Australian Medical Association

# Pre-Budget Submission 2018-19


AMA

Health – the best investment that governments can make

# INTRODUCTION

## Reviews must lead to constructive reform and responsible investment

The conditions are ripe for a new round of significant and meaningful health reform, underpinned by secure, stable, and sufficient long-term funding to ensure the best possible health outcomes for the Australian population.

The 2018-19 Budget provides the Government with the perfect opportunity to reveal its health reform vision, and articulate clearly how it will be funded.

We have seen years of major reviews of some of the pillars of our world class health system.

The review of the Medicare Benefits Schedule is an ambitious project. Its methods and outcomes are becoming clearer. Its best chance of success is if the changes are evidence-based and clinician-led and approved.

A new direction for private health insurance (PHI) has been determined following the PHI Review. We must maintain flexibility and put patients at the centre of the system, but recognise the fundamental importance of the private system to universal health care.

The Medicare freeze will be lifted gradually over the next few years. The co-payment is dead.

There is now a greater focus on the core health issues that will form the health policy battleground at the next election.

Along with the MBS Review and PHI, these include public hospital funding, general practice and primary care, the My Health record, Indigenous health, aged care, mental health, rural health, specific women's and men's health issues, veterans' health, support for pathology and diagnostic imaging, preventive health, and a range of other public health concerns.

This AMA Pre-Budget Submission sets out a range of policies and recommendations that are practical, achievable, and affordable. They will make a difference. We urge the Government to adopt them in the Budget process.

Health should never be considered an expensive line item in the Budget. It is an investment in the welfare, wellbeing, and productivity of the Australian people.

Health is the best investment that governments can make.

Dr Michael Gannon
President

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# 1 GENERAL PRACTICE AND PRIMARY CARE

Primary health care (PHC) is the front line of the healthcare system and usually the first level of contact for individuals, the family, and community with the national health system.

General practice is the cornerstone of successful primary health care. It underpins population health outcomes, and is key to ensuring we have a high-quality, equitable, and sustainable health system into the future.

GPs have a profound influence on both health outcomes and health expenditures. It is estimated that primary healthcare professionals control or influence approximately 80 per cent of healthcare costs, which means that they have an important role to play in ensuring that health expenditure remains sustainable.

The role of the GP is increasingly important as the population ages, and the increases in the burden of chronic disease require continuing long-term care. A primary care system that is adequately funded ensures value for money by providing patients with the right care at the right time, in the community, thereby reducing costly preventable hospital admissions.

GPs are managing more problems in each consultation than they did a decade ago as patients, particularly older patients, present with multiple reasons for the encounter. GPs are also spending more time with patients and manage the vast majority of the problems presented to them. With Australia's growing and ageing population, this trend is set to continue. Yet funding for general practice is not growing in keeping with this trend. The combined forces of rising demand and constrained funding will have a significant impact on the quality of care that practices are able to provide.

## Practice Incentive Program (PIP)

The Government is pursuing significant reforms to the Practice Incentive Program (PIP), including the implementation of a new Quality PIP payment (QPIP).

The PIP represents a significant funding source for general practice. However, the Government has decided to implement the QPIP by taking away funding for other important PIP incentives, including the Aged Care Access Incentive (ACAI). This will leave many general practices worse off overall, and in the ludicrous position of being financially penalised for pursuing quality measures.

The PIP has been subject to successive funding cuts in recent years, hitting the viability of many general practices and undermining the Program's effectiveness in supporting quality improvement and practice accreditation. If the Government wants the PIP to properly support practices to undertake continuous quality improvement activities, it must genuinely recognise practices for their quality improvement efforts. This requires new funding, not fund shifting.

# GENERAL PRACTICE AND PRIMARY CARE

## Wound care

It is estimated that more than 400,000 patients at any one time are suffering from hard to heal wounds. Venous leg ulcers, which are prevalent in the older population, for example, affect around 43,000 people a year.

KPMG, in an evaluation of the use of compression bandages for patients suffering venous leg ulcers, estimated back in 2003 that $166 million a year could be saved with their use.

A study on wound care costs in general practice conducted in 2011 showed that, in most cases, general practices are not recouping the costs of wound care. In providing this critical service, GPs and practices typically incur a loss, with some dressings costing as much as $50.

The Medicare rebate for a standard GP consultation is $37.05. If a GP bulk bills a patient, they are prevented from raising any charges to cover the costs of wound dressings. Proper wound care is essential to managing patients in the community and keeping them out of hospital.

It is a high value service for patients that GPs are finding increasingly hard to maintain in a constrained funding environment.

## After-hours GP services

Access to after-hours GP services is a critical part of the health system for patients. Many families depend on these services, but they should not be seen as a substitute for a visit to a patient's usual GP. If a patient can wait until the next day to see their usual GP, or attend their usual general practice, that is the best option.

A patient's usual GP will be able to provide more comprehensive care – with immediate access to a patient's history and a better understanding of a patient's health care needs for things like allergies or medications, for example.

It is critical that service providers that operate after-hours GP care, particularly those that operate exclusively in the after-hours period, adopt a collaborative model that complements the care provided by a patient's usual GP, or through their regular general practice. Poor models of after-hours GP care have the potential to fragment patient care, result in poorer outcomes for patients, and incur additional costs to the health system.

