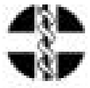

AMA

KEY HEALTH ISSUES

FOR THE 2004 FEDERAL ELECTION

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Introduction

By AMA President, Dr Bill Glasson

Health is one of the key issues that will determine votes at the 2004 election. Health policy affects every Australian every day in some way.

Australia has one of the best health systems in the world with the public and private sectors complementing each other to provide patients with quality choice.

But more and more we are seeing stories about a health system under pressure.

A health system where many Australians are finding it difficult to get to see a doctor.

A health system where people are paying more for their health services as costs continue to rise and Medicare rebates do not keep up with such cost increases.

A public health system feeling the effects of years of under-investment from successive Governments of both persuasions.

High quality affordable health care is a right, not a privilege. But for many Australians that right is being eroded. Access and affordability remain key concerns that must be further addressed.

The AMA has produced **Key Health Issues for the Federal Election 2004** as a guide to judge how the Government and the would-be Government are responding to the health needs of the Australian people.

We have not covered every aspect of health policy or the health system. Instead we have concentrated on the issues that matter right now to the AMA's 28,000 members, their patients, and the wider community.

The AMA does not create its health policies or attitudes in isolation: they are constructed on input from the doctors who work in the health system and the patients who are treated in the health system every day.

Our system of individual choice, of a mix of world-class public hospital provision, accessible high quality private health, and an emerging aged care sector needs support and strengthening.

The independence of the doctor-patient relationship is the foundation of care in each of these settings.

We look forward to an energetic and intelligent debate on health policy during the election campaign.

Whatever the election outcome, the AMA will continue to work with the newly elected Government to inform and advise about making this health system even better – a health system that serves all Australians well into the future, not just for the three-year election cycle.

Dr William Glasson

AMA President

July 2004

1.1 After Hours GP Services

Background

The AMA supports the right of all Australians to timely and appropriate primary medical care. GPs and their practices have an ethical and professional obligation to ensure access to appropriate care and continuity of care for patients who choose to engage them in their care. It is unreasonable, however, to expect any doctor to be available 24 hours a day.

Key Issues For Patients

Patients should be able to access trained GP care whenever they reasonably need to. GP workforce shortages are making provision of after hours care more difficult but GPs are developing innovative solutions to this problem based on local situations and needs.

Key Issues for Governments

Both the Government and the Opposition believe co-located after hours GP services can take pressure off the public hospital system, but a study by the Australasian College for Emergency Medicine shows these clinics will not significantly reduce emergency department overcrowding, and will undermine both community after hours services and continuity of patients' care.

Despite the advice of the AMA and other medical groups, the Federal Government has reached an agreement with the Western Australian Government that will allow GPs in hospital clinics at four hospitals to access the MBS (although regulatory amendment of the Act is still required). NSW is looking for support similar to the model trialed in the Hunter Valley, and Victoria has independently established co-located clinics that bulk bill.

The Australia Health Ministers' Advisory Council (AHMAC) is examining the potential for a national call centre network. The Opposition is considering GP "hot spot" teams, where salaried GPs will be set up in hospital-based clinics in areas where bulk billing and GP numbers are low.

AMA Position

The AMA will not support any proposal that includes "in-hours" services and compulsory bulk billing. These unfairly subsidised clinics would compete with local general practices, potentially undermining their viability, and threatening access for patients.

Any funding for these clinics must be "new" funding and cannot rely on cashing out existing MBS after hours funding. This would unfairly discriminate against patients of existing after hours services and force them out of business, limiting choice for patients.

Clinics can only be established with full support from local GPs.

The function of call centre triage and call centre advice services should only be to advise people on how to access the most appropriate form of service and what choices are available. Call centres must only be used as a tool to access doctor initiated triage and not as a substitute for general practice care, to restrict access to services, or to introduce managed care. Experience is some States indicates these are not cost effective.

1.2 Bulk Billing

Background

The general practice bulk billing rate has fallen significantly since its peak in 1996/97. A slight increase was recorded in the March 2004 quarter but the AMA predicts bulk billing rates will decline again once the Medicare Plus sweeteners are swallowed up by increased practice health delivery costs.

Key Issues for Patients

Bulk billing – or being able to visit your GP at no out of pocket cost – has become an important feature of Australia's medical system for many people, particularly pensioners, health care cardholders and for relatively low income earners.

Bulk billing levels are declining because patient rebates are not keeping pace with practice costs, forcing doctors to charge a co-payment or gap fee in order to cover costs

The level of the patient rebate is an issue between Government and patients. The key to affordability is how large the Government allows the gap between the patient rebate and the cost of a GP service to grow.

Key Issues for Governments

Both the Government and the Opposition have policies with incentives for GPs to increase bulk billing. The Government has reinforced the Medicare safety net providing a measure of comfort and protection to many patients

The Government is offering GPs either $5 (metro) or $7.50 (rural and Tasmania) for every child 15 years and under or concession cardholder bulk billed.

The Opposition has a four year measure which would see an increase in the rebate for all bulk billed consultations to 95 per cent of the schedule fee immediately and to 100 per cent of the schedule fee in the fourth year (doctors will receive the increased rebate each time they bulk bill). There are additional incentives for doctors to increase the proportion of consultations that are bulk billed. The amount of the incentive and the bulk billing target are geographically defined.

AMA Position

The bulk billing rate is not an indicator of the success or failure of the health care system.

The AMA rejects any Government interference in GP billing practices. Any pressure (mandatory or non-mandatory) on GPs to bulk bill is unacceptable, as it will act as a disincentive to participation by GPs in the workforce who see this as a signal that the quality of care that they provide is of no value. This makes it harder for patients to access quality, affordable care.

