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Investing in the strengths of the health system

All the signs indicate that the Federal Budget to be handed down in May this year will be frugal across the board, with health being no exception.

Economic circumstances around the globe are not strong and the Government will be keen to shore up the Australian economy for what many predict could be hard times ahead.

On top of this, the days of ‘big bang’ health reform are behind us for now. Minority Government at the Federal level and the expected further changing of the guard to Coalition governments at the State level mean that big changes in the way that health services are financed and delivered are now almost impossible to achieve. The ‘once in a generation’ opportunity has passed.

It is important, though, that there is no slippage in the positive reforms that have been reached, and that we can adjust those reforms and policies that have not quite hit the mark.

The AMA wanted more from the COAG Agreement but we acknowledge the significant extra funding from the Commonwealth and the move to activity based funding that has been promised.

The single funding pool is a step in the right direction and there is now greater transparency in the system. The States are now unable to pass the blame for the performance or non-performance of their hospitals.

It is in the primary care area, however, where we seek more consultation and cooperation from the Government.

We note that the Medicare Locals are part of the landscape but we do not accept that the governance model has to stay the same. There must be strong GP leadership and management of Medicare Locals.

The Government must revisit the GP Super Clinics program. We have no problem with the concept where they meet genuine community need, but we have serious concerns in many locations. We cannot support them where they compete with existing GPs delivering exactly the same service.

The AMA believes the money would be better spent through the oversubscribed infrastructure grants program on existing general practices that are already committed to their communities.

We continue to battle for a reversal of cuts to the Better Access program for GP mental health services.

The 2012-13 Federal Budget must ensure that the important pillars of health care – the parts of the health system that work well and which patients and communities rely on – are recognised and funded accordingly.
For the AMA, general practice, public hospitals, and medical training and workforce are at the top of the list.

When people are sick or injured or need ongoing quality health advice, they want to see a GP. When they have been involved in an accident or require surgery, they want the comfort of knowing that quality professional care is available at a properly staffed and resourced hospital. Australia needs both a strong private sector and a well-funded public sector to deliver effective health care.

We need to provide the right care at the right time in the right place. This means that services for aged care, mental health, and chronic disease need appropriate funding and well-targeted policies.

People need to be encouraged to do more about their own health and wellbeing, particularly in regards to obesity, smoking, and alcohol. Preventive health programs must be supported.

The AMA is also urging the Government for action in the key areas of Indigenous Health, Climate Change and Health, Health and Medical Research, and changes to the proposed model for an electronic health record.

The AMA Budget Submission proposes practical and affordable policies that would deliver tangible benefits to patients and local communities around Australia.

We urge the Government to give this Submission serious consideration and we look forward to meaningful engagement and consultation with the Government on health funding and health policy development and implementation.

Dr Steve Hambleton
AMA Federal President
Medical workforce and training

Australia is in a widely acknowledged situation of medical workforce shortage, which is most felt in outer metropolitan and rural/remote areas. In response, the Government has moved to significantly increase the number of medical students. Graduate numbers were 1287 per annum in 2004 and will increase to 3786 per annum in 2014.

Increasing the number of medical school places is only one step towards training sufficient doctors to meet health delivery requirements. We must focus on preserving the quality of medical training that Australia is renowned for, and recognise the need to significantly lift the available number of medical training places beyond medical school.

Graduates go on to complete one to two years of generalist (prevocational) training and then three to eight years of specialty training in one of a range of specialties, including general practice. Increasing the number of medical school places will be ineffective in addressing medical workforce shortages unless there is a coordinated increase in:

- clinical training places for medical students;
- intern and prevocational training places; and
- vocational (specialist) training places.

Some steps have already been taken towards meeting these challenges. In 2008, the Council of Australian Governments (COAG) announced a $1.64 billion package to support undergraduate clinical training for the health workforce. In 2010, the Commonwealth committed $640 million to support a significant expansion in prevocational and vocational GP training positions, as well as additional specialist training positions in the private sector.