The Report of the MBS Review of Urgent After-Hours Primary Care Services detailed significant problems in the operation of current Medicare after-hours funding arrangements, and recommended significant reforms. The AMA agrees that changes are required for a number of reasons, including:

- the significant growth in the use of after-hours Medicare items, particularly the use of urgent after-hours items, and the detrimental impact this is having on the link between patients and their usual GP or general practice;

# GENERAL PRACTICE AND PRIMARY CARE

- concern that direct marketing and the promotion of after-hours home visiting services as being free and easy to access is driving much of this growth, as opposed to genuine patient need; and
- poor communication from some after-hours medical services to a patient's usual GP or general practice – resulting in the fragmentation of care.

Ideally, Medicare after hours funding arrangements should be structured to ensure that:

- high quality models of care are adequately funded;
- the doctors providing after-hours services are appropriately trained and supervised, particularly in circumstances where they do not hold a formal GP qualification;
- patients in rural areas can access after-hours services, which are often delivered by local GPs;
- affordable access for patients to after-hours GP services is available when they genuinely need them; and
- medical deputising services (MDSs) work closely with a patient's usual GP or general practice.

## Health Care Homes

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 enjoy a better quality of life.

A stronger general practice is the key to better health outcomes for these patients. The Government's recently commenced Health Care Homes trial for patients with chronic and complex disease aims to strengthen the linkage between patients, their usual general practice, and a nominated general practitioner.

While the AMA has supported the vision for a Health Care Home, the Government has provided no new funding to support the trial. Existing Medicare funding, including Chronic Disease items, is simply being redirected. GPs will be asked to deliver enhanced care for patients with no additional financial support.

This contrasts with successful initiatives like the Department of Veterans' Affairs (DVA) Coordinated Veterans Care (CVC) program that provides significant additional funding support to GPs to provide comprehensive planned and coordinated care to veterans who are at risk of unplanned hospitalisation - with the support of a practice nurse or community nurse.

# GENERAL PRACTICE AND PRIMARY CARE

It is also clear that, while the Health Care Homes trial has commenced, key elements of the trial are still not fully in place, including shared care planning software. This has significant implications for the validity of the trial and its evaluation. This, along with inadequate funding, undermines the potential for the trial to succeed – meaning that patients will not be able to access the improved care they deserve in the community, leaving them at greater risk of hospitalisation.

## AMA POSITION

**The AMA calls on the Government to:**

- **allocate additional funding to the Practice Incentive Program, particularly to avoid the loss of other important PIP incentives, and to ensure that the QPIP provides meaningful support to GPs who engage in quality improvement;**
- **provide funding to cover the costs of wound dressings provided to patients in circumstances where they are bulk-billed by their GP;**
- **implement a new funding model for after-hours GP services provided through a Medical Deputising Service (MDS) by adopting the recommendations of the MBS Review After-Hours Report, and reinvesting some of the savings generated into a specific funding program for MDSs – linked to robust quality standards;**
- **provide more support to general practices that operate for extended hours by changing the Medicare definition of after-hours in rooms consultation items so that they commence at 6.00pm on weeknights and 12 noon on a Saturday;**
- **extend the Health Care Homes trial by at least 12 months, so that it can be properly evaluated; and**
- **provide additional funding for the Health Care Homes trial, using the DVA CVC program as the basis to calculate how much extra money is required.**

# 2 PUBLIC HOSPITALS

Public hospitals are a critical part of our health system. The doctors, nurses, and other staff who work in them are some of the most skilled in the world. In 2015-16, public hospitals provided more than six million episodes of admitted patient care and managed 92 per cent of emergency admissions.

Despite their importance, and despite our reliance on our hospitals to save lives and improve quality of life, they have been chronically underfunded for too long.

Between 2010-11 and 2015-16, average growth in Federal Government funding for public hospitals has been virtually stagnant – a mere 2.8 per cent.

The AMA welcomes that, between 2014-15 and 2015-16, the Federal Government boosted its recurrent public hospital expenditure by 8.4 per cent. But a one-off modest boost from a very low base is not enough.

Frequent media headlines tell a story of public hospitals under enormous pressure. These headlines are backed by the findings in the AMA's 2017 Public Hospital Report Card. It profiles the statistics that show bed numbers per 1000 population are static and the performance of our public hospitals is essentially frozen at unsatisfactory levels. And we know the waiting list figures only tell part of the story – there are many more patients waiting for treatment, often for painful conditions.

The AMA's recently published 2016 Safe Hours Audit is a window into the lived experience of dedicated doctors, struggling to deliver quality care in chronically under-funded hospitals.

One in two (53 per cent) public hospital doctors are working unsafe hours that put them at significant risk of fatigue. Those who report dangerous levels of fatigue are intensive care specialists (75 per cent), surgeons (73 per cent), obstetricians and gynaecologists (58 per cent) and emergency doctors (38 per cent). We know the strain and the pressure on our public hospitals is having a detrimental impact on the health of our doctors.

Against this background, financial penalties for what are deemed avoidable re-admissions and hospital-acquired complications were recently imposed. In under-resourced public hospitals, financial penalties for struggling hospitals will not help.

The Federal Government has signalled that the 2020 hospital funding agreement will place greater financial pressures on public hospitals to cut 'waste', increase productivity, and stop what the Government calls 'low value' care. Public hospitals will also be expected to extend their responsibilities to engage in the care of chronically ill patients, post-discharge.

The necessary infrastructure and human resource capacity to achieve this cannot be built without new investment.

The design and collection of patient outcome data, analytics, outcome reviews, and a redesign of patient-led care will cost time and money. Adding more work, without the matching additional resources, will lock them into a cycle of struggle.

