AMA

KEY HEALTH ISSUES

FOR THE 2019 FEDERAL ELECTION


PHILIPS
Ward
Name :
VMO :
Admission Date :
GP :
Expected Date of Discharge :
Diet :
Mobility :
Mobility aid required :
Special Instructions :
ALERTS
Falls
Skin integrity
Lymphoedema
Family and carer questions?

Contents

Foreword – AMA President Dr Tony Bartone 2

General practice and primary care 4

Public hospitals 6

A futureproofed Medicare 8

Medical care for older Australians 10

Private health 11

Diagnostic imaging 13

Pathology 15

Task substitution 16

Mental health 18

Asylum seeker and refugee health 20

Climate change and health 22

Indigenous health 23

Prevention 25

Obesity 26

Alcohol 27

Tobacco 28

Addiction 29

Immunisation 30

Rural health 32

Medical workforce 34

Supporting GP training 36

FOREWORD

Voting for the health of every Australian

Health policy will be a vital factor in the outcome of the 2019 Federal Election. It influences votes at every election. It must.

The AMA represents all Australian doctors, not just our members, and we advocate for the best health system and the best health outcomes for all Australians.

Doctors witness the best and worst of government health policy every minute of every day across the country.

We witness it in public hospitals, private hospitals, in general practice, in private non-GP specialist practice, in aged care facilities, mental health, in people's homes, in emergency situations, in medical research, in academia. In all settings.

We witness it in the CBDs of our major cities, in the inner and outer suburbs, in the large regional centres, in towns and villages, in rural and regional outposts, in the outback, and in remote Indigenous communities. In all locations.

We witness it at all stages of life – from pregnancy to childbirth to infancy to teens to adult years and to aged care.

Doctors are uniquely placed to comment on health policy. We have the daily lived experience to know what works and what doesn't work. Our patients tell us what is good and bad about their patient journey.

Doctors are very good health policy advisers. The AMA collects this knowledge from the grassroots of health service delivery, and we pass this knowledge on to all governments.

Some listen. Some don't. Some win elections. Some don't. And health policy is usually at the core of the outcome – either way.

Our *Key Health Issues for the 2019 Federal Election* document sets out what the AMA and the medical profession believe needs to be done to keep the Australian health system up there as one of the best in the world.

And it is one of the best in the world, if not the best. But it will take hard work, good policy, and significant well-targeted funding to keep it working efficiently to meet growing community demand.

The health system has many parts, and they are all linked. Governments cannot concentrate on a few, and neglect the others. Otherwise, patients will be the ultimate losers.

The priorities remain the pillars of the health system –primary care led by general practice, public hospitals, and the private health system, which includes private hospitals and private health insurance – with the strong underpinning of Medicare.

But other sectors are gaining in prominence and need, most notably aged care and mental health. The AMA will highlight these areas ahead of the election.

We have seen some early policy announcements in the Budget and the Budget Reply. The Government announced a very welcome and much-needed significant investment in primary care, with the focus rightly on general practice. The Opposition responded with a considerable Medicare Cancer Plan, which will ease the financial pressure on cancer patients and their families.

These are both worthy contributions to the health policy contest we need to see in this election campaign, but there is so much more to do across the health system.

Indigenous health still requires significant new funding. It also needs better coordination between levels of government to ensure programs and services and health professionals are targeted to achieve the best results. This will require partnership and input from community-controlled health organisations and other local experts.

Mental health is another priority. Demand for services is growing, and better coordination is needed right across the system. GPs must have a key role.

The AMA remains committed to providing quality health services for asylum seekers and refugees, and will continue to advocate strongly on their behalf.

We also strongly believe that climate change affects human health. We want to see Government policies that recognise the science and act to reduce the impact of climate change on populations around the world.

The AMA wants the next Government to renew its commitment to prevention. As a nation, we need to do more to educate people to adjust their lifestyles to improve their health.

We need to address the obesity crisis, we need to get people more active, and we need to get people to be more responsible about killer habits such as smoking, alcohol consumption, and drug abuse. This will require nationally-coordinated education and information programs, and cooperation and coordination across all levels of government.

Primary health care, especially general practice, must be at the top of the list of the health policy agendas of the major parties at this election.

General practice touches all parts of the health system. It is the glue that holds everything together. It is the lifeblood that keeps people moving and healthy through the system.

GPs help people navigate their way to the right care for them at the right time. GPs are with their patients throughout life. They need to be supported in this vital role.

General practice is the most cost-effective sector of the health system. General practice keeps patients away from more expensive hospital care. General practice stays with patients as they enter aged care. GPs are trusted. General practice delivers.

The Government has recognised this with its Budget announcements on primary care. The Opposition must at least match this commitment.

The AMA will urge the major parties to adopt the policies and recommendations of this document. For our patients. For our communities.

And we will judge them accordingly.

Health is the best investment that any government can make.

Dr Tony Bartone
Federal AMA President

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 the community with the health system.

General practice is the cornerstone of successful primary health care, which 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 burden of chronic disease grows, requiring continuing long-term care for patients. An adequately funded primary care system 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 most 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 keeping up with this trend. This will have a significant impact on the quality of care that practices are able to provide.

In the 2019-20 Federal Budget, the Government responded to the AMA's call for significant investment to general practice. Its GP funding package includes:

- $448.5 million to improve continuity of care for patients over 70 with chronic conditions;
- increased funding for the Quality Improvement Incentive for general practices and retention of the Aged Care Access Incentive ($201.5 million);
- $62.2 million for rural generalist training; and
- $187.2 million for lifting of the freeze on over 100 Medicare items for general practice.

The Opposition has a similar commitment in relation to the Medicare freeze.

This election is an opportunity for all parties to not only lock in these levels of funding commitments, but look to build on them in order to strengthen our world renowned system of primary care.

> AMA POSITION

Immediate measures

The AMA calls on the major parties to:

- ensure that funding to support and improve the continuity of care for patients in general practice is structured in a similar way to the successful Coordinated Veterans' Care program established by the Department of Veterans' Affairs;
- increase support for longer GP consultations through the introduction of an 'extended' Level B MBS consultation item or a Service Incentive Payment that recognises the extra work involved for those GPs who spend more time with their patients;
- improve access to after-hours GP services for patients by bringing forward 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;
- introduce specific MBS rebates for GP telehealth consultations provided by a patient's usual GP for:
  + after-hours services,
  + patients with a GP Management Plan,
  + patients with mobility problems, and
  + patients in residential aged care facilities;
- support patients with hard-to-heal wounds by funding the costs of dressings for patients who:
  + have a diabetic foot ulcer or diabetic leg ulcer; or
  + have a venous or arterial leg ulcer; or
  + are 65 years of age and over; and
- support enhanced access to GP-led team-based care for patients by lifting the caps on subsidies available through the incoming Workforce Incentive Program, better supporting the employment of nurses, pharmacists, and allied health professionals in general practice.

Long-term change

While these measures will provide much-needed support for general practice in the short term, a long-term funding plan is required to transform general practices into high-performing patient-centred medical homes.