However, the above investments will not be enough to ensure that Australia’s future medical graduates can progress through prevocational and vocational training and realise their full potential as medical practitioners. To illustrate the challenge ahead, in 2010 there were 2394 intern places in Australia, which falls well short of the more than 3700 positions that will potentially be needed for domestic and international graduates in 2014. If current rates of expansion continue, there will only be 3200 positions in 2014.
AMA POSITION

In January 2012, Health Workforce Australia will deliver the National Training Plan (NTP) to Health Ministers, which will set out the number of prevocational and vocational medical training positions required to match the increased output of medical schools and enhance the capacity of the health system to meet the community’s needs through until 2025. The implementation of the NTP will require significant funding, planning, and coordination and this will only be delivered if there is support at the highest levels across all governments.

The AMA calls on the Commonwealth, following the finalisation of the NTP, to convene a specific COAG meeting to:

- reach agreement on the number of quality prevocational and vocational medical training places needed, based on the analysis provided by the NTP;
- reach agreement on the implementation of the NTP, including the respective financial contribution of each government;
- agree on improved subsidy arrangements to attract more supervisors to become involved in medical training, including an increase in the subsidies paid to general practices for this purpose;
- agree on robust performance benchmarks to measure achievement against the NTP and COAG commitments, with the Medical Training Review Panel (MTRP) to monitor and report on progress against these targets; and
- commit to the development, in consultation with the profession, of performance benchmarks that would be monitored by the MTRP to ensure that the quality of medical training is sustained.

The costs of providing additional training places will be dependant upon the final recommendations of the NTP.
The capacity of the public hospital system is one of the fundamental foundations for delivering high quality, safe, and accessible health services.

The public hospital system continues to have insufficient capacity to ensure that patients are treated in the emergency department or admitted into hospital within safe, clinically appropriate timeframes. This is despite additional Commonwealth funding in recent years.

The number of public hospital beds per capita, which is the strongest measure of capacity, continues to decline. In 2009-10, only 378 new beds were opened across the country. In 2009-10, the number of public hospital beds per 1000 population (2.6) fell by 3.5 per cent.

The percentage of emergency department patients classified as urgent, who are seen within the recommended 30 minutes, has remained at 64 per cent for two years running.

In 2009-10, the percentage of Category 2 elective surgery patients seen within the clinically recommended time of 90 days (77 per cent) fell by one percentage point. At the same time, the national median waiting time for elective surgery increased by one day to 35 days.

These statistics confirm that fewer beds mean longer waiting times in emergency departments and longer waiting times for elective surgery.

General practitioners experience the capacity problems of the public hospital system when they try to get elderly and medically sick people into public hospitals for treatment. The elective surgery waiting list data hide the actual times that patients are waiting to be treated in the public hospital system. The time that patients wait from when they are referred by their general practitioner to a surgeon for assessment is not counted. It is only after patients have seen the surgeon that they are added to the official waiting list. The publicly available elective surgery waiting list data understate the real time that people wait for elective surgery.

The State and Territory Governments have committed to arrangements that provide greater transparency of the flow of funding to hospitals and on hospital performance. As the managers of the public hospital system, the State and Territory Governments are squarely responsible for ensuring that public hospitals receive sufficient funding so that they have the capacity to meet access and quality targets set by COAG.

Most public hospitals also undertake research and training as part of their normal functions. Ensuring that on the ground research and training is ongoing in public hospitals means that we can continue to improve the care of future patients and to train future generations of medical practitioners.

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1 2008-09 and 2009-10
AMA POSITION

Public hospital beds

The Performance and Accountability Framework\(^2\) should include bed numbers and average bed occupancy rates as critical indicators of public hospital capacity. The National Health Performance Authority should track the bed numbers to ensure that additional Commonwealth funding provided to State and Territory Governments actually results in the opening of new beds.

Elective surgery waiting lists

Public waiting lists must be nationally consistent and provide clear and accurate information about the number of people who have been referred by a general practitioner for assessment, the number of people who are waiting for elective surgery, the length of time people wait, and the number of elective surgeries performed.

Public hospital funding

The goal of hospital funding systems should be to support effective health care services, rather than the cheapest services. A nationally efficient price risks underestimating and oversimplifying the complexity of hospital services across different hospitals and different geographical areas and, therefore, their capacity to meet demand.

The prices for activity based funding and costs for block funding for services provided by public hospitals must cover the reasonable expenses of providing effective, comprehensive, high quality health services including teaching, training, research, service development, and quality improvement.