To improve access and affordability, the Government must appropriately fund and index MBS rebates and establish schedule fees that more closely reflect the true value of the GP service provided.

1.3 Red Tape

Background

The Productivity Commission has estimated that red tape costs every GP in Australia $13,000 a year. An AMA survey found 13 per cent of GPs spend 11 hours or more completing paperwork, 20 per cent spend 10 hours, and 52 per cent spend between five and 10 hours.

Red Tape has a significant impact on reducing clinical time with patients. It also impacts on poor morale through the unnecessary additional hours of unpaid time it consumes. GPs would prefer to spend time with patients.

Key Issues for Patients

Red tape significantly reduces the amount of time GPs have to spend with patients. Red tape is a major factor in GPs leaving the profession, reducing their hours and for students choosing an alternative medical career. It contributes to the workforce shortage and limits patient access to services.

Key Issues for Governments

The Government implemented a Red Tape Review and established the Red Tape Task Force. Following consultation and agreement with stakeholders, the Task Force submitted its report to Cabinet in December 2003. Health Minister, Tony Abbott, released his response in May 2004.

He committed to implementation of the Task Force's Option 1 (Simplify and Streamline) within six weeks and to establish a working group, including GP Groups, to develop an implementation plan by October 2004 to progress reform towards Option 2 (Radical Redesign) as agreed by all GP Groups at the final Red Tape Steering Group meeting on 27 November 2003.

The Government's Medicare Plus package contains a number of measures that will contribute to the administrative burden carried by GPs.

AMA Position

The AMA does not support any initiative that increases the red tape nightmare for GPs and their patients.

In relation to outcomes of the Red Tape Taskforce Report on Practice Incentive Payments (PIP) and Enhanced Primary Care (EPC), the AMA will accept nothing less than the implementation of the PIP and EPC Option 2 proposed by the Red Tape Steering Group by budget 2005 as a stop gap measure until the implementation of a fully funded and indexed 7-tier attendance item structure. Option 2 includes restructuring PIP into a single practice infrastructure payment, restructuring and simplifying the EPC, retaining health assessments, simplifying the care plan to a chronic disease management plan, and eliminating all SIPs (disease specific items) and outcome payments.

1.4 Remuneration

Background

Remuneration is a significant factor contributing to the reduced participation of GPs in the workforce. The lack of GPs is a major part of the overall medical workforce shortage in Australia.

The ABS publication 'Private Medical Practices 2001-02' (released December 2003) found GP expenditure rose 6.3 per cent a year during this period compared to a less than three per cent annual increase in MBS patient rebates.

Key Issues for Patients

Unless general practice is made more attractive, doctor numbers will fail to keep up with demand, particularly as our population ages and requires more complex care. This means that more and more Australians will not be able to find a local GP to provide continuity of care. Continuity is what enables a GP to understand a patient's health needs and offer ongoing care.

Key Issues for Governments

For Australians to have access to affordable health care in the future, the Government must properly value the service provided to the community by GPs.

The current outdated MBS rewards 'six minute medicine'. The Average GP consultation is 14.6 minutes. As costs incurred are not reflected in patient rebates, it is increasingly difficult for doctors who bulk bill to stay in business. GPs understand that their services have a value. In order to continue to provide high quality care, GPs are increasingly privately billing their patients. When MBS rebates move closer to the value that doctors place on their services, the gap between the doctor's fee and the patient rebate will be smaller.

Political parties are focusing on creating incentives for doctors to bulk bill. AMA sees this as a further devaluation of the role of GPs in the absence of any discussion on measures to ensure that patient rebates and the schedule fee truly reflect the value of a GP service.

AMA Position

The AMA calls for the introduction of a fully funded and appropriately indexed 7-tier general practice consultation item structure. This patient rebate structure properly values GP services and would enable the ongoing provision of high quality primary health care, particularly for patients with chronic and complex care needs.

GPs must establish their billing practices based on the real value of the services they provide and the cost of delivering those services and avoid any practices which compromise the viability of their business and their personal and family security.

1.5 GP Workforce

Background

Australia has a shortage of between 2000 and 3000 full time equivalent GPs. The participation rate in general practice is now about 64 per cent and falling.

The "feminisation" of the workforce is the most significant factor that will impact on participation rates into the future.

AMA figures indicate a current average GP working week of 50 hours. Many would prefer to reduce those face-to-face hours. A drop in average GP time of just two hours per week is equivalent to the loss of about 1000 GPs from the workforce.

Key Issues for Patients

There are GP shortages across Australia. Many communities are finding that when a GP leaves or retires, a replacement cannot be found. Patients are finding it increasingly difficult to see a GP when they want. Many cannot get to see a GP at all.

In some areas, demand has so outstripped supply that GPs are being forced to close their books and are unable to take on new patients.

People in regions with inadequate access to medical services experience poorer health than other Australians.

Key Issues for Governments

Both the Government and Opposition are offering increased medical training places, but are doing nothing specific to bolster the GP workforce.

Worse, they both support unfunded bonded training places (refer Issue 3.6, page 15).

AMA Position

The AMA calls for policies to encourage more GPs to enter the workforce, stay in the workforce, and increase their participation rate.

Training numbers must be increased to take into account the growing trend within general practice for a better balance between work and home life. Increased workforce participation and retention is key to the future of service delivery and depend on an appropriately funded and properly indexed 7-tier rebate system. Flexible training opportunities and exposure to quality general practice and GP mentors early in a career are important.

The AMA is strongly opposed to the unfunded bonding of medical students. International evidence has shown that bonding is not the most effective way of increasing GP numbers or encouraging doctors to practise in areas of need.