This transformation is necessary to ensure general practice can rise to the challenge of delivering quality care - which is patient-centred and cost effective, and which will reduce patients' need for more complex, high-cost health care - to patients, particularly to those with chronic disease or at risk of chronic disease.

The AMA calls on the major parties to commit to working with the profession to design and implement a more robust long-term funding model for general practice, which builds on existing fee-for-service arrangements and enables patients to access improved care in the community.

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. The most recent available data shows that, in 2016-17, public hospitals provided more than six and a half million episodes of admitted patient care[1] and, in 2017-18, managed over eight million emergency presentations[2].

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 2011-12 and 2016-17, average annual real growth in Federal Government recurrent funding for public hospitals was 3.7 per cent[3]. This is a slight improvement from the mere 2.8 per cent per annum growth over the period, 2010-11 to 2015-16[4].

The AMA recognises Federal Government recurrent funding rose by 6.2 per cent over the 12 months to 2016-17[5]. We also note this follows an 8.4 per cent increase in Federal recurrent funding the previous year, 2014-15 to 2015-16[6]. Despite these reported statistics, doctors and nurses working at the public hospital coalface know these Federal funding statistics mainly reflect an increase in the number of admitted public hospital episodes.

Between 2015-16 and 2016-17, separations grew by 5.0 per cent - a level of growth slightly higher than the longer-term average of 4.5 per cent over the four years, 2012-13 to 2016-17[7].

The statistics tell the story of activity-based funding and the terms of the healthcare agreement between the Commonwealth and the States. Activity-based funding is good at driving public hospitals hard to increase volume growth and technical efficiency to deliver services within tight budgets. However, activity-based funding also forces public hospitals into a spiral of cost minimisation and patient churn to survive. The healthcare agreements do nothing to require governments – Federal or State – to invest the money needed to improve the quality and safety of patient care.

Frequent media headlines tell a story of public hospitals under enormous pressure. Likewise, the AMA 2018 Public Hospital Report Card and Safe Hours Audit are a window into the lived experience of dedicated doctors, struggling to deliver quality care in over-crowded, under-funded public hospitals.

Instead of investing more to ensure public hospitals have the resources they need to improve patient safety and quality, governments decided to financially punish public hospitals for poor patient safety events. The AMA wants to see improved safety and quality of care in Australian public hospitals – but there is no conclusive evidence to show that financial penalties work.

Health care is complex. Not all patient complications can be avoided. Adverse patient safety events escalate with poor staff communication, high patient-to-doctor ratios, delayed treatment, and unsafe doctor work hours.

Financial penalties will only escalate these risk factors and do nothing to help improve patient safety and quality.

The funding parameters of the 2020-25 hospital funding agreement do little to improve the situation. It is time that governments acknowledge activity-based funding does not contribute ongoing funding towards the commitments in the agreements to co-ordinate patient care post-discharge and prevent avoidable admissions.

The AMA supports better discharge planning and integrated care, especially for patients with complex and chronic disease. But the ageing population and the increasing incidence of obesity and chronic disease means this will cost money – a lot of it. Public hospital budgets must not be used to fund this work. The recently announced Community Health and Hospital Fund may end up with some funded projects aimed at better coordinated care. What is needed, instead, is long-term, ongoing Commonwealth hospital funding to enable all hospitals to invest and develop the critical linkages and systems needed to achieve integrated care pathways for patients on discharge.

> AMA POSITION

The AMA calls on the major parties to:

- boost funding for public hospital services beyond levels set out in the 2020-2025 agreement, and lift public hospitals out of their current funding crisis, which is putting doctors and patients at risk;
- stop penalising hospitals for adverse patient safety events;
- stop the blame game that perpetuates a hospital funding see-saw where increases at one level of government are countered by decreased funding at the other;
- fully fund hospitals so they can improve patient safety and build their internal capacity to deliver high value care in the medium to long term;
- include an explicit ongoing Commonwealth contribution above and beyond the activity-based formula, to fund the obligations on jurisdictions to deliver integrated care post-discharge to prevent avoidable re-admissions;
- include an explicit ongoing Commonwealth contribution above and beyond the activity-based formula, to fund the obligations on jurisdictions to reduce potentially avoidable admissions for patients with complex and chronic disease as specified in the 2020-25 agreement; and
- fully compensate States and Territories for any loss in private patient revenue and avoid funding or policy decisions that would have the effect of diminishing support for patients who elect to be treated as a private patient in a public hospital.

[1] AIHW Australian Hospital Statistics, Admitted Patient Care 2016-17 Table 2.1
[2] AIHW Australian Hospital Statistics, Emergency Department Care 2017-18 Table 2.1
[3] AIHW Australian Hospital Statistics, Health Expenditure Australia 2016-17 Table A10
[4] AIHW Australian Hospital Statistics, Health Expenditure Australia 2015-16 Table A10
[5] AIHW Australian Hospital Statistics, Health Expenditure Australia 2016-17 Table A10
[6] AIHW Australian Hospital Statistics, Health Expenditure Australia 2016-17 Table A10
[7] AIHW Australian Hospital Statistics, Admitted Patient Care 2016-17 Table 2.1

A futureproofed Medicare

The AMA supports a Medicare Benefits Schedule (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. One based on robust research and a strong evidence base. It also needs to be one that provides adequate patient rebates so that we don't end up with a two-tier system – those who can afford treatment and those who can't.

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 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 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. It also includes clinicians who have the right experience – those who work with and use the MBS daily.

As with all important policy development, implementation is critical. We call on an incoming Government to ensure appropriate planning and introduction of recommendations from the MBS Review. This includes allowing adequate lead time for consultation with private health insurers, the relevant profession/s, peak bodies, and various compensation schemes. If an incoming Government fails to do so, they risk jeopardising the private health insurance reforms, which could lead to creation of unexpected out-of-pocket costs for patients, or simply fail to see the intent of the MBS Review realised. Overlooking this vital part of the Review process risks undoing the significant work, and goodwill, of the many clinicians who have invested their time and skill in the MBS Review.

The AMA also stated the MBS Review must not be a savings exercise. Any savings must be reinvested in Medicare – and that investment should be in the form of increased rebates, new items, and a more contemporary system. Funding increased volume and indexing Medicare merely keeps the system afloat – the savings from the review need to be investment above and beyond the business as usual responsibilities of government. An answer provided in October 2018, to a Senate Estimates question in May, confirmed that savings of $686.5 million have been generated from the MBS Review to date, and there will no doubt be further savings as the review continues.

In addition to re-investment in Medicare through new and amended items, the AMA calls on an incoming Government to continue annual indexation and at an adequate rate. Failing to do so will only make out-of-pockets grow further.

The MBS needs an ongoing review mechanism, beyond the current MBS Review Taskforce, to ensure it continues to reflect current and innovative clinical best practice.

Finally, in the lead-up to, and during the election campaign, parties will announce various commitments to improving MBS services and rebates, and we call on them to consult closely with the AMA on the implementation of these investments.