The National Health Reform Agreement allows State and Territory Governments to pay public hospitals less than the full efficient price determined by the Independent Pricing Authority (clause A65).

The Commonwealth must ensure that State and Territory Governments should be required to publicly report whether they have paid hospitals the full price set by the National Independent Pricing Authority, or the actual amount paid if it is less than the full efficient price, so that it is clear when poor performance is linked to insufficient funding.

Secure funding for research and training in public hospitals

Research and training are integral parts of the role of public hospitals in improving patient care and in training junior doctors. The Government must ensure that:

- there is sufficient funding allocated for research and training undertaken in public hospitals;
- medical practitioners are involved in how this funding is distributed and used at the local level; and
- funding for research and training in public hospitals is linked to transparently reported and independently audited performance indicators.

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\(^2\) National Health Reform Agreement, pgs 44-45, Schedule C
Mental health

The Better Access (to Psychiatrists, Psychologists and General Practitioners) Program was introduced in November 2006 under the COAG National Action Plan on Mental Health 2006-11 in response to low treatment rates for common mental disorders. GPs were recognised as a core part of the general mental health workforce and a key feature of this initiative was the establishment of specific Medicare rebates for patients accessing GP mental health services.

A review of the Better Access Program in 2009 indicated that around 90 per cent of all registered GPs had delivered Better Access services and 85 per cent of these were through the patient’s usual GP or usual general practice, suggesting that care is well coordinated and comprehensive. Better Access has been independently evaluated and shown to be cost effective and delivering good outcomes for patients. Around one million patients each year benefit from GP mental health services under this program.

Changes to the Better Access Program announced by the Government in the 2011-12 Federal Budget have significantly reduced funding for general practice mental health services and allied psychological services.

More than $400 million over five years has been removed from Medicare rebates for patients to access GP mental health services and a further $175 million over five years has been removed from funding for psychological services available under the Better Access Program. The Budget cuts mean that Medicare rebates have been cut by up to 46 per cent, with Medicare funding for these services cut by around 30 per cent over the next five years.

AMA POSITION

The Government’s cuts to mental health funding are having a negative impact on some of the most vulnerable patients in the community. The AMA’s own survey found that 85 per cent of GPs believe that cuts to the Better Access Program will reduce access to care for patients with a mental illness. Initial Medicare Australia statistics also confirm that the number of GP mental health services has fallen since the Government’s cuts came into effect on 1 November 2011.

The AMA calls on the Government to restore funding for the Better Access Program and to work collaboratively with the profession to address those areas where the operation of the Better Access Program can be improved.

Based on the 2011-12 Budget cuts, this measure would cost $517.7 million over four years.
The gap in life expectancy between Aboriginal peoples and Torres Strait Islanders and other Australians is unacceptable. There continue to be high levels of chronic and communicable diseases, and social and emotional health conditions among Aboriginal and Torres Strait Islander communities. There is a limited availability of a health and medical workforce for culturally appropriate primary care services, and a range of social, environmental and economic factors act to entrench health problems. If the gap in life expectancy is to be closed within a generation, further efforts are needed to improve the access of Aboriginal peoples and Torres Strait Islanders to high quality health care.

AMA POSITION

The AMA welcomes the decision by the Federal Government to partner with Aboriginal peoples and Torres Strait Islanders to develop a new National Aboriginal and Torres Strait Islander Health Plan to close the gap.

The Commonwealth should also provide funding for the expansion of the workforce for Aboriginal and Torres Strait Islander health, through additional grants to enhance infrastructure and services, to allow Aboriginal Medical Services to:

- offer mentoring and training in Aboriginal communities to Aboriginal and non-Aboriginal medical students and vocational trainees;
- offer salary and conditions for doctors working in Aboriginal Medical Services that are comparable to those of State salaried doctors; and
- provide suitable accommodation options, so health and medical staff who wish to work in remote locations can be appropriately housed.

The Commonwealth must develop a network of Centres of Excellence in Aboriginal and Torres Strait Islander Health across Australia to act as training and research hubs for medical professionals seeking high quality practical experience and accreditation in Aboriginal and Torres Strait Islander health.

With the right support and access to appropriate health care, Aboriginal peoples and Torres Strait Islanders also have the capacity to develop practical solutions and preventive approaches to some of the health-related problems in their communities. It is important to engage Aboriginal peoples and Torres Strait Islanders in their own healthcare solutions.