1.6 GP Attendance Item Structure, Funding and Indexation

Background

The current indexation system for Medicare patient rebates (WCI5) does not produce indexation adjustments that are sustainable. WCI5 erodes rebates in real terms.

WCI5 is unsustainable because it substantially overstates productivity gains available in general practice very substantially; implicitly assumes that all productivity gains flow through into cost reduction, not quality improvement; implicitly assumes that the nature of the services is unchanging; completely excludes fast rising costs such as medical indemnity premiums; and takes no account of the increasing capital investment that is required to generate productivity gains.

Key Issues for Patients

The relationship between quality and length of consultation indicates that longer consultation times are associated with better health outcomes.

Under the current attendance item structure, financial incentives favour shorter GP consultations. The MBS rebate is the same for a six minute and 19 minute consultation.

The existing MBS item structure is denying patients the best possible quality care.

Key Issues for Governments

The Government will not commit to implementing the 7-tier item structure on the basis that it requires new money. The Minister has acknowledged that the arguments in support of its implementation are logical and, intellectually, he agrees with them.

The Opposition has called on the Government to implement the 7-tier item structure but is unwilling to commit to its implementation as part of its election policy platform, citing an inability to cost the measure in Opposition.

Access Economics advises that costing for the 7-tier item structure of around $850 million per year is credible.

In relation to indexation the Government argues that WCI5 is part of "whole of government" arrangements applied by the Department of Finance. Central agencies will resist the establishment of special arrangements for GP rebates for fear of setting precedents.

AMA Position

The AMA has called for the introduction of a fully funded and appropriately indexed 7-tier general practice consultation item structure as recommended by the Attendance Item Restructure Working Group (AIRWG).

Following adoption of new indexation arrangements for GPs, the AMA will advocate for similar indexation arrangements for other specialists.

2.1 Indemnity, Compensation, and Patient Long-Term Care and Rehabilitation Arrangements

Background

The broader indemnity crisis of the past few years has eased following the Federal Government's Medical Indemnity Rescue Package of December 2003 and the passing of the Run-Off Cover Scheme (ROCS) legislation in June 2004.

More needs to be done to fix the deficiencies in the delivery of compensation by our adversarial court system, if current indemnity issues are to stay fixed for the long term.

Key Issues for Patients

Secure and affordable indemnity cover is a prerequisite for patient access to affordable quality medical care. Patients, too, need secure and affordable arrangements for their ongoing care needs in the event of injury from a medical mishap.

Key Issues for Governments

The Government has implemented a political solution to the indemnity crisis that depends upon its continuing financial support and further commitment to tort law reform by the State and Territory governments.

The Opposition has supported the work by governments at both levels so far, with some qualifications.

The State and Territory Governments need to do more on tort law reform to achieve national consistency and fairness.

The Federal Government must establish a long-term care and rehabilitation scheme for the severely injured.

AMA Position

The AMA has worked closely with the Federal Government and the medical indemnity insurers to formulate indemnity arrangements that provide doctors and their patients with affordable cover that gives the security they require. The Government and the AMA will review the success of these arrangements over the next year.

The AMA has urged the development and implementation of a national long-term care and rehabilitation scheme for those severely disabled from medical accidents. Both the Government and the Opposition are slow to commit to this scheme.

Medical indemnity premiums must come down in response to the reforms.

2.2 National Integrated Clinical Risk Management Program

Background

In tandem with the Federal Government's assistance in resolving the medical indemnity crisis, the medical profession is working to improve quality and safety in medical practice.

The AMA, the Colleges and the Medical Indemnity Insurers are working together towards a national integrated risk-management program to improve Australia's already good record of quality and safety in medicine.

Key Issues for Patients

Patients are entitled to expect that the medical profession's work to improve quality and safety in health care never ceases.

Doctors and their medical indemnity insurers are committed to improving clinical risk management programs.

Key Issues for Governments

The medical profession wants to do as much as it can to minimise unintended medical consequences. The currently disjointed approach to Risk Management by individual practitioners, Colleges, Medical Indemnity Organisations, private hospitals and State Governments and their health systems is undesirable.

It is generally agreed that a national integrated approach to clinical and legal risk management programs is required.

AMA Position

The AMA has opened discussions with the Medical Colleges and the medical indemnity insurers and established a Risk Management Working Party.

A key objective of the group is to create a pilot, accredited, national Risk Management program to be implemented by June 2005.

3.1 Aged Care

Background

Demand for aged care services is rapidly growing as the population ages.

In 1998, the number of Australians aged over 65 years was 2.3 million. This figure is projected to increase to 4 million in 2021 and to 5.7 million in 2041.

Those people aged eighty-five and over are projected to rise from about 1.3 per cent of the population to 2.1 per cent of the population by 2021.

Key Issues for Patients

Older Australians must have access to quality aged care services.

Thousands of Australians are trapped in the wrong environment for the type of care they need. There are many people in hospital who no longer need acute care, but are unable to care for themselves at home and cannot access appropriate residential or community care.

Similarly, there are people in nursing homes who should be in hospital, and people in the community who ought to be in either hospital to treat particular conditions, or in aged care homes.

Shortages of adequately skilled staff and disincentives for GPs to visit residential aged care facilities impact on the quality of care provided to residents.

Key Issues for Governments

The Federal Government provided a 6.4 per cent boost to aged care in the 2004-05 Budget. The Opposition is yet to detail its aged care policies.

GP participation in Residential Aged Care facilities has declined. Only 16 per cent of GPs visit nursing homes on more than 50 occasions per year (i.e. less than 1 visit per week). There must be incentives for GPs to visit aged care facilities more often, and stay longer.