# PUBLIC HOSPITALS

## AMA POSITION

**The AMA calls on the Government to:**

- **boost funding for public hospitals for the period to 2020, and lift public hospitals out of their current funding crisis, which is putting doctors and patients at risk;**
- **recognise the magnitude of organisational change required to succeed in delivering the goals of the reform agenda in the 2020 Hospital Agreement;**
- **fully fund hospitals to build their internal capacity to deliver high value care in the medium to long term, and do not penalise struggling hospitals in order to free up funds;**
- **fully fund hospitals to expand their responsibility for integrated care; and**
- **fully compensate States and Territories for any loss in private patient revenue, and not make any funding or policy decisions that would have the effect of diminishing support for patients who elect to be treated as a private patient.**

# 3 PRIVATE HEALTH INSURANCE

Private health insurance premiums continue to rise year on year beyond the Consumer Price or Wage Price indices. While affordability of private health insurance is important to consumers, value is even more important. When patients are sick, they need to be certain that they will get the care they need.

The current complex web of private health insurance policy offerings is confusing for consumers. Coupled with low benefits in many policies, and the very complex health financing system, there is a perceived lack of value undermining private health insurance.

The Government must clamp down on misleading policies – too often patients only find out they aren't covered when they go to use their insurance. Policies must cover patients in private hospitals, unless they are specifically and clearly identifiable as public hospital only policies.

Allowing private health insurers to restrict cover in the fine print is unconscionable. Further, patients need to be allowed to use their policies in public hospitals, if they so choose – this right needs to be protected in the forthcoming hospitals agreement.

Reforms that result in nothing more than rebadging a bad set of policies with a glossy name will not ensure the ongoing viability of the private system. This will not make insurance easier for the public to purchase. The end result will be a system where additional pressure will be placed on public hospitals, which are already struggling to meet ever-growing demand.

## AMA POSITION

**The AMA calls on the Government to:**

- **scrap junk policies - policies that are designed to avoid the Medicare levy surcharge only, and which do not clearly explain their low levels of coverage;**
- **ensure low cost policies are clear in what they will not cover, and in what settings;**
- **ensure obstetric services are included in Gold, Silver, and Bronze levels of cover;**
- **ensure mental health services are not reduced through restrictions in policies;**
- **retain community rating, which is essential to maintain the delicate balance between public and private hospital sectors in Australia;**
- **ensure health insurance policies are clear on what is covered. Consumers should be able to purchase, or compare a policy, with easy to understand and standardised terminology; and**
- **maintain the affordability of private health insurance through the Private Health Insurance rebate.**

**The AMA does not support the retention of restrictions in private health insurance products – a policy becomes junk when a consumer believes they are covered for use in a private setting, only to find they can only use it in a public hospital.**

# 4 MEDICARE BENEFITS SCHEDULE (MBS) REVIEW

The AMA supports an MBS system that reflects contemporary best practice – one that provides for the innovations and improvements that have been made in medicine, and the opportunities that technological advancements can offer.

In 2015, the medical profession made a commitment to work with the MBS Review and the many Clinical Committees and Working Groups working under the Review Taskforce. The medical professionals on the many Clinical Committees and Working Groups continue to provide their time and expertise to the task of modernising the MBS.

The AMA called for a review process that is absolutely transparent, throughout the full lifespan of the review. This includes consultation and feedback on proposed implementation plans and consideration of the overall impacts on health funding, and on viable service delivery.

After two years of the MBS Review, concerns are increasing among the medical specialty groups that there are both deficiencies and significant variations in the process adopted by the MBS Review Taskforce and the Clinical Committees.

The Anaesthesia Clinical Committee is a good example where an individualised approach is required. The fee for an Anaesthetic service can include multiple components. This added complexity demands a careful approach, with even deeper engagement with clinicians working at the front line of patient care in the private hospital system.

The AMA continues to call on Government to ensure that the MBS Taskforce works closely with the clinical groups who hold carriage of each item, and listens carefully to clinicians who operate at the 'coalface' of healthcare delivery. Early engagement will improve understanding of how changes to the MBS can practically impact upon the operation of medical practices. It will create a more streamlined process overall. What we don't want to see is a confusing MBS that delivers sub-optimal care and that sets up medical practitioners to fail.

# MEDICARE BENEFITS SCHEDULE (MBS) REVIEW

## AMA POSITION

**The AMA calls on the Government to provide a robust and transparent process to ensure decisions taken in the MBS Review do not have unintended consequences for patients, and that the MBS Review does not become a mechanism for shaping the scope of practice. This can be achieved by:**

- **transparency of Clinical Committee scope, consultation feedback received, and final decision making;**
- **re-investing into the MBS – new items should be able to be recommended by all committees, not just some;**
- **uncomplicated MBS item descriptions – clinicians rely on years of training and expertise, and need scope to be able to make clinical decisions that aren't driven by overly complex item descriptions;**
- **ensure the membership of the Clinical Committees and Working Groups includes leaders from the Colleges, Associations, and Societies – those who are familiar with the history and use of the items in question, and will ensure recommendations are practical and consistent;**
- **ensure that there is adequate time to consult with the Colleges, Associations, and Societies with regard to the draft recommendations to address key problems, before they are finalised for public consultation; and**
- **ensure consistency in the approach to the Review, including consultation with relevant Government departments and agencies, such as Medicare Compliance.**

**The AMA believes a sustainable MBS supports holistic patient care, encourages prevention, prioritises quality of life, and promotes longevity. A Review that leads to arbitrary cost-cutting, or diverts any savings from services to the Budget bottom line, will therefore not be supported.**

# 5 PREVENTIVE HEALTH

Preventing illness is better than treating it. Investing in health prevention is not only the responsible and right approach to health care, it is economically and socially the smartest investment governments can make in the health portfolio.