> AMA POSITION

The AMA calls on the major parties to:

- establish a Medicare Reinvestment Fund – one that ensures every cent taken out of the MBS Reviews is reinvested in new and improved items recommended by the Committees, and kept separate from the funding needed to fund indexation and increased volume;
- ensure there is a robust and transparent implementation process, with appropriate time 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;
- that indexation is never again frozen, and that patient rebates are indexed at an adequate rate; and
- there is an enduring process for reforming and reinvesting in the MBS beyond the current time limited MBS Review Taskforce.

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 and coordination in the aged care and health systems.

This inequity 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.

Over the past financial year, we have seen extensive consultation with stakeholders and consumers on the future of our aged care system, via numerous reviews. Now is the time for action.

There are several factors that contribute to poor quality care. However, many quality issues could be rectified by improving the capacity and capability of the aged care workforce.

An increase in funding for GP visits to Residential Aged Care Facilities (RACFs) can improve access to primary care and would result in savings from reduced ambulance transfers to hospital emergency departments. MYEFO 2018 made a start, but much more is needed.

We also need to ensure that the critical role registered nurses play in caring for older Australians is recognised via minimum standards for nursing availability under staff ratios in RACFs.

> AMA POSITION

The AMA calls on the major parties to:

- take responsibility to ensure quality of, and timely access to, specialist support and allied health in all aged care settings. This includes palliative care, mental health care, physiotherapy, audiometry, dentistry, optometry, and occupational therapy;
- introduce a mandatory minimum staff to resident ratio that reflects the level of care needs, and ensures 24 hour on-site registered nurse availability;
- act on the results of the AMA aged care survey by significantly increasing Medicare rebates by 50 per cent - $500 million over four years (on top of announcements in MYEFO 2018) for services in RACFs so that they adequately cover the time that doctors spend with the patient assessing and diagnosing their condition and providing medical care. While the $98 million MYEFO 2018 funding is supported, it leaves GPs who treat a large number of patients in a single RACF financially worse off than before the MYEFO change. Considering the benefits a usual GP brings to their patient, we need to encourage GPs to see more RACF patients, not fewer;
- provide better funding support for services being delivered on site (such as mobile radiology services), which can save on costly hospital transfers;
- 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; and
- prevent older people from prematurely entering RACFs and hospitals by increasing the number of home care packages to reduce waiting times.

Private health

The AMA believes in a simpler and fairer private health insurance system to better support the Australian private health system. Without the private system, the public system would likely collapse. Already we have struggling public hospitals - we can't allow this to get any worse.

It was impossible for consumers to understand the multiplicity of carveouts, restrictions, and exclusions of the 70,000 variations of policies that made up our private health insurance system. Something had to change. This is the reason the AMA supported the Government's reforms of private health insurance, including the concept of developing the Gold, Silver, Bronze, and Basic health insurance products – but we believe we must go further.

There is increasing corporatisation of private health and the market power is shifting in favour of private health insurers. Insurers should not determine the provision of treatment in Australia. They should not interfere with the clinical judgement of qualified and experienced medical practitioners. Australian medical practitioners have at least a decade or more of training and experience behind them. They are best placed to determine what is appropriate for their patients. Australians do not support a US-style managed care health system, and neither does the AMA.

The AMA acknowledges that the system needs to change if we are to improve consumer confidence. Out-of-pocket costs are negatively affecting consumers' view of the value of having insurance. As a profession, the AMA realises we have some heavy lifting to do on this. The AMA has been vocal. We do not support egregious billing or the use of administrative and booking fees. They are unprofessional, inappropriate, and unacceptable.

But let us be clear about what constitutes out-of-pocket costs to patients – this is not a conversation that can be limited to what doctors charge. Doctors' fees are meaningless in a system where most services are provided at no, or known, gap rates.

Nationally, Australians spent $29.4 billion on out-of-pocket health-related expenses in 2016-17. Most of this was on prescription and non-prescription medications ($10.8 billion or 37 per cent), dental services ($5.7 billion or 19 per cent), and other health care such as aids and allied health services outside Medicare ($6.7 billion or 23 per cent). Medical costs make up only 21 per cent of out-of-pocket expenditure for individuals[1]. Additionally, medical services represent approximately 16 per cent of private health insurance Benefit outlays for hospital treatments[2].

Also contributing to out-of-pocket costs are the wild variations that occur between what insurers pay as rebates across the industry, and even across States. To tackle the issue of out-of-pocket costs, the Government has announced the development of a website that will list doctors' fees. Doctors' fees without information on insurer's rebates will not inform patients about their out-of-pocket costs.

We must be honest about the reason out-of-pocket costs arise. There has also been a five-year freeze on the MBS rebate – which was inadequate to begin with.

But practice rents, staff, and consumable costs have not been frozen. Doctors have had to buy new equipment, they have mandatory training they must complete every year, and registration fees - and none of these were frozen.

Yes, we must do better, but we must do better across the whole system. We cannot scapegoat one group and expect the problem to be resolved.

The AMA has been at the table for private health insurance reforms working alongside insurers, hospital groups, consumer groups, and the Government on an approach we can all agree on, and we have been at the table on out-of-pocket costs. But there is no doubt that further reform is needed, and it needs to consider the full range of underlying concerns our patients have.

> AMA POSITION

The AMA calls on the major parties to:

- ensure the development of a fee transparency website that is helpful to patients. Patients want to know what their out-of-pocket cost will be for a health procedure. A website that only shows doctors' fees will not deliver this. To determine an out-of-pocket cost, patients need to know what rebates they will receive from their health insurers – some are certainly far better than others;
- further, due to the current policy settings in private health insurance, rebates revert back to the MBS figure if the gap rate is exceeded. This means out-of-pocket costs can increase dramatically – making it harder for doctors and patients to know what the true out-of-pocket cost will be. An incoming Government should consider a review of this policy mechanism and include insurer fee setting in it; and
- ensure that a future review of private health insurance addresses;
    + insurer-related gaps – some insurers are linking their gap schemes to specific facilities. If your hospital does not have or cannot get an agreement with your insurer, even if your doctor has signed up for a no-gap scheme, it can't be used under some insurer's arrangements. In this case, you are left with the default 25 per cent of the Medicare rebate paid by the insurer and a large out-of-pocket cost;
    + indexation of rebates – private health insurance rebates are based on MBS rebates and, like the MBS, are undervalued and have failed to keep pace with health inflation. Doctors costs continue to increase, and out-of-pocket costs grow;
    + variation in rebates - private health insurance products are now based on the same clinical definitions and are not allowed restrictions above the Basic level. Rebates should now match this level of transparency. Rebates vary across insurers and can even vary across States for the same insurer. If we can simplify the private health insurance products, we must be able to make rebate transparency possible as well; and
    + insurer contracts - the AMA is increasingly worried about the growing power wielded by the private health insurers. Through their contractual arrangements we are seeing insurers exert more influence on the patient, impacting their clinical choices. If we don't prevent insurers making these changes, we will move closer to a managed care system. Patients see choice as a key component of value for private health insurance. They want their choice of doctor, and they want their choice of hospital.