There must be additional beds in aged care homes, more community care places, and more transitional care must be provided if ageing Australians are to receive adequate and appropriate care.

Dementia must be made a National Health Priority. All aged care workers must be better paid for the work they do.

AMA Position

There must be better integration between the health and aged care sectors. We need a national model for funding of Commonwealth and State programs for improved coordination of hospital, residential aged care facilities and community-based services.

We need more attractive MBS items for medical services to the aged to attract doctors to provide community and residential services to older Australians.

3.2 Medicare Reform – Level of Responsibility for Health

Background

Health funding is a political football, especially when there is a crisis in public hospitals or aged care facilities. The Commonwealth blames the States. The States blame the Commonwealth.

Key Issues for Patients

Patients want decisions about the most appropriate treatment and location of services to be based on clinical need without the hindrance of cost shifting or blame shifting considerations.

They also want Governments to be clearly accountable for their funding and service delivery decisions and to avoid a situation where there is flick passing of responsibilities.

Key Issues for Governments

Governments need to be seen to be making genuine efforts to improve access and affordability for patients and to be actively pursuing helpful reforms that guarantee high quality medical services for al Australians.

The Minister for Health, Tony Abbott, has regularly floated the idea of the Commonwealth taking over responsibility for public hospitals.

The Opposition has promised a National Health Reform Commission to be established in the first month of taking office to develop a plan for long-term reform.

AMA Position

The AMA will push to ensure that any reform of health financing arrangements and health responsibilities between the Commonwealth and the States be evidence-based and pass the test on:

- Access to health and hospital services for all patients
- Affordability to patients and government
- Integration with related health services
- Quality of health services
- Levels of bureaucracy associated with the proposals be minimised
- Extent to which the proposal will encourage a move to national standards
- Political accountability and responsibility for performance
- Likely acceptance by the public
- Maximising individual choice as to the quantity and location of health services desired.

The AMA strongly believes that the above aims will be best achieved in a healthcare system where fee-for-service remains the dominant method of payment for medical services.

3.3 Access to Quality Pharmaceuticals

Background

The Pharmaceutical Benefits Scheme (PBS) is a vital part of the Australian health system. It ensures that Australian patients have access at an affordable price to the best available medicines to treat their condition. The PBS protects the poorest and the sickest in the community.

The Government, supported by the Opposition, has introduced major increases to PBS co-payments.

Key Issues for Patients

Patients want access to a comprehensive range of safe and effective pharmaceuticals, including new drugs; affordable prices at the point of use based on ability to pay; and no unnecessary bureaucratic hurdles or obstacles to that access. Draconian co-payment increases threaten public access to necessary pharmaceuticals and are a major safety and quality issue.

Key Issues for Governments

The Pharmaceutical Benefits Scheme (PBS) is expensive and has been growing more rapidly than other health programs. This makes it a target for the attention of central expenditure control departments due to both its size and the rate of growth of spending. It cost $5 billion in 2003-04.

The Government uses a mixture of policy instruments to moderate PBS expenditure including restricting the access of pharmaceuticals onto the PBS, increasing co-payments to patients and imposing bureaucratic hurdles and barriers on providers.

Government needs to acknowledge that quality is the key issue and that unreasonable restriction of PBS spending may cause higher offsetting expenditure in other health programs and that increases in PBS expenditure may cause offsetting reductions in other health programs.

AMA Position

The AMA supports the principles of the PBS to provide access to safe and affordable medicines for the public.

AMA believes that co-payments can be effective in moderating demand for pharmaceuticals without negative consequences for the health of patients if the co-payments are increased incrementally by amounts consistent with CPI, AWE and other relevant indices.

The Government must ensure that the PBS is not threatened by any of the Australia-US Free Trade Agreement (FTA) initiatives.

The AMA is concerned that the move to a trans-Tasman regulatory body in 2005 must not jeopardise Australia's record of ensuring quality, safety and efficacy of pharmaceuticals.

3.4 Private Health Insurance – Commitment to the 30 per cent Rebate and Lifetime Community Rating

Background

The 30 per cent private health insurance rebate and Lifetime Health Cover together have increased participation in private health insurance to more than 43 per cent of the population by making the product more affordable and by making people think about continuity of membership.

Since 1995-96, private hospital admissions have risen by 54 per cent compared to 11 per cent in the public sector. So the rebate and Lifetime Health Cover have given Australians much greater access to the private system and this has freed up the public system for those who most need it.

Key Issues for Patients

Patients want choice, access and affordability.

Patients want a continuation of the current policy settings so they can continue to enjoy access to private insurance and, through it, the private hospitals.

Key Issues for Governments

Today 50 per cent of surgery is done in the private sector and nearly 40 per cent of all admissions are in the private sector. It is a strong complement to Medicare and not a supplement to Medicare, as was previously thought. The public system relies on the private system to carry a big share of the load.

Many think that by abolishing the rebate, $2.4 billion would become available for spending elsewhere in health. The fact is much more than this amount would be required to be spent in hospitals to make up for the loss of private spending.

The Government has been completely committed to the maintenance of the rebate and Lifetime Health Cover. The Opposition has said it will retain the 30 per cent rebate but has not ruled out some form of capping on rebate expenditure.

AMA Position

The AMA supports both the 30 per cent private health insurance rebate and the Lifetime Health Cover policy. These measures have given Australians greater access to health care and have reduced the demand on public hospitals

The AMA calls on both parties to give an unequivocal commitment to the maintenance of these policies in their current form.