This requires the provision of grants of $10 million per annum over 10 years to NGOs and community groups for health-related capacity building in Aboriginal and Torres Strait Islander communities throughout Australia.
Health financing

The Australian health system is a balance between the public and private sectors.

Under Medicare, the Government subsidises private medical services to ensure that they remain affordable for patients.

The private hospital sector now performs 40 per cent of all admissions and 64 per cent of elective surgery in Australia. It is a key part of Medicare and the public hospital system could not survive without it.

Government subsidies for private health insurance premiums and the Extended Medicare Safety Net (EMSN) alleviate the financial pressure faced by many Australians in accessing private hospital treatment and private medical services in the community.

Most out-of-hospital medical services are provided by private medical practitioners and Medicare rebates assist patients with the costs of these services. The real value of Medicare rebates for patients has not kept pace with the increasing cost of running medical practices because successive Governments have failed to index the Medicare schedule fees in line with other indices such as CPI and average weekly earnings.

Instead of increasing Medicare rebates, the EMSN was introduced to assist patients with high out-of-pocket costs for medical services provided out of hospital. The EMSN structure helps share these costs between patients and the Government.

In the year to September 2011, the Labour Price Index increased by 3.77 per cent and the CPI by 3.28 per cent. In contrast, some MBS items were indexed by a very modest 2 per cent and rebates for services provided by non-vocationally registered GPs, and pathology and diagnostic imaging items have not been indexed at all for 12 years.

In addition, the Government has made the following cuts to Medicare rebates since taking office in 2007:

<table>
<thead>
<tr>
<th>Date</th>
<th>Description</th>
<th>Saving</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 July 2009</td>
<td>Pathology</td>
<td>$4.1 million over 4 years</td>
</tr>
<tr>
<td>1 November 2009</td>
<td>Joint injections, coronary angiography and cataract surgery</td>
<td>$70.4 million over 5 years</td>
</tr>
<tr>
<td>1 May 2010</td>
<td>Restructuring health assessment and case conferencing items</td>
<td>$15.5 million over 5 years</td>
</tr>
<tr>
<td>1 November 2011</td>
<td>Better Access Program GP mental health services</td>
<td>$405.9 million over 5 years</td>
</tr>
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Consequently, out-of-pocket costs for patients continue to increase.
In 2009, the Government shifted more of the burden of the costs onto patients by introducing a cap on the total EMSN benefits paid for some medical services.

The savings from capping EMSN benefits have far exceeded the Government’s estimates of $262.3m over the three-year period from July 2009 to June 2012. A report by the Centre for Health and Economic Research and Evaluation (CHERE) released in June 2011 shows that the Government saved $226.8m in 2010 alone.

The Government has shifted nearly $227 million in costs to patients in 2010.

But, more importantly, the caps may be shifting services away from the private sector. The CHERE report says that the number of private obstetric confinements fell by 4 per cent, with the biggest falls occurring in the latter part of 2010.

Access to private out-of-hospital medical services in the community must remain affordable so that patients can seek early medical attention. As well as being detrimental to patients’ health, delayed diagnosis and treatment will simply add to the cost of other parts of the health system.

Practice costs, including employing practice staff and operating expenses such as rent, electricity, computers and professional indemnity insurance, must all be met from the fee charged by the medical practitioner.

Though 80 per cent of GP services are bulk billed, there is cross subsidising by patients who incur a gap, and their gap is increasing. Only 27.2 per cent of specialist consultations are bulk billed, and for patients who are not bulk billed the average out-of-pocket cost is $49. Patient out-of-pocket costs for pathology and diagnostic imaging services are also rising.

Poor or no MBS indexation, cuts to existing rebates such as GP Mental Health Services, and caps on ESMN benefits by the Government simply shift costs to patients and make medical services less accessible.

**AMA POSITION**

**Extended Medicare Safety Net**

The current EMSN must be maintained with appropriate indexation of the safety net benefits payable. There must be no further caps introduced without a proper review of the likely impact on patient out-of-pocket costs.

The existing cap amounts must be adjusted to reflect the original projected savings.

