated \$1.5 billion each year, contributes to almost one-quarter of the cardiovascular burden of disease in Australia, and causes an estimated 14,000 deaths each year.

Physical inactivity increases the risk of heart disease, stroke, diabetes and some cancers and is a major contributor to Australia's obesity epidemic, with more than half of all Australian adults overweight or obese.

Widespread and effective participation in physical activity across the population could lead to a reduction in the incidence of hypertension, type 2 diabetes, osteoarthritis, major fractures, bowel cancer, the incidence of heart disease, osteoporosis, low back pain, falls in the elderly, stroke, depression, and dementia.

There's an economic incentive for government: increasing physical activity in Australia by just 10 per cent could lead to cost savings of over \$250 million, and 37 per cent of those savings would be in the health sector.

If physical activity was a drug, it would be listed on the PBS.

AMA POSITION

The Government must provide:

- **a National Physical Activity Strategy that clearly defines practical, prioritised and evaluated measures and national indicators of physical activity participation;**
- **Federal leadership to bring together stakeholders and all tiers of government to boost participation rates in physical activity, especially among those groups known to have low participation rates;**
- **opportunities to work with State and Territory governments to provide structured opportunities for young people to be physically active;**
- **low and no cost opportunities and information about easily accessible participation in physical activity should be promoted by Government; and**
- **active transport measures should be a priority in all transport and infrastructure policies. Many countries have developed innovative ways to provide and promote active transport, and in turn reap the benefits. The Government should be examining these, and applying them to the Australian context.**

18**IMMUNISATION**

Routine infant and child immunisation is a proven, cost effective public health measure that reduces the spread of communicable disease. Immunisation provides a level of protection for the individual receiving the vaccination.

Despite the strong evidence supporting routine childhood immunisation, an increasing number of Australian children are not receiving the recommended vaccines.

This is a major concern leading to the re-emergence of vaccine preventable diseases which may result in life long complications and even death.

All children have the right to be protected from vaccine preventable diseases. This includes infants who are too young to be immunised as well as those infants and children who are medically unable to receive immunisations.

Immunising as many infants and children as possible affords these vulnerable infants and children the protection they deserve.

AMA POSITION

- 1. The AMA believes that every effort should be made to put an end to vaccine preventable disease and death in Australia. As a result, immunisation rates must remain high, across all areas of the country;**
- 2. The AMA supports efforts to increase immunisation rates among children. The benefits of routine childhood immunisation extends from vaccinated children through to the broader community;**
- 3. Any savings generated from the *Social Services Legislation Amendment (No Jab, No Pay) Bill 2015* should be directed towards research and other activities that continue to boost childhood immunisation rates; and**
- 4. Families who decide to engage in a program of catch-up vaccination, in order to access the relevant family payments, may encounter significant cost. As this is a disincentive, programs of catch-up vaccination for children should also be paid for by Government. Common sense indicates that the cost incurred by the Government will be offset by the hospital costs for the management of any associated disease.**