3.5 Public Hospitals – Funding and Performance

Background

Australia's public hospitals are national treasures that are being allowed to suffer due to a combination of Government neglect at Federal and State level, overworked staff, and under funding.

They are also our great teaching hospitals for the next generation of doctors. This role, too, is being diminished, because of under-funding and under-resourcing.

Key Issues for Patients

The five per cent per annum increase in public hospital funding under the current Australian Health Care Agreements (AHCAs) will not be enough to fund public hospitals in the coming five years. Patient access will be threatened unless there is a cooperative effort between the Federal and State Governments.

Key Issues for Governments

The Federal Government needs to be prepared to review its indexation as the need arises and for States to match that indexation so that adequate funding is available.

The reform agenda under the AHCAs needs to be pursued. In particular, there is a need to improve the links between the acute care sector and the sub acute, community, residential aged care and primary care sectors. A national pharmaceutical scheme with application in the community, and in public and private hospitals is also required.

AMA Position

The AMA wants the Federal and State Governments to work co-operatively to resolve the issues confronting the public hospital system. Governments need to be collectively responsible for access and waiting list problems. The reform agenda needs to be pursued particularly at the boundaries between aged and acute, and acute and community, and we recommend a national pharmaceutical program.

The AMA:

- supports a process of incremental change to health service delivery built on funding partnerships between the Commonwealth, the States and Territories
- encourages funding initiatives that address the obstacles brought about by the interaction between the hospital, community and residential care sectors
- encourages funding initiatives that address the obstacles brought about by the interaction between the hospital, community and residential care sectors
- supports the position that the primary cause of overcrowding and access block in Emergency Departments is the restriction of funding to the public hospitals and the consequent shortage of beds and hospital workforce
- calls on State and Federal Governments to adopt a mean maximum bed occupancy of 85 per cent as a key performance indicator for public hospitals
- calls for greater cooperation between the education sector and the Commonwealth and State Governments to ensure that public hospitals have sufficient funding and infrastructure to continue providing 'world's best' medical training and research.

3.6 Unfunded Bonding of Medical School Places

Background

To address workforce shortages in particular areas, the Government has essentially adopted two forms of bonding for medical school places, one being a scholarship based system and the other being an unfunded HECS based system.

Medical Rural Bonded Scholarships (MRBS) provide 100 scholarships each year worth in the vicinity of $20,000 to new medical students who are prepared to commit to at least 6 years of rural practice once they complete their basic medical and post graduate training.

The Federal Government has established 234 additional medical school places on the condition that students taking up the positions are bonded to work for 6 years in a "District of Workforce Shortage" (DWS). This unfunded program is the Bonded Medical Places (BMP) Scheme, which has no attached scholarship and to which HECS repayments apply.

Key Issues for Patients

Unfunded bonding does not address the underlying causes of medical workforce shortages and nor does it make the practice of medicine in areas of medical workforce shortage any more attractive.

The conscription of specialists and GPs to work in Government designated localities 10 or more years after starting medical school will simply create a pool of disgruntled doctors focussed on finding alternatives to being uprooted from their established professional and community networks. As a consequence, patients in the designated localities will be the ultimate losers.

Key Issues for Governments

The bonding of undergraduate students will be ineffective in improving medical services in areas of need, is unfair and inequitable and introduces inequality of access to the higher education system. This view is based on a careful analysis of comparative OECD and US studies of the impact of student bonding on medical workforce distribution and extensive surveys of medical students.

Overseas studies have demonstrated that bonding medical students has led to serious morale and job satisfaction issues. The BMP Scheme will require the aspiring medical student to sign a contract with the Commonwealth. The standard contract has a number of serious deficiencies.

AMA Position

The AMA has proposed an alternative scholarship based scheme to the Government that involves selection to medical school not conditional on accepting a contract; payment of a scholarship to the student; exemption from HECS for the medical degree course; a shorter return of service period of four years taking account of the shorter graduate medical degree courses; return of service from commencement of postgraduate vocational training rather than after completion of specialist training.

3.7 DVA Payments for the Treatment of Veterans

Background

The AMA has been actively lobbying the Commonwealth Government for increased funding for medical services provided to veterans under the Local Medical Officer (LMO) scheme and Repatriation Private Patient Scheme (RPPS). This has met with limited success.

Key Issues for Patients

The principle under which both the LMO scheme and RPPS operate is that veterans should have the same access and standards of health care as a private patient. Payments currently made by DVA do not reflect this principle, as they are lower than that which a doctor would otherwise receive when treating a private patient.

This is not sustainable and in effect leaves doctors in the position of having to subsidise the costs of veterans' care. The veterans miss out on the level of care promised by the Government because the Government refuses to properly fund the schemes.

Key Issues For Governments

GPs are contracted to provide services to veterans as LMOs. They are paid the Medicare scheduled fee plus a special $3.05 Veterans Access Fee. The AMA won the latter in 2003 when a significant number of members declined to renew DVA contracts.

The AMA saw this additional payment as an interim measure, which only partially addressed the gap between what is paid by DVA in comparison to what a private patient would be charged. The LMO payment is now insufficient and doctors will drop out of the system if the Scheme is not properly funded.

Specialists are currently paid the scheduled CMBS fee for treating veterans. While the overall number of specialists billing DVA has remained constant, the number of specialists billing DVA on a regular basis has declined by around 25 per cent over the last three years.

The Government has moved to address this to some extent in the 2004/2005 Federal Budget with an extra $158m in funding over four years for specialists treating veterans. Specialist consultations from 1 January 2005 will rise to 115 per cent of the CMBS, while procedures will increase to 120 per cent. These rates remain well below those in the AMA's List of Medical Services and Fees.