One in two Australians have a chronic disease. While welcoming the efforts of successive governments to reduce chronic disease by reducing the rates of smoking, governments have failed to apply the same approach to reducing premature deaths and illness caused by obesity and excess weight; the harmful use of alcohol; and the decrease in physical activity.

The AMA supports a dedicated preventive health body that can deliver preventive health policies and programs, and support investment and infrastructure in preventive health. Obesity, nutrition, alcohol, tobacco and physical activity are health policy areas desperately in need of funded national strategies and measurable targets. These are best delivered through an independent, dedicated organisation. To achieve measurable outcomes, the Government must engage with this prevention organisation and act on their recommendations and initiatives to improve the health of Australians.

## Obesity

Obesity is a major health problem. More than half (62 per cent) of Australian adults are overweight (35 per cent) or obese (27 per cent), and about one quarter of children and adolescents are overweight (18 per cent) and obese (7 per cent).

About 70 per cent of Australians who are obese have at least one established morbidity.

The experience in tobacco control shows that price signals can act as a deterrent. The AMA wants to see similar price signals applied to sugar-sweetened beverages.

Australian economic modelling predicts that an increase in the price of sugary drinks by 20 per cent would see consumption reduced by more than 12 per cent.

## Physical inactivity

Each year, physical inactivity causes an estimated 14,000 deaths and increases the risk of heart disease, stroke, diabetes, and some cancers.

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

Being active also reduces overweight and obesity. If the Government wants to reduce healthcare expenditure, then increasing physical activity by just 10 per cent could lead to cost savings estimated at more than $250 million.

# PREVENTIVE HEALTH

## Tobacco

Tobacco is unique among consumer products in that it causes disease and premature death when used as intended.

The National Tobacco Strategy expires in 2018. An updated, innovative, and well-funded Strategy is required to ensure that Australia continues to be a leader in tobacco control. It is unlikely that the national goal of reducing smoking to 10 per cent will be met. The Government must continue to facilitate and enhance 'quit smoking' campaigns, and make tobacco more difficult for children and adolescents to obtain.

## Alcohol

Australians continue to consume too much alcohol.

The abuse of alcohol results in deaths, injuries and trauma, and is also a leading cause of preventable birth defects and intellectual disability, including fetal alcohol spectrum disorder (FASD).

The AMA wants effective warning labels on the front of all alcohol containers to alert the community to the dangers of alcohol consumption during pregnancy. In order to address the availability of large quantities of cheap alcohol, serious reconsideration must be given to the benefits of implementing volumetric alcohol taxation in Australia. Treatments and support must be available for all Australians who want to address alcohol issues.

## Drug and alcohol treatment programs

A major transition has occurred in the funding of drug and alcohol treatment programs in an effort to support local communities to respond to local drug and alcohol problems.

The effectiveness of this approach remains to be seen, but treatment services for a range of substances and behaviours must be available.

## Women's health

Recognise the importance of women's health care and the developmental origins of health and disease (DOHaD) in prioritising adequate funding for care of women in the pre-conceptual, antenatal, intrapartum, and postnatal period.

# PREVENTIVE HEALTH

## AMA POSITION

**The AMA calls on the Government to:**

- **establish a dedicated preventive health body;**
- **protect children and adolescents from the marketing and promotion of products that are known to adversely impact on their health, including junk food and beverages, alcohol, and gambling;**
- **fund community-based initiatives and programs that can reduce obesity in local communities;**
- **continue funding, evaluating, and refining the Health Star Rating (HSR) front of pack food labelling system; with uptake of HSR closely monitored;**
- **further consider and model the significant reductions in harm that can be achieved by implementing volumetric taxation on alcohol products;**
- **introduce front-of-pack warnings on all alcohol containers that alert people to the dangers of consuming alcohol during pregnancy;**
- **continue investment to increase the capacity of drug and alcohol treatment programs. This includes monitoring whether each PHN is delivering effective drug and alcohol treatment services that meet demand;**
- **support community-driven measures designed by Aboriginal and Torres Strait Islander people that specifically address drug and alcohol use and misuse;**
- **bring together stakeholders and all tiers of government to help boost participation rates in physical activity, especially among those groups known to have low participation rates;**
- **develop information alerting people to low and no-cost opportunities to engage in physical activity in their local area (similar to that which was developed under the Active Scotland Strategy);**
- **make active transport measures a priority in all transport and infrastructure policies; and**
- **develop National Public Health Strategies that support coordinated and strategic responses to a range of public health issues including, but not limited to obesity, physical activity, alcohol, tobacco, and breastfeeding. These strategies must be developed, reviewed, and updated in a timely manner, and should contain properly funded, measurable, and deliverable outcomes.**

# 6 DIAGNOSTIC IMAGING

Government spending on quality diagnostic imaging services that reflect best clinical practice is an investment. High quality and timely diagnostic imaging prevents much higher downstream costs to the health system - costs that arise from more expensive hospital stays and higher cost medical care.

However, Medicare rebates for diagnostic imaging services have not been indexed for nearly 20 years. The Government announced last year that rebates will rise slightly in 2020 for a handful of services, but the vast majority of diagnostic imaging rebates will remain frozen.

Higher out-of-pocket costs for patients impact on affordability, with the sickest and most vulnerable people being effectively priced out of care. This is particularly exacerbated for diagnostic imaging services where, for some tests, patients have to pay up-front costs of hundreds of dollars. This means that people either delay important tests or simply don't have them.