[1] https://www.aihw.gov.au/reports/health-welfare-expenditure/patient-out-pocket-spending-medicare-2016-17/contents/summary

[2] https://www.apra.gov.au/publications/private-health-insurance-quarterly-statistics

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.

Medicare rebates for diagnostic imaging services have not been indexed for nearly 20 years. The Government's pre-Budget announcement that Medicare rebates for most diagnostic imaging services will again be indexed from 1 July 2020 is therefore welcomed, as is the additional funding for other diagnostic imaging services. The AMA calls on the major parties to commit to implementing this positive change, as a minimum, should they be elected to Government in the forthcoming election.

Indexation will provide some minor relief for patients and is a step in the right direction. 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 must 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. The Government MYEFO announcement that new MBS funding had been approved for a handful of diagnostic imaging services is also welcomed.

However, the Diagnostic Imaging Clinical Committee under the MBS Review has also made numerous recommendations for new items reflecting contemporary medical practice. An incoming Government must approve funding for these tests without delay.

An incoming Government also needs to do more to support rural, regional, and remote patients by allowing a more flexible and adaptive system of referrals and patient management to reduce the need for patients to make numerous trips to larger towns and cities 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 save on Medicare expenses by skipping unnecessary services.

Again, the Diagnostic Imaging Clinical Committee has made recommendations that will help support patients better.

An incoming Government should also scrap the licensing system for magnetic resonance imaging (MRI) 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. The AMA therefore welcomes the announcement by the ALP that it will remove licensing restrictions for MRI machines for cancer scans, and increase rebates, as a first step.

Policies, regulations, and funding should support the right patients getting the right service at the right time.

> AMA POSITION

The AMA calls on the major parties 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.

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.

At the same time, pathology providers must provide quick and efficient services with many operating 24 hours a day, 7 days a week, to underpin the care of critically ill patients, surgical emergencies, and emergency obstetrics. This responsiveness comes at an increased cost.

But essential support for these cost-effective services is eroding. Government rebates for pathology services have not been indexed in two decades. Unlike most rebates for diagnostic imaging which the Government announced would be indexed from 1 July 2020, no similar relief is in sight for pathology. 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 dependency must be considered in any future item changes.

An incoming Government must 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.

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

Supporting a diverse and highly skilled pathology workforce is also critical to meet the challenges of evolving health care, most clearly demonstrated through the rapidly evolving field of genomics.

Health genomics enables precise and tailored treatments for individuals. As well as saving patients from undergoing therapy that won't be effective, it allows targeting of expenditure so that expensive treatment is directed to those it will help.

Investment in an appropriately skilled pathology workforce and contemporary, evidence-based pathology services is necessary to meet this challenge.

> AMA POSITION

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

- ensuring that Medicare rebates for pathology services are adequately funded so that patients receive quality services;
- investing in a sustainable, diverse pathology workforce, including in regional areas; and
- increasing investment in the development of a health genomics workforce and patient access to genomics-based health services in both the private and public sector.

Task substitution

Quality health care for patients depends on a well-trained workforce providing coordinated care under the direction of fully-educated, trained, and accredited doctors.

The AMA recognises the challenge of maintaining a health workforce of adequate size and quality to meet the future health needs of the community. There are current and projected shortages across many sectors of the medical and health workforces.

The AMA supports the model of healthcare teams led by a doctor, and believes that this underpins the high quality of care in this country. A healthcare team may involve other specialist doctors as well as other health practitioners, where each member of the healthcare team contributes an essential mix of skills and experience to achieve the highest quality of care for the patient.

The AMA is extremely concerned that patient safety and quality of care could be at risk by the expansion of the roles of non-medical health practitioners into areas outside their field of expertise.

Task substitution also risks undermining training programs for doctors and can negatively impact on health expenditure. Where there is minimal evidence and substantial risk, non-medical health practitioners must not replace doctors.

In addition to the fact that the patient will be cared for by a lesser-trained professional, there are specific quality issues involved, including reduced patient-physician contact, fragmented and inefficient service, lack of proper follow-up, incorrect diagnosis and treatment, and inability to deal with complications.

The AMA supports appropriate delegation of tasks to other types of health practitioner where it can be demonstrated that there is an improvement in the delivery and maintenance of quality patient care, and where there is agreement between the relevant practitioners.

For the delegation of medical tasks to be safe and effective, it must be performed in a team environment, where supervision can be provided and responsibility taken by a doctor.

Task substitution should not be undertaken or viewed as a cost-saving measure because the economic benefits of task substitution remain unsubstantiated. Credible analysis of the economic benefits of task shifting should be conducted in order to measure health outcomes, cost effectiveness, and productivity.

Workforce reform may contribute to more efficient use of available resources and may form part of the solution to the current workforce crisis. However, the overall numbers of practitioners and the quality of their training cannot be ignored. The substitution of doctors with other health practitioners is not the solution to improve access to care where doctors are in undersupply.

Proper, long-term health workforce planning and adequate funding of the entire system is required to maintain a flexible, well-structured and organised health workforce that is equipped to meet the current and future health needs of the community.

> AMA POSITION

The AMA calls on the major parties to:

- provide enough funding to develop the health workforce to meet the healthcare needs of communities;
- provide enough funding to support the development of multidisciplinary healthcare teams led by doctors to better integrate, not fragment, patient care;
- provide enough funding to ensure communities living in rural and remote areas of Australia receive access to high-quality health care through access to appropriate doctor-led care;
- consult with and involve doctors and their professional associations from the beginning on any proposal for expanded scopes of practice, especially in the reform of legislation and regulation;
- ensure that any current or proposed doctor role substitution measures are rigorously assessed to ensure the community continues to receive health care to the high medical standards they currently enjoy and deserve;
- reject ad hoc 'medical to non-medical' role substitution programs in all healthcare sectors and settings; and
- ensure that the non-medical health practitioner boards enforce limits on scope of practice to those validated by comprehensive assessment on education, training, and competence.

Mental health

Mental health should be a national priority.

The extent of mental health conditions in the community is significant, with almost half the Australian adult population expected to experience a mental health problem in their lifetime. Yet this sector receives less than half the funding of the comparable burden of disease funding.

Mental health is grossly underfunded when compared to physical health.

Despite recent investments in the Budget and welcome new initiatives for people with eating disorders and in perinatal mental health, funding is not properly weighted between community-based mental health services, acute care, and advocacy. There is still no overarching effective and evidence-based approach to mental health services in Australia.

There is marked lack of capacity at all levels of mental health care, causing unacceptable delays to care and undue pressures on the public health system, especially emergency departments.

Investing in Australia's mental health will deliver enhanced economic and social returns, including a reduction in avoidable emergency department admissions and presentations, reduced demand on public hospital beds, reduction in homelessness, less absenteeism, and improved economic productivity and greater workforce participation.

The medical profession plays a key role in the prevention and amelioration of issues causing mental illnesses. The AMA believes that a multi-faceted, multi-disciplinary strategy is required to improve access and care to this very vulnerable group of Australians. This strategy should encompass:

- improved service delivery;
- significantly increased funding;
- improved coordination;
- workforce planning and investment;
- prevention, education, and research; and
- e-health/telemedicine solutions.