AMA Position

The AMA believes that the Government should adequately fund the RPPS and LMO Schemes so that they can meet the Government's commitment to deliver private patient services to veterans, without relying on doctors to subsidise these services – which in the longer term is not sustainable.

The AMA is particularly concerned about the future of the LMO program, which requires an urgent injection of funding in order to ensure that GPs receive a fair rate of remuneration for delivering an increasingly complex range of treatments to the veterans' community.

3.8 Medical Workforce – Overseas Trained Doctors (OTDs)

Background

The availability of Australian trained doctors is falling well below both demand and the requirements of the Australian community, with the shortfall being partially covered by a major increase in the recruitment of overseas trained and temporary resident doctors. These shortages are most acute in outer metropolitan and rural areas.

A high level of reliance is being placed on the recruitment of overseas trained doctors to address Australia's workforce shortages. While the AMA recognises that overseas trained doctors (OTD) are a crucial part of the medical workforce, global shortages and ethical considerations make this an unsustainable strategy in the longer term. Australia must train more doctors to meet its needs.

Key Issues for Patients

Towns, suburbs and communities are losing doctors and there are no new doctors to take their place.

OTDs are filling the gaps for the short term, but are not a long-term solution to the medical workforce problem.

Key Issues for Governments

OTD recruitment in Australia is characterised by the inconsistent application of standards, a lack of transparency in processes, differing standards between jurisdictions, and a lack of suitable resources to assist OTDs become part of both the medical workforce and the general community.

AMA Position

OTDs form an important part of the medical workforce. To ensure high standards of patient care and to provide better support for OTDs in their work, the AMA believes that the following measures are necessary:

- OTDs across Australia, with the Medical Colleges having responsibility for assessing overseas qualifications and determining additional training or oversightrequired;
- Introduction of streamlined processes of assessment including the pre-recognition of some qualifications;
- Ensuring that OTDs have access to support mechanisms including mandatory orientation, mentoring, community facilities and services, Ensuring that OTDs have access to working conditions that are equal to comparable Australian trained doctors in like locations;
- Streamlining of Area of Need and District of Workforce Shortage definitions with a requirement that an objective assessment be undertaken of the reasons for not filling a position with an Australian resident doctor before recruiting an OTD.

4.1 Asylum Seekers - Health Care

Background

Asylum seekers have featured in the news in recent years due to human rights and health issues.

Evidence indicates that asylum seekers suffer the same health problems as the general population and are at particular risk from a range of conditions including psychological disorders such as post-traumatic stress disorder, anxiety, depression, and possibly even the physical effects of persecution and torture suffered in their country of origin.

Key Issues for Patients

Asylum seekers have been through a great deal of stress and trauma in their countries of origin, and possibly on their journeys to Australia.

Asylum seekers not only want their health care needs to be addressed, but want to be treated with respect and dignity as equal human beings.

While in the care of the Australian Government, they should have access to a similar level of health and medical care as the Australian population.

Key Issues for Governments

For those who are Temporary Protection Visa (TPV) holders, the Government's current limitations on family reunion, as well as the recent changes to migration legislation preventing many TPV holders from applying for permanent protection, imposes ongoing uncertainty regarding their eligibility to remain in Australia, which, in turn, creates further mental and physical health problems.

Australia's international reputation and tradition of a 'fair go' have been diminished because of treatment of asylum seekers in recent years.

AMA Position

The AMA continues to speak out on issues concerning the health of asylum seekers.

The AMA is a member of the Professional Alliance for the Health of Asylum Seekers and Their Children (the alliance consists of professional organisations representing medical and allied health workers).

The AMA's Ethics and Medico-Legal Committee is currently developing a position statement on the health care of asylum seekers and is also conducting a project to solicit and collate the experiences of medical practitioners who treat asylum seekers.

The AMA believes that those seeking asylum within Australia have the right to the same standard of health care as all Australians, without discrimination, regardless of citizenship or visa status.

4.2 Climate Change and Health

Background

Climate change as projected by climatologists will have a major impact on human health on a scale not previously encountered by human society.

Human induced climate change is one of the most intensely debated issues of our time.

On the balance of available evidence it is clear that human activities - predominantly the burning of fossil fuels (such as oil, coal and gas) and changes in land cover due to deforestation- have contributed to recent global changes in climate.

Key Issues for Patients

Health impacts may entail increased mortality rates from existing diseases.

Even minor changes in climactic conditions in our region of the world will have extreme consequences. We face increased mortality rates from existing diseases and an increase in heat related illness. We could also see a change in patterns of disease transmission

The potential health impact of climate change in Australia includes temperature extremes; extreme weather; water- and food-borne diseases; vector-borne and rodent-borne diseases; food and water shortages; and population displacement.

Key Issues for Governments

Failure to commit to reducing greenhouse gas emissions has the potential to cause significant global public health problems

An effective emissions control program could be instituted without having a negative impact on the Australian economy. This can best be achieved by combining energy conservation with new alternative technologies that would reduce dependency on fossil fuels.

The Government has indicated it will not ratify the Kyoto Protocol. The Opposition has indicated it will ratify the Kyoto Protocol.

AMA Position

The AMA calls on the Federal Government to ratify and implement the Kyoto protocol.

The AMA believes that the Federal Government should implement a National Greenhouse Policy that engages all Australians in ensuring that we meet the Kyoto target and start to dramatically cut our greenhouse pollution. The AMA recognises the importance of developing renewable energy sources as a means of affecting global climate change and its health ramifications. The AMA calls on the Federal Government to set a Mandatory Renewable Energy Target (MRET) of 10 per cent by 2010.