In addition, the MBS has not kept up with advances in testing, many of which are now accepted best practice. Patients have to pay again if they want to go ahead with evidence-based care.

The Government also needs to do more to support country patients by allowing a more flexible and adaptive system of referrals and patient management to reduce the need for country patients to make numerous trips for diagnostic tests and specialist appointments.

Providing radiologists with the capacity to proceed with additional diagnostic scans, substitute a requested scan for a more clinically appropriate scan, and/or refer a patient directly to another medical practitioner – in consultation with the patient's initially-referring doctor – has the potential to enhance and shorten a patient's journey through the healthcare system, and also save on Medicare expenses by skipping unnecessary services.

The Government should also scrap the licensing system for MRI (magnetic resonance imaging) machines. The licensing system only seeks to ration access to services, and does nothing to meet clinical need, ensure evidence-based care, or improve the quality of equipment.

Government policies, regulations, and funding arrangements should support the right patients getting the right service at the right time.

## AMA POSITION

**The AMA calls on the Government to:**

- **ensure that Medicare rebates for diagnostic imaging services are adequately funded so that patients receive quality medical services;**
- **introduce new MBS rebates for clinically appropriate, evidence-based diagnostic imaging services, reflecting current practice;**
- **introduce a billing system to allow patients to pay just the gap up front;**
- **scrap the MRI licensing system; and**
- **fund referral arrangements that support better access to high quality, timely, and affordable services in regional and remote Australia.**

# 7 PATHOLOGY

Pathology services are the lifeblood of the Australian health system. Pathology generates savings to the healthcare system and the economy by enabling early diagnosis, and therefore intervention and management of health conditions. Pathology services are a critical element in preventing much higher costs in acute care from undiagnosed disease and illness. Pathology underpins and is central to Australia's outstanding record of cancer diagnosis and survival.

But essential support for these cost-effective services is eroding.

Government rebates for pathology services have not been indexed in two decades. While the Government dropped its policy to cut bulk billing incentives, incentives that help the pathology sector minimise out-of-pocket costs for patients, there is no end in sight to the pathology rebate freeze.

In addition, cuts to pathology services arising from the MBS Review are still looming. Furthermore, the lack of positive reform to the pathology Schedule by successive governments has meant that the sector has had to rely on cost-subsidisation of services – and this dependancy must be taken into account in any future item changes.

The Government needs to reinvest any savings stripped from pathology services via the MBS Review back into the pathology sector. Investment in a sustainable and stable pathology sector, and a highly skilled pathology workforce, is vital to ensuring high quality and diverse pathology services.

The critical nature of the pathology workforce was most recently evidenced when, following the delayed introduction of the National Cervical Screening Register, the specialist workforce was recalled to cover the extended period and ensure patients could continue to be tested with confidence.

Without appropriate Government funding arrangements, patients will not have access to timely and necessary services.

# PATHOLOGY

## AMA POSITION

**The AMA calls on the Government to provide funding arrangements for pathology services that:**

- **enhance management of patients and improve patient outcomes;**
- **recognise the evolving roles of genomics in the prevention and treatment of disease;**
- **support high levels of access and quality services for patients and treating doctors, including in rural and remote areas; and**
- **support high quality training, research, and development activities.**

**The AMA calls on the Government to adequately support pathology services through:**

- **ensuring that Medicare rebates for pathology services are adequately funded so that patients receive quality services;**
- **investment in a sustainable pathology workforce, including in regional areas; and**
- **invest in the development of genomics, which has the potential to revolutionalise medicine.**

# 8 MENTAL HEALTH AND THE NATIONAL DISABILTY INSURANCE SCHEME (NDIS)

Mental health and psychiatric care are grossly underfunded when compared to physical health, the burden of disease, and lives lost.

The balance between funding acute care in public hospitals, primary care, and community-managed mental health is not yet correctly weighted. Government funding for mental health care and services must be on the basis of need and demand, and not a competition between sectors and specific mental health conditions.

Every day, GPs struggle to obtain appropriate acute and sub-acute mental health care for their patients. Emergency departments are not the ideal environment for many people with mental illness.

The Federal Government must work with the States and Territories to build capacity in step-down facilities for ongoing care, and address the chronic underinvestment by all governments in mental health.

The AMA supports the major reforms – Primary Health Networks (PHNs) and the National Disability Insurance Scheme (NDIS) – along with co-ordinated local/regional mental health initiatives. The NDIS and PHNs have the potential to transform the current patchwork of fragmented, competing, and overlapping services into a system founded on evidence-based investment and sustainable funding.

The AMA recognises that the NDIS is a complex and massive reform that will take time to be fully delivered. However, the boundaries and interface between the NDIS and other non-NDIS service provision is still problematic. At this stage, the right balance between medical mental health treatments and psychosocial supports has not yet been achieved.

People with mental health issues should have access to adequate and quality mental health care, regardless of whether they are eligible for the NDIS.

Access to mental health services for people in regional and remote areas, for Indigenous people living remotely, and for those with disability and mobility needs is an ongoing concern for the AMA.

Investments and reforms in mental health should be accompanied by workforce strategies to ensure that there is a properly trained professional medical workforce able to deliver mental health care throughout Australia.

The AMA supports the role of the National Mental Health Commission in guiding mental health policy and reform in Australia.