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> AMA POSITION

The AMA calls on the major parties to:

- take a leadership role in managing the distribution of ongoing evidence-based funding across the States and Territories to ensure there are no gaps that leave vulnerable Australians without access to mental health care;
- base mental health policies and funding on sound research, and enhanced by input from practising clinicians and from consumers and carers;
- increase consistent capacity across the country for Primary Health Networks (PHNs) to coordinate and deliver mental health policies;
- fund and resource an appropriately sized, skilled, and resourced mental health workforce – addressing workforce gaps should be a priority;
- invest in initiatives that will build up workforce capacity and service delivery for those living in regional and remote areas;
- commit to a level of funding that allows for a mix in the range and level of mental health care available for all Australians, regardless of their geographical location, level of income, and ethnic background; and
- provide increased access to e-health and telemedicine for service delivery.

NDIS

- the National Disability Insurance Scheme (NDIS) must be properly and adequately resourced so that patients are not left without support or care for their mental health issues;
- properly fund NDIS providers; and
- commit to using any NDIS underspends on improving staff capabilities and IT systems used by the NDIS.

Asylum seeker and refugee health

The AMA reaffirms its position that those who are seeking, or who have been granted, asylum within Australia have the right to receive appropriate medical care without discrimination, regardless of citizenship, visa status, or ability to pay.

Like all people seeking health care, asylum seekers and refugees in Australia, under the protection of the Australian Government, or in off-shore or mainland detention facilities, should be treated with compassion, respect, and dignity.

The AMA believes that decisions made by clinicians treating asylum seekers must be respected and never be undermined, delayed, or countermanded by Government officials with no medical qualifications.

Refugees and asylum seekers experience more health problems than the general population, and they are at particular risk from a range of conditions including psychological disorders such as post-traumatic stress disorder, anxiety, depression, and the physical effects of persecution and torture.

They may also suffer the effects of poor dental hygiene, poor nutrition and diet, and infectious diseases such as tuberculosis, which may be more common in their countries of origin.

All asylum seekers and refugees should have access to the same level of health care as all Australian citizens.

They should have their special needs, including cultural, linguistic, and health-related, appropriately addressed.

The AMA supports the establishment of an Independent Health Advice Panel (IHAP) with the power to investigate and advise the Parliament on the health and welfare of asylum seekers and refugees.

Asylum seekers and refugees should not be transferred to off-shore locations where they cannot access appropriate physical and mental health care, including telemedicine.

The AMA also wants refugees and asylum seekers living in the community to have access to Medicare and the Pharmaceutical Benefits Scheme (PBS), State welfare and employment support, and appropriate settlement services.

Immigration policies that restrict the social and economic rights of disadvantaged groups of people, such as asylum seekers and refugees, can have adverse impacts on their health and wellbeing.

The AMA implores the Australian Parliament to take every measure to ensure that the health needs of refugees and asylum seekers are appropriately met.

> AMA POSITION

The AMA calls on the major parties to:

- guarantee that no asylum seeker children and their families remain on Nauru and Manus Island and they are accommodated where they can receive appropriate health care in a public and transparent way, preferably in Australia;
- support the work of the Independent Health Advice Panel (IHAP) to monitor, assess, and report on the physical and mental health or refugees, asylum seekers, and transitory persons in regional processing countries;
- provide funding to IHAP to cover all costs associated with its operations, including funding for IHAP members to carry out their tasks, such as travel, accommodation, and appropriate remunerations; and
- ensure refugees, asylum seekers, and transitory persons have access to appropriate GP and specialist medical care, including telemedicine.

Climate change and health

The AMA recognises that human health is ultimately dependent on the health of the planet and its ecosystem. Climate change is having significant impacts on human health and health systems, and these impacts will increase in severity as the planet warms.

The serious direct and indirect health impacts of climate change include mortality and morbidity resulting from heat stress and extreme weather events; an increase in the transmission of vector-borne diseases; food insecurity; mental ill-health; and negative effects from adverse changes in air pollution. There is inequity in the distribution of these impacts both within and between countries.

Although almost all Australians acknowledge the environmental harms associated with climate change, the connection between climate change and human health is less understood. National leadership and coordination is required to draw attention to this issue and to implement interventions to mitigate the health impacts of climate change.

> AMA POSITION

The AMA calls on the major parties to:

- commit Australia to shouldering its fair share of the burden for global greenhouse gas emissions reduction by adopting mitigation targets within an Australian carbon budget;
- develop and fund a national strategy for climate change and health;
- pursue an urgent transition from fossil fuel energy to renewable energy;
- commit to reducing exposure to harm from nearby sources of air pollution, including by ensuring that current air quality standards are aligned with international best practice;
- establish an Australian Sustainable Development Unit (SDU) to coordinate efforts to enhance the environmental sustainability of the healthcare sector; and
- establish an Australian National Centre for Disease Control (CDC), with a national focus on current and emerging communicable disease threats, engaging in global health surveillance, health security, epidemiology, and research.

Indigenous health

Despite modest gains in the life expectancy for Aboriginal and Torres Strait Islander people in recent years, progress is frustratingly slow and much more needs to be done to close the unacceptable gap in health outcomes between Indigenous and non-Indigenous Australians.

Statistics paint a disturbing picture in 21st century Australia, including:

- a life expectancy gap of around 10 years between Aboriginal and Torres Strait Islander people and other Australians, which is now widening;
- a death rate for Aboriginal and Torres Strait Islander children that is more than double the rate for non-Indigenous children;
- preventable hospital admissions and deaths being three times higher for Aboriginal and Torres Strait Islander people than their non-Indigenous peers; and
- Medicare expenditure being about half the needs-based requirements, and Pharmaceutical Benefits Scheme (PBS) expenditure being about one-third the needs-based requirements.

> AMA POSITION

The AMA calls on the major parties to:

- properly fund the Indigenous health portfolio by identifying areas of poor health and inadequate services for Aboriginal and Torres Strait Islander people and direct funding according to need;
- adopt recommendations from the AMA Report Cards on Indigenous Health, especially:
  - + committing to a target to prevent new cases of Rheumatic Heart Disease (RHD) and committing to fully funding and implementing a strategy to end RHD in Australia, as called for in the AMA's 2016 Report Card on Indigenous Health; and
  - + committing to a coordinated national strategic response to addressing chronic otitis media, as called for in the AMA's 2017 Report Card on Indigenous Health.
- fund and implement existing Government strategies and plans for Aboriginal and Torres Strait Islander health that have not yet commenced or been delivered;
- fund Aboriginal community-controlled health organisations (ACCHOs) according to need, and develop systemic linkages between ACCHOs and mainstream health services to ensure high-quality and culturally-safe continuity of care;
- implement measures to increase access to primary care and medical specialist services for Aboriginal and Torres Strait Islander people;
- establish new or strengthen existing training programs to address the shortfall of Aboriginal and Torres Strait Islander people in the health workforce;

- increase funding for Aboriginal and Torres Strait Islander mental health services and increase investment into suicide prevention;
- increase funding for family violence and frontline legal services for Aboriginal and Torres Strait Islander people;
- adopt a justice reinvestment approach by increasing funding to services to divert Aboriginal and Torres Strait Islander people from prison, given the strong link between health and incarceration;
- work with State and Territory Governments to raise the age of criminal responsibility to 14 years-of-age;
- commit to the Uluru Statement from the Heart; and
- ensure that the social determinants of health including poverty, poor quality housing, insufficient access to affordable healthy food and potable water, and the absence of health infrastructure are at the core of health policies and programs.