The AMA supports research, education, prevention, monitoring, and assessment relating to the public health issues that may arise from climate change.

4.3 Indigenous Health – Financing

Background

Aborigines and Torres Strait Islanders suffer from poor health, which in some aspects is worse than the health of people in some Third World Countries.

They die younger and their kids are sicker, and too many of their babies die at birth or are born with low bodyweight and chronic health conditions.

Doctors working in some communities say that the state of Indigenous health is worse than it has been for 20 years. It is Australia's national shame.

Key Issues For Patients

At present the whole Aboriginal and Torres Strait Islander population, whether rural and remote or urban, has limited access to fully staffed comprehensive primary health care.

Any increase in financing of these services will have an immediate impact on access and, over time, will turn around some of the appalling health statistics.

Key Issues for Governments

Genuine political will is needed to increase the present funding levels.

None of the major political parties has made Indigenous health an election issue. This is unlikely, as their pollsters will tell them there are no votes in improving Indigenous health.

AMA Position

The AMA calls upon the political parties to make election commitments to:

- increase funding to integrated primary care services provided principally to Aboriginal and Torres Strait Islanders by $500 million a year recurrently;
- provide a clear four year plan to achieve this full increase by the end of the period;
- to fully fund the Workforce National Strategic Framework including the required training places.

4.4 Indigenous Health – Whole of Life Approach

Background

For Aborigines and Torres Strait Islander peoples, life expectancy at birth is between 16 and 19 years less than for non-Indigenous Australians. Standardised mortality rates are more than three times the expected rate and death rates between 25-54 years of age are 5-8 times that seen in non-Indigenous Australians. The percentage of the Indigenous population expected to live to 65 is less than in many developing countries.

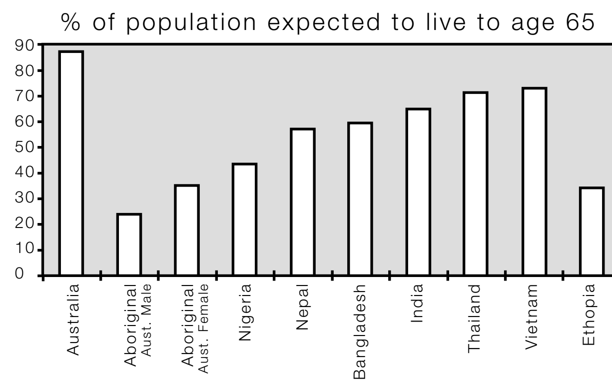
Key Issues for Patients

Australia's indigenous people are admitted to hospital at twice the rate of non-indigenous people.

They have much higher rates of renal disease, diabetes, injury and poisoning.

Infant mortality rates are three times that of the Australian total.

Life expectancy remains 20 years less than that for non-indigenous Australians and the gap has not closed over the past decade.



Key Issues for Governments

There are many acknowledged determinants of health – income and social status; social support networks; education and literacy; employment/working conditions; social environments; physical environments/housing/nutrition; personal health practices and coping skills; healthy child development; biology and genetic endowment; health services; gender and culture.

It is impossible to expect changes in the health service provision to Aboriginal and Torres Strait Islanders alone to transform the present health reality. An integrated approach across all Government Departments is required.

Any solution to Indigenous heath problems will involve empowering communities and individuals to take control across the whole range of economic and social areas.

AMA Position

The AMA calls upon the Government and Opposition to enunciate a fully funded plan to improve the health of Indigenous Australians to at least the levels achieved in the equivalent populations in NZ, Canada and the USA – and in the long term to the same as the rest of the Australian population.

This will involve a whole of Government approach involving the integration of health, education and social policy and resources.

4.5 Indigenous Health – Indigenous Medical Workforce

Background

The government produced an unfunded Aboriginal and Torres Strait Islander Health Workforce National Strategic Framework in May 2002. The Framework is vague about numbers of each type of health worker and the finances required to implement the plan.

The AMA's concrete contribution in this area is the Indigenous Scholarship. There are two recipients of the scholarship in training at the moment. The AMA is also working with the Australian Indigenous Doctors Association and the Royal Australasian College of Physicians on a mentoring program for Indigenous students interested in or already in health professional training. There are other initiatives, including a support program run by the AMA (WA) in conjunction with the Department of Employment, Workplace Relations and Small Business.

The soon-to-be-released AMA 2004 Indigenous Health Report Card – "Healing Hands" – is focused on Indigenous Health Workforce issues and provides figures for the numbers of doctors, nurses, Aboriginal Health Workers and Allied Health professionals required. It also estimates the cost to both train and then employ this additional workforce in the Aboriginal and Torres Strait Islander health sector.

Key Issues For Patients

At present the whole Aboriginal and Torres Strait Islander population, whether rural and remote or urban, has limited access to fully staffed comprehensive primary health care.

There are very few Indigenous health workers in Aboriginal and Torres Strait Islander communities.

Key Issues for Governments

As with all Indigenous health issues there is no obvious political gain for any of the parties on this. None has a position on this issue. With the whole medical workforce an issue it is doubly difficult to find doctors and other health professionals willing to work in the difficult conditions often encountered by those providing services to the Indigenous population.

It is important to remember the focus is not just rural and remote. There is equally a needfor this workforce in the cities and large rural towns.

AMA Position

The AMA calls on the Government to put workforce figures to their Workforce National Strategic Framework and fully fund the implementation of the strategy. This should include fully funding all the required training places, not requiring these to be funded through mainstream training funding streams

We also call for an exploration of incentives for medical officers working in Aboriginal Medical Services and greater support to registrars to undertake training in Aboriginal Medical Services.