**Appropriate indexation of the MBS**

MBS indexation must be on par with increases in the Labour Price Index and the CPI so that indexation reflects the real increases in the cost of providing medical services and running medical practices. This will ensure that the Government provides appropriate financial assistance to patients to maintain affordability of medical services provided outside the hospital setting.

MBS indexation must be applied to all medical services on the MBS, including pathology and diagnostic imaging services.
Health and medical research

Australia has a proud record of achievement in health and medical research. Health and medical research funded through the National Health and Medical Research Council (NHMRC), other agencies and charitable foundations is crucial to ensuring best practice health and medical care in Australia. The assessment of health system reforms, innovation, new treatments and new technologies is essential to the continuous improvement of both the efficacy and efficiency of health service delivery.

Increased support for health and medical research in areas such as child health, chronic disease, primary care, clinical trials and basic epidemiological and laboratory research is essential if Australia is to gain the maximum benefit from the expertise that exists in our hospitals, universities and community. The challenge associated with increasing numbers of older Australians requires medical research to properly inform decisions based on the cost-effectiveness of health care and the prevention of illnesses that would otherwise require health care.

Health and medical research is a substantial part of Australia’s contribution to global science, and investments in this research result in significant broader benefits to the Australian economy.

AMA POSITION

The Government must increase support for health and medical research by at least 10 per cent each year over the next four years. Specific funding should be allocated to improve the evidence base for preventive medicine and chronic disease management. In particular, the Government should provide additional funding to:

- enable the NHMRC to provide stronger support for research to address rising rates of conditions such as diabetes, cancer and dementia, and to build workplace productivity and address population ageing;
- build health research infrastructure and increase program and project grant funding to improve the evidence base for health care and to ensure that high quality evidence is implemented as an integrated component of routine clinical care. This is essential to the evaluation of health reforms and will provide evidence to drive excellence and continuous improvement in the health system;
- support an arrangement where groups conducting research that produces cost savings for the community can share in a proportion of those savings in order to fund future research;
- provide stronger support for clinical trials to capitalise on the results of basic research. This would be best achieved by central infrastructure support for the non-cancer clinical trials group of the same type that is provided to the cancer clinical trials groups by Cancer Australia;
• increase funding to enable innovative ideas and new technologies from Australia to transition to the world market in an environment where the available venture capital support is discordant with the quality of publicly funded science; and

• reform tax and other relevant arrangements to provide an environment for greater and more effective philanthropic contributions to medical research.

Funding of research within hospitals is recognised as part of existing health budgets, but this funding is often lost because it is not separated out from the cost of clinical care (and can be used to fund clinical care). Funding for research is also not appropriately coordinated across areas of need when it is allocated at hospital level. To avoid these problems, the Government must:

• explicitly identify the research component within the cost of health care; and

• establish a health system-wide process for distributing that funding so that it has maximum impact.
Demand for health care services to meet the needs of older Australians is growing rapidly. Between 2010 and 2050, the number of older people (65-84 years) will more than double, from 2.6 million to 6.3 million, and the number of very old (85 and over) will more than quadruple, from 0.4 million to 1.8 million.

Future generations of older people are likely to have more complex health needs and expect a higher quality and level of service. There will be an increasing preference by older Australians to live and be cared for in the community wherever possible and for as long as possible. The demand for quality dementia and palliative care in all settings will increase.

Many older Australians are transferred into residential aged care facilities from hospital after a long and complex hospital admission, and have multiple and complex health care needs that require ongoing medical care and management. This trend will continue.

The residential aged care sector must be able to provide the level and quality of medical and nursing services to meet the needs of an ageing population.

Further, properly funded medical care provided to residents will help provide older Australians with quality care in appropriate settings as they reach the end of their lives. This will have the added bonus of freeing up acute care beds.

**AMA POSITION**

MBS rebates for services provided by medical practitioners and practice nurses must reflect the time and complexity of providing ongoing medical and dementia care to older people living in aged care facilities and in the community. The current Medicare rebate for these services should be at least doubled.

Efficiency gains in providing medical care can be achieved by extending the Medicare items for video consultations to general practitioner consultations to residents of aged care facilities and patients who are immobile.

Palliative care in residential aged care and the community must be improved through the introduction of dedicated Medicare rebates specific to the medical care provided to people at the end of their life.