Prevention

Investing in preventive health measures can reduce the rate of chronic ill health and improve the health and wellbeing of all Australians.

Harmful use of alcohol, illicit drugs, poor food choices, and overconsumption - combined with an obesity epidemic, sedentary behaviour, and a lack of physical activity - are contributing to Australia's high rates of cardiovascular conditions and poor health outcomes. Preventive health measures that help Australians to avoid or alter these behaviours are likely to have significant health and economic gains.

Primary and secondary prevention methods are also needed to address the public health impact of family and domestic violence. Primary prevention, in the form of respectful relationships education, workplace equality programs, and the use of multiple levers to induce cultural change, requires long-term, planned funding and national coordination. For women and children experiencing violence, appropriately funded legal and community services, crisis accommodation, and financial support are needed to prevent further harm.

Governments have shown initiative in some areas of health prevention, especially in reducing smoking rates through higher tobacco taxes and plain packaging. However, successive governments have underinvested in evidence-based health prevention and early intervention. This is even though spending upstream on effective prevention and early intervention measures results in significant downstream cost savings.

Health prevention is an investment not only in the individual, but there are social, economic, and community savings to be realised by helping Australians to be healthier and make better health decisions.

> AMA POSITION

The AMA calls on the major parties to:

- establish and support a dedicated preventive health promotion agency or organisation;
- fund prevention and early intervention services, recognising that such investment is sound and fiscally responsible for individuals as well as the Australian health system; and
- provide dedicated funding for a national physical activity strategy.

Obesity

An increasing number of Australians are obese, and obesity is challenging tobacco smoking as the major cause of preventable death in Australia. Obesity substantially contributes to preventable, non-communicable diseases, shortened life expectancy, and impaired quality of life.

Combating obesity demands a whole of society approach, with the participation of all governments, non-government organisations, the health and food industries, the media, employers, schools, and community organisations.

> AMA POSITION

The AMA calls on the major parties to:

- develop, fund, and implement a National Strategy to coordinate and prioritise efforts to reduce obesity;
- introduce a tax or levy on sugar-sweetened beverages, recognising that a price signal will reduce consumption;
- legislate restrictions on the marketing and promotion of junk food and soft drinks to children and adolescents;
- make active transport measures a priority in all transport and infrastructure policies; and
- make dedicated efforts to increase participation in physical activity, which recognise that not everyone wishes to participate in competitive sport.

Alcohol

Australians drink a large volume of alcohol overall, and many drink at harmful levels, including teenagers and young adults. Many young Australians drink in a way that puts their own and others' health at risk. Recent statistics show an increase in risky drinking in middle-aged and older Australians.

A range of factors can contribute to harmful alcohol use, including the marketing and glamorisation of alcohol, the social acceptability of hazardous use, the ready availability of alcohol, and its affordability.

The harms of excessive alcohol use are significant and warrant serious measures, especially regarding adolescents and youth.

The AMA is committed to Australia achieving the greatest possible reduction in the harmful effects of excess alcohol consumption.

The AMA believes these harms are best reduced through targeted prevention and early intervention, and fully resourced best-practice treatment.

> AMA POSITION

The AMA calls on the major parties to:

- coordinate national action by urgently releasing and implementing the National Alcohol Strategy, the last iteration of which ended in 2011;
- lead a consistent national approach to the supply of, and access to, alcohol;
- monitor and evaluate the success of the October 2018 implementation in the Northern Territory of a floor price on alcohol, and, if successful, look for opportunities for expansion into other jurisdictions;
- implement volumetric taxation on alcohol products;
- legislate mandatory front-of-pack warnings on all packaged alcoholic beverages;
- initiate and fund effective and sustained advertising campaigns especially targeting young people, pregnant women, and Aboriginal and Torres Strait Islander people;
- tighten regulations for alcohol marketing and promotion; and
- increase the availability of targeted alcohol prevention and treatment services.

Tobacco

The AMA recognises that tobacco is unique among consumer products in that it causes disease and premature death when used exactly as intended. There is no safe level of tobacco smoking.

The AMA believes that doctors have a responsibility to encourage all smokers to quit smoking.

Doctors share a responsibility to advise their patients on the well-established risks associated with smoking, to assist patients in their attempts to quit smoking, and to cooperate with community education programs that aim to discourage smoking.

The AMA acknowledges that the highly addictive quality of nicotine makes it difficult for smokers to quit. For this reason, smokers must be encouraged and supported to give up smoking at every opportunity. Workplaces can play an important role in this regard.

Pharmaceuticals that assist in quitting smoking, such as medications and nicotine replacement therapy, should be affordable and less expensive than cigarettes.

> AMA POSITION

The AMA calls on the major parties to:

- update and fully fund the National Tobacco Strategy to ensure that Australia continues to be a world leader in tobacco control;
- provide dedicated funding for the Strategy to support a national advertising and awareness raising campaign, updated graphic warnings, plain tobacco packaging, and continued increases in excise;
- monitor and assess the evidence around the effectiveness of e-cigarettes as cessation aids;
- provide appropriate funding for doctors who take the time to support their patients through the process of smoking cessation, recognising that patients require tailored advice, and may require referral and ongoing support to reinforce their decision to quit smoking;
- provide funding and support to the various jurisdictions to pursue and expand smoke-free environments, recognising nationally-consistent legislation is in everyone's best interest;
- apply the same marketing and advertising restrictions to e-cigarettes that apply to tobacco products;
- continue funding for international litigation to fight efforts to undermine Australia's world-leading tobacco control measures; and
- increase funding for the Tackling Indigenous Smoking program to achieve continued decreases in the rates of smoking among Aboriginal and Torres Strait Islander peoples.

Addiction

Drug and alcohol dependence is a health issue and should be treated as such.

People affected by drug and alcohol dependence should be treated like other patients with serious illness, and be offered the best available treatments and supports to recovery.

The AMA has raised concerns about the capacity of the drug and alcohol treatment sector in Australia, because in most instances demand outweighs availability.

Australia needs a major change in funding priorities from policing and prosecution of substance users to interventions that avoid or reduce use, promote resilience, and reduce societal harms.

> AMA POSITION

The AMA calls on the major parties to:

- monitor and evaluate the drug and alcohol treatment funding that is administered through the Primary Health Networks to ensure people are getting access to the services that they need in a timely fashion;
- provide greater focus and funding for support services for those dependencies and addictions, including alcohol, that cause the greatest levels of harm to individuals and society, regardless of whether it is socially palatable;
- invest in programs that promote resilience, prevention, reduced drug use, and early interventions and treatments;
- provide support for families and communities affected by dependence and addiction; and
- support sanctioned, appropriately supervised, and monitored high-quality pill testing trials to minimise the risk to young people, and build an evidence base to determine the effectiveness of pill testing in Australia.