# MENTAL HEALTH AND THE NATIONAL DISABILTY INSURANCE SCHEME (NDIS)

## AMA POSITION

**The AMA calls on the Government to:**

- **address the inequity gap in per capita spending on mental health. Significant investment is needed to reduce the deficits in mental health care, fragmentation, and lack of coordination of and access to effective care;**
- **invest in evidence-based mental health prevention programs;**
- **ensure all Australians with a mental illness have ready access to quality mental health care based on their particular needs;**
- **deliver culturally appropriate mental health services to Aboriginal and Torres Strait Islander people;**
- **promote perinatal, child, and adolescent mental health services and early intervention programs;**
- **deliver community–managed mental health care that is properly funded and better coordinated to ensure improved access to essential services, which include psycho-geriatricians, mental health nurses, psychologists, paediatricians, counsellors, and drug, alcohol, and gambling support staff;**
- **extend MBS and PBS access to those in custodial settings, many of whom have specific mental health needs;**
- **facilitate increased access to e-health and telemedicine; and**
- **implement the recommendations in the Productivity Commission report, *National Disability Insurance Scheme (NDIS) Costs*; and from the Joint Standing Committee on the National Disability Insurance Scheme.**

# 9 MEDICAL CARE FOR OLDER AUSTRALIANS

Older Australians all too frequently do not have the same access to medical care as other age groups - a longstanding result of inadequate funding in the aged care system. This inequality will likely only grow as the Australian population ages with more complex, chronic medical conditions. This population group will require more medical attention than ever before, and we need to improve the system to cope with this demand. We need to look at innovative solutions – for example, around 50 per cent of our surveyed members said it was very difficult for their patients living in Residential Aged Care Facilities (RACFs) to access radiology services.

Over the past financial year, we have seen extensive consultation with stakeholders and consumers on the future of our aged care system.

The AMA lodged submissions with the *Aged Care Legislated Review, the Review of National Aged Care Quality Regulatory Processes; the Senate Inquiry into the Effectiveness of the Aged Care Quality Assessment and accreditation framework for protecting residents from abuse and poor practices, and ensuring proper clinical and medical care standards are maintained and practised; the Future reform – an integrated care at home program to support older Australians review;* and several consultations into My Aged Care, including the AMR *My Aged Care Evaluation.*

Most of the following AMA positions have since been recommended by these independent reviews.

It is now time to take action on these recommendations and invest in aged care to produce the foundations of a higher quality system.

An increase in funding for GP visits to RACFs would result in savings from reduced ambulance transfers to hospital emergency departments. Changes to after-hours care remuneration must take into account services currently provided under 'urgent' item numbers to patients in RACFs.

## AMA POSITION

### Resourcing aged care

**The AMA calls on the Government to:**

- **introduce an Aged Care Commissioner to bring leadership and accountability to the aged care system;**
- **introduce Medicare rebates that adequately cover the time that doctors spend with the patient assessing and diagnosing their condition and providing medical care;**

# MEDICAL CARE FOR OLDER AUSTRALIANS

- introduce new telehealth Medicare items that compensate GPs, and other medical specialists, for the time spent organising and coordinating services for the patient, and the time that they spend with the patient's family and carers to plan and manage the patient's care and treatment;
- provide funding for the recruitment and retention of quality, appropriately trained, aged care staff;
- reverse the decline in the proportion of Registered Nurses in aged care; and
- ensure that staff receive specific training to deal with the issues that older people face.

## Technology in aged care

**The AMA calls on the Government to provide urgently needed and overdue funding to significantly improve the My Aged Care (MAC) system to:**

- avoid delays in accessing care;
- consider doctor workflows to develop a faster and more effective referral pathway; and
- prioritise developing interoperability between all software systems to improve communication – MAC and clinical software, the My Health Record, and aged care provider software.

## Clinical aged care

**The AMA calls on the Government to:**

- introduce an 'access to medical care' standard into the Aged Care Accreditation Standards;
- ensure clear, specific, and confidential complaints referral pathways in each Residential Aged Care Facility (RACF) so information on complaints processes is easily accessible to both residents and staff; and
- provide better funding support services being delivered on site, such as mobile radiology services, which can save on costly hospital transfers.

# 10 MY HEALTH RECORD

The My Health Record will offer digital access to a core summary of important patient clinical data when it matters most– at the time of treatment – irrespective of the clinician's specialty or physical location in Australia.

Electronic medical records promise much. Early wins are expected in reduced duplication of diagnostic tests and reduced adverse drug events. A recent study estimated that admissions due to adverse drug events could be as high as 230,000 per year, and cost $1.2 billion per year. It has the potential to improve the information flow between hospital doctors and general practitioners when patients present to hospital and are discharged.

We note Government estimates anticipate that the My Health Record will generate savings of around $123 million by 2020-21. Further iterations of the My Health Record could become even more useful to clinicians and patients alike via features such as recording specific prosthesis details, enabling targeted notification of drug recalls, and providing the opportunity for understanding of aged care directives and patient wishes.

But more work is required. The return on investment will hinge in the short term on ease of use for medical practitioners who upload the clinical data. Interoperability with the multiple software packages used across the medical profession and broader health sector must be seamless.

Problems uploading specialists' letters, poor search functionality, time-consuming adaptations to existing medical practitioner work practices, or inappropriate workarounds will erode clinical utility and deter doctor use – and, more importantly, take time away from focusing on the patient.

Doctors do not have time to talk their patients through the My Health Record arrangements for opt-out, privacy, setting access controls in standing consent for health providers to upload health information. This is the work of the Government. Doctors must be allowed to focus on what they do best – caring for patients. The lack of reliable broadband is also a barrier that will need to be addressed if nationwide, digitised health care is to be achieved.