Additional funding should be provided to encourage arrangements between aged care providers and medical practitioners to ensure ongoing access to medical care in residential aged care.

Aged care must make appropriate facilities available – including adequately equipped clinical treatment areas that afford patient privacy, and information technology to enable access to medical records and improve medication management.

Nursing care in the aged care sector must be adequate to meet the needs of residents and support the ongoing medical care of residents.

Community care, including domiciliary services for older people, is of crucial importance. Services should be matched to the needs of each individual, be comprehensive, be linked to the medical services received by the patient, and be coordinated at the practice level.
The Government has committed $650 million to develop 64 GP Super Clinics in locations across the country. The program is not meeting its targets with delays in construction, funding problems, and difficulties encountered in recruiting GPs and other health professionals. At least three planned clinics will not proceed at this time.

The Government’s GP Super Clinic program is an expensive program that is failing to reach the vast majority of the community, including those patients who are living in areas with poor access to health services. Rather than focusing excessive subsidies on a very small number of practices, the Government could achieve much more for patients by providing reasonable grant funding to a larger number of existing practices to improve their facilities and expand available services and opportunities for teaching and training.

**AMA POSITION**

The Government should redirect funding from the GP Super Clinics program into GP infrastructure grants for those GP Super Clinics that are not yet finalised and not fully supported by the communities, including the medical community, involved. No additional expenditure would be involved in this measure.

In addition, the Government should increase funding to GP infrastructure grants by an additional 575 grants at the level of the existing grants (on average $300,000 each) at a total cost of $175 million. This would enable a third round of GP infrastructure grants in addition to the funding increases that may be available as a result of redirected GP Super Clinic funding.
Tackling chronic disease

The Australian Institute of Health and Welfare Report, *General Practice Activity Australia in 2009-10*, confirms that GPs are increasingly treating older patients with more complex care needs. The management of chronic and complex disease is a key part of general practice, with chronic conditions making up 35 per cent of all problems managed.

The report highlights that the chronic problems most often managed by GPs are hypertension, depressive disorder, diabetes, cholesterol-related disorders, chronic arthritis, oesophageal disease, and asthma. Many older patients are suffering from two or more chronic illnesses and these co-morbidities complicate diagnosis and management.

Australia has moved to implement more structured arrangements through Medicare to tackle chronic and complex disease. However, these arrangements could be significantly improved through the removal of red tape, streamlined access to GP referred allied health services, funding for other support services, and the adoption of a more proactive approach to managing the care of individual patients.

**AMA POSITION**

The AMA has a comprehensive plan to manage chronic disease by improving GP-coordinated access for patients to multi-disciplinary care and other support services. This plan can be found at [http://www.ama.com.au/node/5519](http://www.ama.com.au/node/5519)

Under the AMA plan, existing Medicare arrangements would be enhanced so that patients would have streamlined access to GP-referred allied health services and a range of other support services such as mobility aids. The plan focuses on the clinical needs of patients and will help improve their quality of life.

The AMA also supports a more proactive approach to the coordinated management of patients with chronic and complex disease. 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 DVA CVC program was developed with strong clinical input and has broad stakeholder support. 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.

These measures have the potential to be cost neutral. They include reform of existing Medicare Chronic Disease items and, overall, have the potential to reduce avoidable hospital admissions.
Shared Electronic Health Records

An e-health system that connects patient information across health care settings, and which can be accessed and contributed to by treating medical practitioners and other health practitioners will improve the safety and quality of medical care in Australia.

The benefits of e-health in making the best use of existing health care services and avoiding errors, duplication and waste are well known. To treating medical practitioners, e-health means being able to access all of the clinically relevant medical information about a patient at the time of diagnosis or treatment.

Personally controlled electronic health records (PCEHRs) empower and encourage individuals to take responsibility for their own health, but their use may be limited for medical practitioners in terms of their accessibility, content, accuracy, and the comprehensiveness of information.

Health care of the patient is best served when the medical practitioner has access to the most basic information that is critical to patient care – pathology and diagnostic imaging results, hospital discharge summaries, and information on medications dispensed.

Medicare rebates for GP video consultations

The Government’s new telehealth arrangements have the potential to improve access to quality medical services for people in rural, remote, and outer metropolitan areas over time. The AMA welcomed the Government’s decision to fund video consultations for referred specialist consultations, and the funding to encourage medical practices to set up facilities to provide video consultations.