Immunisation

Immunisation is a safe and effective way to prevent the spread of serious disease that can result in illness, disability, and even death. Policies that promote and support immunisation are vital to the continued success of childhood immunisation in Australia.

Routine childhood immunisation not only conveys protection to the immunised child, it also provides a level of protection for the broader community through herd immunity. Herd immunity reduces the spread of vaccine-preventable disease and is vitally important for those vulnerable individuals in the community who are unable to be immunised. While the proportion of the population that needs to be vaccinated to achieve herd immunity varies on each disease, 95 per cent is the established goal for highly contagious diseases, and 90 per cent for less contagious disease.

Australia's National Immunisation Program (NIP) is the key vehicle for the funding and delivery for routine childhood immunisation in Australia. The NIP has been recognised nationally and internationally as a success, but we must not become complacent. Data from September 2018 reveals that:

- 94.02 per cent of all one-year olds were fully vaccinated.
- 90.63 per cent of all two-year olds were fully vaccinated.
- 94.62 per cent of all five-year olds were fully vaccinated.

Recent population level policies such as No Jab No Pay have resulted in a measurable improvement in childhood immunisation coverage. However, national figures overlook the geographic pockets of low immunisation rates that exist in some Australian communities.

Throughout the country, in both metropolitan and rural areas, there are communities where the immunisation coverage rates fall to as low as 88 per cent. In these communities, better targeted initiatives are required to improve coverage - initiatives that address misconceptions or misunderstandings about the benefits of immunisation, as well as initiatives that seek to improve access to routine childhood immunisations.

It should be a goal of any incoming Government to see childhood immunisation coverage increase to 95 per cent and above for all vaccine-preventable diseases.

> AMA POSITION

The AMA calls on the major parties to:

- commit to the necessary funding to ensure that new vaccines recommended and supported by the Australian Technical Advisory Group on Immunisation (ATAGI) and the Pharmaceutical Benefits Advisory Committee (PBAC) be included on the National Immunisation Program Schedule in a timely manner;
- continue support for population level measures, such as No Jab No Pay, to ensure Australia achieves and maintains high levels of immunisation within the Australian community. This support must extend to initiatives such as the Australian Immunisation Register, as well as canvass potential new initiatives that will further support increased immunisation;
- support doctors to play a vitally important role in supporting routine childhood immunisation. This role must be recognised and supported as part of efforts to improve immunisation coverage. Financial and other support must also be provided to develop and disseminate trustworthy authoritative materials that educate and support parents with vaccine-related questions;
- fund initiatives that target those geographic areas known to have low levels of immunisation. These initiatives must be tailored to the specific needs of communities, which may involve consultation with parents who have concerns about vaccination. The effectiveness of such initiatives must be closely monitored;
- continue funding for vaccine monitoring and surveillance activities, including surveillance for new and emerging disease threats; and
- consider the potential benefits of a no-fault vaccines compensation program. Such programs exist internationally and may provide reassurance for those who are concerned about vaccine-related injury.

Rural health

The AMA welcomed the Government's commitment in the 2019-2020 Federal Budget to fast track the National Rural Generalist Pathway (NRGP) with $62.2 million funding, building on the 100 NRGP places announced in last year's Budget, and due to commence in 2021.

This is an important step as part of the broader Stronger Rural Health Strategy announced in the 2018-19 Federal Budget to improve the distribution of the medical workforce in Australia, with an emphasis on encouraging more doctors to live and work in rural and regional Australia.

The AMA calls on the major parties to commit to implementing this positive change, as a minimum, should they be elected to Government in the forthcoming election. In addition to this, the AMA calls for further investment in rural health through initiatives such as rural GP infrastructure grants and significant additional rural medical specialist training places as key parts of an overall suite of measures to deliver more doctors and better health outcomes for rural communities.

The 2019 AMA Rural Health Issues survey revealed that the most critical issue for rural doctors who responded was the provision of extra funding and resources to support improved staffing levels, including core visiting medical officers, to allow workable rosters.

The second most important issue was access to high-speed broadband for medical practices, encompassing general practice and specialist practice, followed by support for the specialty training in rural areas - subject to appropriate experience and supervision.

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.

The More Doctors for Rural Australia Program (MDRAP), along with a one-off fellowship program, will encourage non-vocationally registered doctors practising rurally to join a path to fellowship by providing them with access to Medicare items. However, this will require funding for significant additional supervision and resources to be provided by already overworked rural GPs.

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.

Evidence shows that if a medical student spends two to three years training in regional hospitals and general practice, they are four times more likely to choose a rural career. Students who spend one year training rurally are almost twice as likely to work in the same region.

While this progress is positive, there are still important areas where policy must improve. Students must be provided with more opportunities to gain rural experience, and more support must be provided to supervisors.

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 (ANAO) reports that infrastructure funding grants are effective and a good value-for-money investment.

> AMA Position

The AMA calls on the major parties to:

- provide funding and resources to support improved staffing levels and workable rosters for rural doctors, including better access to locum relief and investment in hospital facilities, equipment, and practice infrastructure;
- expand the successful Specialist Training Program to 1,400 places by 2021, with higher priority being given to training places in regional and rural areas, generalist training, and specialties that are under-supplied;
- fund a further 425 rural GP infrastructure grants of up to $500,000 each;
- provide additional funding/grants to individual GPs and practices to support non-vocationally registered doctors to attain fellowship through the MDRAP; and
- 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.

Medical workforce and training

The health of a population relies upon care from a highly skilled, well-trained medical workforce and a strong comprehensive primary health care sector.

Over the past decade, the number of doctors in Australia has increased significantly, driven by a significant rise in the number of medical schools and medical graduates. The number of doctors in Australia in 2015 sits just above the Organisation for Economic Cooperation and Development (OECD) average at 3.5 per 1000 population (compared to UK 2.8 per 1000 and USA 2.6 per 1000 population). Record growth in medical graduate numbers well above the OECD average has raised concerns about a potential medical workforce oversupply in the years ahead.

Notwithstanding this, distribution of the medical workforce remains an issue both geographically and by specialty.

Australia continues to rely heavily on overseas trained doctors to fill workforce gaps, particularly in rural and remote areas. Some medical specialties are in under-supply, with others in over-supply, especially in metropolitan areas. This is exacerbated by a shortage of vocational training places, increased competition for entry into vocational training, the suitability of the unaccredited registrar employment model, and how to better manage workforce planning in the prevocational space and exit block for employment of new Fellows.

While the 2018-19 Federal Budget proposed a network of medical schools and training organisations building on existing infrastructure to create end-to-end medical school programs, and promised not to increase Commonwealth-supported medical school places, additional overseas full-fee-paying places have been announced. But this will not address community need. Medical school places must be determined by medical workforce modelling by the National Medical Training Advisory Network (NMTAN).

The medical workforce is changing, and there is a shift to focus on workplace culture, and doctor health and wellbeing issues.