The shift to opt-out arrangements in mid to late 2018 is also a critical success factor. Some Australians will be surprised to learn that a My Health Record has been created for them without their explicit consent. The communication campaign must reach as many Australians as possible, and promote a positive attitude towards the My Health Record created for them.

Privacy, health data security, and health data disclosure are also hot button issues – for doctors and patients. These will need to be carefully managed to maintain a high level of participation post opt-out.

The AMA believes a fully functioning and widely used My Health Record will not only save money but save lives. Ongoing improvements will help ensure its success.

# MY HEALTH RECORD

## AMA POSITION

**The AMA calls on the Government to:**

- **guarantee that doctors will not bear unnecessary costs for guiding patients through the intricacies of the My Health Record system for arrangements for opt-out, privacy, setting access controls in standing consent for health providers to upload health information;**
- **fully fund an opt-out communication campaign to avoid widespread fear-driven decisions to opt out;**
- **appreciate the high level of community concern about the My Health Record's impact on patient privacy and health data security;**
- **invest in the ongoing improvement of the clinical utility of the My Health Record so it becomes a value add tool for clinicians in their day to day delivery of quality patient care;**
- **provide specific support for specialists to adopt the My Health Record;**
- **fund work to achieve a seamless interface between the My Health Record and My Aged Care; and**
- **excellerate the establishment of health data standards needed to make interoperability a short-term reality.**

# 11 RURAL HEALTH

## Workforce

The Commonwealth has a range of programs designed to improve recruitment of doctors in training to rural Australia, including in relation to medical school enrolment targets, and prevocational and specialist training. Despite this, rural workforce shortages persist. The latest data from the Medical Students Outcome Database Survey (MSOD) reports that 76 per cent of domestic graduates are living in capital cities.

The Government has also pursued programs that bond medical graduates to working in areas of workforce shortage, including rural Australia. Despite recruiting more than 9000 participants, these programs have so far failed to attract doctors into the rural workforce. They offer medical graduates very little flexibility or support and most participants receive no financial help or incentive.

International evidence also shows that long-term retention rates of bonded doctors in workforce shortage areas are poor, with retention rates around half that of doctors who practise in these areas voluntarily.

In contrast, the best available evidence shows doctors who come from a rural background and/or spend time training in a rural area are more likely to take up long-term practice in a rural location.

## Infrastructure

General practice is the backbone of rural health care, providing high quality primary care services for patients, procedural and emergency services at local hospitals, as well as training the next generation of GPs.

Rural GPs would like to do more, but face significant infrastructure limitations in areas such as IT, equipment, and physical space.

If rural general practices are properly funded to improve their available infrastructure, they can expand the services that they provide to patients including GP, nursing, and allied health.

Such funding can also support improved opportunities for teaching in general practice for prevocational and vocational trainee doctors, as well as other health professionals.

Previous rounds of infrastructure grant funding have delivered real results for rural communities, with local practices taking realistic steps to improve patient access to services and support teaching activities.

The Australian National Audit Office reports that infrastructure funding grants are effective and a good value-for-money investment.

# RURAL HEALTH

## AMA POSITION

**The AMA calls on the Government to:**

- **incorporate the Rural Junior Doctor Training Innovation Fund into a broader Community Residency Program to provide prevocational doctors with expanded access to three month general practice placements, particularly in rural areas;**
- **expand the successful Specialist Training Program to 1,400 places by 2020, with higher priority being given to training places in regional and rural areas, generalist training, and specialties that are under-supplied;**
- **support further reforms to medical school selection criteria for Commonwealth-supported students; and introduce changes to the structure of courses so that the targeted intake of medical students from a rural background is lifted from 25 per cent of all new enrolments to one-third of all new enrolments and the proportion of medical students required to undertake at least one year of clinical training in a rural area is lifted from 25 per cent to one-third;**
- **reform bonded medical graduate programs by introducing fairer and more flexible return of service arrangements and restoring the Bonded Support Program; and**
- **fund a further 425 rural GP infrastructure grants of up to $500,000 each.**

# 12 INDIGENOUS HEALTH

It is unacceptable that Australia, one of the world's wealthiest nations, cannot address health and social justice issues affecting Aboriginal and Torres Strait Islander people, who comprise just three per cent of the population. Funding for Aboriginal and Torres Strait Islander Health is inadequate to meet the burden of illness.

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

The AMA values the progress being made in reducing early childhood mortality rates, and in addressing major risk factors for chronic disease, such as smoking. But if the Government is serious about building on this early but slow progress, it must create sustainable, long-term improvements by increasing funding and resourcing for culturally appropriate primary health care for Aboriginal and Torres Strait Islander people. It must also increase and properly resource the health workforce.

Many of the chronic health conditions experienced by Aboriginal and Torres Strait Islander people should not be endemic in a highly-developed country like Australia. Chronic diseases are known to be the main cause of the life expectancy gap between Indigenous and non-Indigenous Australians.

Despite some recent health gains for Aboriginal and Torres Strait Islander people, awareness and political will is frustratingly slow-moving. There is an urgent need for the Commonwealth to deliver on the well-documented research and national strategies showing how to tackle health inequalities and the social determinants of health.

Closing the gap in health outcomes means addressing: poverty; unhygienic, overcrowded conditions; poor food security and access to potable drinking water; lack of transport; and an absence of health services.

Every year, the AMA says that this situation is not acceptable, and every year governments fail to implement the health plans, recommendations, and strategies that will deliver improvements and hasten the closing of the gap in health outcomes. The 2018-19 Budget is an opportunity to start properly funding and resourcing Indigenous Health.