Telehealth could considerably enhance access to general practitioner services for specific patient groups and deliver productivity gains in general practice.

The delivery of health services to Indigenous populations in remote Australia is almost exclusively through remote health centres. Medical care is provided by specialised general practitioners who reside in urban centres such as Darwin or Alice Springs. These practitioners could enhance their face-to-face care of Indigenous populations with video consultations from urban centres to remote health centres.

The AMA has highlighted the problems with ongoing access to medical care for residents of aged care facilities for many years. The telehealth initiative provides incentives for aged care providers to set up video conferencing facilities. It is extremely inefficient for these facilities to be used only for referred specialist consultations. Medicare rebates for GP video consultations to residents of aged care facilities will improve the efficiency of providing follow up care by general practitioners, and ensure full use is made of the video consultation infrastructure in aged care funded by Government.
Similarly, there are rural, remote and outer metropolitan patients who have difficulty attending general practices because of mobility problems or because of distance. Medicare rebates for GP video consultations to these patients will improve the efficiency of providing follow up care by general practitioners, and ensure full use is made of the video consultation infrastructure funded by Government.

**AMA POSITION**

Shared Electronic Health Records must:

- contain reliable and relevant medical information about individuals;
- align with clinical workflows and integrate with existing medical practice software;
- be governed by a single national entity; and
- be fully funded by Government, and supported by appropriate incentives, education and training.

Extending the MBS telehealth items to general practitioner consultations for remote Indigenous Australians, aged care residents, people with mobility problems and rural people who live some distance from general practitioners will considerably improve access to medical care for these groups.
Climate change

Changes to the world’s climate are likely to pose significant challenges to the health and wellbeing of Australians. Extreme weather events such as storms, floods, heat-waves and fires, as well as longer term changes such as drought and changes to the food and water supply will all have serious health implications. This will place increasing demand on the health system over time. Australians of all ages need to be confident that they can continue to receive good quality timely access to their family doctor, and other health and medical professionals. This will be especially important in emergency situations, when good communication and organisation in the health sector is paramount.

AMA POSITION

The Government must develop a National Strategy for Health and Climate Change to ensure that Australia can respond effectively to the health impacts of climate change, extreme events, and to people’s medium to long-term recovery needs.

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;
- nationally coordinated surveillance measures to prevent exotic disease vectors from becoming established in Australia;
- 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; and
- a register of recently retired competent medical practitioners who are willing to assist in providing medical services during a national emergency.
Excessive alcohol use, excess weight and smoking continue to put Australians at high risk of serious diseases, and these behaviours reduce people’s life expectancy by five years on average. Rates of overweight and obesity are also unacceptably high among Australian children. It needs to be easier for individuals of all ages to make healthy choices about their lives. Strategic, long-term and properly resourced population based approaches to preventive health can be effective in reducing these risks and providing healthy opportunities. There has been significant progress on the part of government’s in tackling smoking rates, but gaps remain regarding excess weight and excess alcohol use.

AMA POSITION

The Government must tackle harmful alcohol use and excess weight by:

- restricting alcohol advertising and promotion to publications, locations and times that minimise their influence on people under the age of 18;
- prohibiting the targeted marketing of alcohol products to adolescents and teenagers, and banning the sponsorship of sporting events by alcohol manufacturers;
- prohibiting the broadcast advertising of energy-dense and nutrient-poor food products and beverages (i.e., junk food) to children, particularly in children’s television viewing times;
- supporting the Legislative and Governance Forum on Food Regulation to recommend mandatory adoption of a system of traffic light labelling for packaged food products;
- including health literacy as a core component of the National Curriculum for both primary and secondary level schooling; and
- making it easier for doctors to provide the best health and medical advice and interventions to patients at risk of overweight and obesity by making it a priority for the Australian National Preventive Health Agency to sponsor research on best-practice interventions and support for doctors treating patients who are overweight or obese.

The Government must also maintain a sufficient funding stream to AusAid to ensure that the capacity in Papua New Guinea to address tuberculosis is strengthened to avert the risk of transmission into Northern Australia. The Government must also maintain an appropriate level of pandemic surveillance activity to monitor this situation.