Women now make up a greater proportion of the medical workforce, with the gap between males and females continuing to decrease. In 2013, 38.5 per cent of the workforce was female compared to 40.7 per cent in 2016.

The change we propose is an important step to removing barriers to career paths and to instil a supportive workplace culture. There is also a perceivable trend that men are seeking to take on primary carer responsibility for children.

The historic public sector role in leading community expectations and industry employment standards some time ago led to State/Territory Public Sector Management Acts recognising long service Leave (LSL) employment service arising from another jurisdiction's public sector employment.

The AMA believes this policy of interstate recognition should also extend to Medical Officer Parental Leave entitlements; particularly recognition of the qualifying period required to access paid and unpaid leave release.

> AMA Position

The AMA calls on the major parties to:

- introduce legislation to regulate full-fee paying domestic and international medical student numbers, and to commit to no further increase in the total number of medical school places to address issues of oversupply;
- show national leadership through the Council of Australian Governments (COAG) to commit to fund and resource the appropriate agencies to undertake the accreditation of all prevocational training positions to address issues of poor-quality training for prevocational doctors not in a College training program;
- work with medical Colleges and jurisdictions to increase specialty training positions and create employment opportunities to improve the distribution of the medical workforce in areas of unmet community need, based on the advice of the National Medical Training Advisory Network (NMTAN); and
- demonstrate national leadership by recommending the introduction of a national system to recognise public hospital employment service/leave accruals when moving interstate.

Supporting GP training

Since 2015, we have seen a 20 per cent fall in the number of applications for GP training and a six per cent drop in the number of first year GP training posts filled. For 2019, 63 first year GP training places went unfilled even though multiple recruitment rounds were initiated.

This is despite Australia now graduating around 3700 medical students each year. This is an incredibly ominous sign for the future of the general practice workforce.

There are several reasons why prevocational doctors choose another specialty over general practice. A crucially important one is the prospect of a significant cut in pay, along with the inferior conditions that moving from a hospital-based role to a GP registrar position involves.

While conditions vary across the country, GP registrars earn significantly less than their hospital-based counterparts when they first commence work in a general practice.

The current employment arrangements for GP registrars also mean that their leave entitlements are much less generous and, unlike the public sector, this leave is not portable as they move around to satisfy their training requirements.

In this regard, the personal/carers leave accumulation for a GP registrar is badly affected. GP trainees who have children are also particularly vulnerable, with no access to paid parental leave other than the Government's own scheme, in contrast to public sector trainees.

None of these problems is the fault of supervising practices who commit significant resources to training the next generation of GPs and often suffer a reduction in practice income as a result.

The disparity in employment conditions for GP trainees and the recruitment problems this presents were recently recognised in the advice from the National Rural Generalist Pathway (NRGP) Taskforce prepared for the National Rural Health Commissioner.

Rural Generalist Training is part of general practice training, and the Taskforce recommended the establishment of a 'single employer' model for rural generalist GP trainees. This would ensure they were not disadvantaged in comparison to their hospital-based colleagues, and would encourage recruitment to the Pathway.

Unfortunately, the broader general practice training program suffers from the same recruitment problems.

> AMA Position

The AMA calls on the major parties to publicly commit to an immediate review of the employment model for the GP training program.

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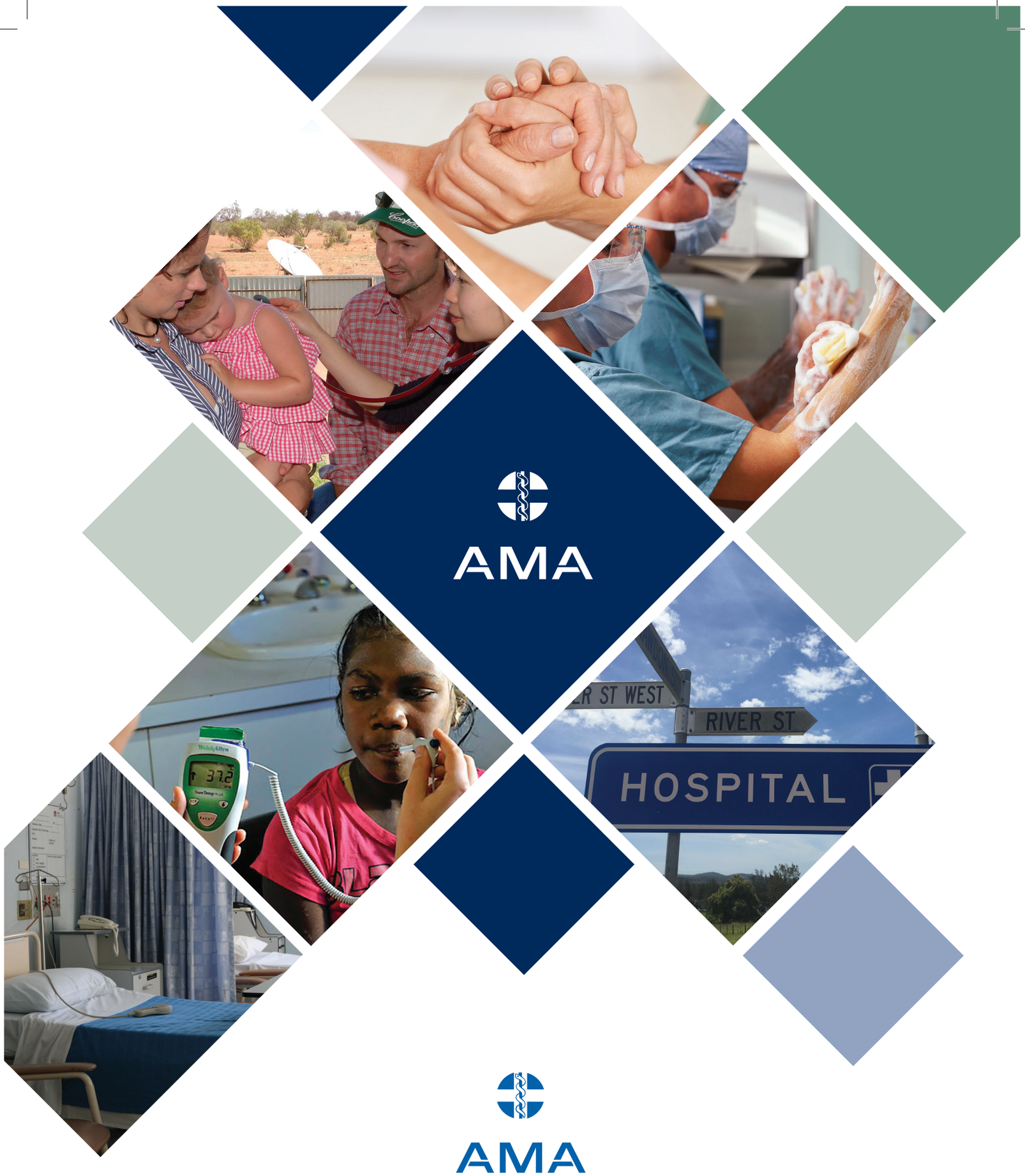

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