# INDIGENOUS HEALTH

## AMA POSITION

**The AMA calls on the Government to:**

- **prioritise Indigenous health funding in the 2018-19 Budget and fund Aboriginal and Torres Strait Islander health services according to need;**
- **support measures to increase the uptake of MBS and PBS items;**
- **fund and implement the National Aboriginal and Torres Strait Islander Health Plan;**
- **adopt the recommendations in the AMA's Report Cards on Indigenous Health, in particular the recommendations in the 2016 Report Card calling for a target to eradicate new cases of Rheumatic Heart Disease (RHD); and the recommendations in the 2017 Report Card to address ear health (otitis media);**
- **given the strong link between health and incarceration, support the justice reinvestment approach to health by appropriately funding services that divert Aboriginal and Torres Strait Islander people from prison;**
- **commit to the principles of the Redfern Statement, which calls on all political parties to make Aboriginal and Torres Strait Islander affairs a key election priority;**
- **meaningfully address the disadvantage experienced by Aboriginal and Torres Strait Islander people by reversing cuts to the Indigenous Affairs portfolio;**
- **reinvest in health, justice, early childhood, and disability services, as well as services to prevent violence;**
- **increase investment in Aboriginal and Torres Strait Islander community-controlled health organisations to build their capacity to be sustainable over the long term;**
- **recognise that chronic disease in Indigenous communities is inextricably connected to the social determinants of health such as: poverty; inappropriately designed, unhygienic, overcrowded housing conditions; inadequate access to affordable food and potable water supplies; and an absence of health services;**
- **acknowledge the wealth of existing reports, Parliamentary inquiries, strategies, and plans to improve Indigenous health and close the gap, and start to fund and implement them; and**
- **fund 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.**

# 13 MEDICAL WORKFORCE

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

This represents only one step toward training sufficient numbers of doctors to meet health delivery requirements, with data from the former Health Workforce Australia (HWA) showing that Australia now has sufficient numbers of medical graduates.

HWA and, more recently, the Department of Health, have confirmed that we must now focus on better distributing the medical workforce, and providing enough postgraduate medical training places, particularly in rural areas and in under-supplied medical specialties. Indeed, it is now clear that some medical specialties are moving into a situation of serious oversupply.

## AMA POSITION

**In addition to the workforce measures outlined in Rural Health, the AMA calls on the Government to:**

- **fix the overall number of Commonwealth Supported Places at medical schools at current levels until medical workforce modelling by the National Medical Training Advisory Network recommends otherwise;**
- **introduce legislation to regulate medical school places at public universities that have established or propose to establish medical schools catering exclusively to full fee paying students; and**
- **based on the advice of the National Medical Training Advisory Network (NMTAN), work with the learned Colleges and jurisdictions to increase specialty training positions in areas of unmet community need.**

# 14 CLIMATE CHANGE AND HEALTH

Climate change and extreme weather is already causing increased levels of ill health and deaths in Australia. Heat waves, rising temperatures, and local changes to rainfall will continue to impact on the health and wellbeing of Australians, and impact on food and water security.

Hot weather increases mortality in Australia, and air pollution exacerbates health problems. As the climate changes, so too will the health of Australians, with increasing and unpredictable demands being placed on Australia's health system.

The direct effects of climate change are already evident: injuries and deaths from increased heat stress, floods, fires, drought, increased frequency of intense storms, and extreme weather. This is why mitigation of climate change should be considered a public health measure. Policies to reduce greenhouse gas emissions have potentially large public health benefits.

Australia also faces health threats beyond our borders from current and emerging communicable diseases. Diseases and health threats do not respect borders, and the prevention of epidemics, pandemics, and other threats, and the capacity to conduct national responses, must be undertaken by an appropriately funded and staffed Centre for Disease Control (CDC).

## AMA POSITION

**The AMA calls on the Government to:**

- **develop and fund a National Strategy for Health and Climate Change, including a broad reaching adaptation plan to reduce the health impacts of climate change;**
- **pursue active transition from fossil fuels to renewable energy sources;**
- **enact the call by the World Medical Association for national governments to provide designated funds for the strengthening of health systems to combat climate change;**
- **adopt mitigation targets within an Australian carbon budget that represents Australia's fair share of global greenhouse gas emissions;**
- **reduce greenhouse gas emissions within a global carbon budget to prevent further climate harm as a result of human activity; and**
- **establish a National Centre for Disease Control (CDC) to coordinate, manage, and address potential threats. A national CDC is needed to provide surveillance of imported communicable diseases and national health emergencies; and to coordinate and manage programs for immunisation, sexual health, blood-borne viruses, tuberculosis, leprosy, and other mycobacterial diseases.**

# 15 VETERANS' CARE

The Department of Veterans' Affairs provides eligible veterans with extensive access to allied health services on referral from a GP. However, current referral arrangements do not encourage Allied Health Providers (AHPs) to report back to the GP and may, in some circumstances, encourage treatment by an AHP to persist beyond what is clinically indicated.

Feedback from AMA members suggests that it is quite common for AHPs to fail to collaborate effectively with the patient's GP, which means that important aspects of clinical management such as continuity of care and clinical accountability are lost. A more collaborative approach is essential to ensure that patient care is well coordinated and the care provided remains relevant to the clinical needs of the patient.

## AMA POSITION

**The AMA calls on the Government to:**

- **re-introduce a limit on the number of GP-referred allied health services that an eligible veteran may receive before having to obtain a further referral from their usual GP.**