4.6 Tobacco Control

Background

Smoking is the largest preventable cause of death and disease in Australia.

Key Issues for Patients

Smoking kills.

Too many Australians are still dying each year or contracting terminal illnesses due to smoking.

Too many Australian kids and teenagers – especially young girls – are taking up smoking despite the warnings.

Key Issues for Governments

Smoking-related illness places a huge burden on the Australian health system.

The Government recently took the soft option when implementing plans for shock warnings on cigarette packs.

While the Opposition is to be congratulated for adopting a policy of not accepting political donations from the tobacco industry, we are yet to see its full policy on tobacco control.

Not enough is being spent in combating smoking in Australia.

AMA Position

The AMA calls on the Government and the Opposition to release funded tobacco control policies before the election.

The AMA calls upon all governments to review relevant legislation with a view to banning smoking in all public places within 12 months of the legislation being passed.

The AMA believes all Australians have a right to a smokefree workplace.

The AMA calls on the Government to introduce the toughest possible graphic warnings on cigarette packets within six months of the legislation being passed.

The AMA calls on the Government to introduce legislation to prevent the tobacco companies stockpiling their products in anticipation of a change in health warnings.

The AMA calls for the introduction of generic cigarette packaging.

4.7 Medicare Under 16 – Parental Access To Information

Background

The Federal Government in late 2003 announced that it would be amending legislation to allow parents to have access to their children's Medicare records up to the age of 16 years.

Reports from HIC (unsubstantiated) are that in the last year only six parents have sought to access their children's records.

All leading medical organisations as well as the peak youth and sexual health organisations in this country have uniformly condemned this legislation.

Key Issues for Patients

This legislation would create a barrier to young people accessing confidential health services.

Where possible and developmentally appropriate, doctors should afford young people the same respect, rights and responsibilities as older patients. If a young person is able to make autonomous decisions regarding medical treatment, and wishes that treatment to remain confidential, then their doctor must respect and maintain that confidentiality.

As young people move through adolescence, relationships with their families and communities change. Issues relating to mental health, self-esteem, body image and sexuality are more prominent as self-awareness increases and youth develop their own identity.

For many young people, the transition to independence and self-reliance is achieved with relative safety and seen as a time for self-exploration and growth. For others, however, it is a time of increased exposure to health-compromising behaviours such as eating disorders, alcohol and other drug abuse, use of tobacco, and unsafe sexual practices.

Teenagers from all socio-economic backgrounds need a safe confidential source of health information and advice at a sensitive time in their development physically and emotionally.

Key Issues for Governments

It is understood that the Government will seek to re-introduce the legislation despite opposition within its own ranks, including an impassioned plea by Dr Mal Washer who revealed a teen suicide incident to illustrate the need to reject the legislation.

The Opposition has remained mute on the issue.

AMA Position

The AMA has lobbied quite aggressively over a considerable period against this proposal on the grounds that it fundamentally undermines the sanctity of the doctor-patient relationship and erodes the principle of confidentiality. We believe it is poor health policy and poor social policy that would place undue pressure on young Australians and their families.

4.8 National Anti-Obesity Program

Background

Obesity in Australia is a national emergency that requires a whole of government approach to the issue.

The incidence of childhood and adolescent obesity has trebled over the last decade. Many of these children progress into adult obesity. Currently 56 per cent of Australian adults and 27 per cent of Australian children are overweight or obese.

New disorders presenting in obese adolescents include asthma, fatty liver, hypertension, type 2 diabetes, and sleep apnoea.

Key Issues for Patients

Poor health in children that could stay with them throughout life.

Adults with a poor quality of life and shorter life expectancy.

Low self esteem.

Key Issues for Governments

The Government has announced a $116 million package over four years to encourage more exercise and better eating habits among Australian children. A good start but this is a whole-of-population issue that should be ongoing.

The Opposition has announced a proposal to ban all food advertisements during children's viewing hours.

AMA Position

The AMA released a comprehensive statement on combating obesity on 20 June 2004.

The AMA believes that should be a national anti-obesity program for all Australians – children and adults – based on good diet and regular exercise.

The AMA is calling on the Government and the Opposition to extend their current policies to provide permanent anti-obesity programs to get all Australians fitter and healthier.

Full details of the AMA's proposals are available on the AMA website.

4.9 Child Abuse

Background

Child protection is a serious public health issue that is complicated by a system that is fragmented by differing approaches and regulations across State and Territory boundaries.

There is an increasing rate of reported/suspected cases of child abuse and neglect and an increased number of substantiated cases in all parts of Australia. Indigenous children are at an even higher risk of child abuse and neglect than other groups.

Key Issues for Patients

There is now evidence that adverse childhood experiences are very common and that such experiences are strong predictors of health behaviours in adolescence and adult life. Other factors that can lead to an increased risk of child abuse and neglect are changes in family structures such as:

- A marked increase in the number of children who live in families where there is no adult in paid employment.
- The increasing number of single parent families which, for many children, means living in poverty and being in close contact with men with whom they have no kinship ties and who may pose a greater risk of abuse.
- More children are growing up in families where parents are drug or alcohol dependent, or have a mental illness or a degree of intellectual disability.
- The children of persons held in immigration detention are of special concern.These children have a ten-fold increase in the rate of mental disorders subsequent to detention.

Key Issues for Governments

The prevention and treatment of child abuse and neglect needs a multi-disciplinary approach that involves medical, nursing, teaching, childcare, social work, law and both non-government and government agencies working together. Governments must provide support and education for parents to help prevent child abuse and neglect from occurring.

AMA Position

The AMA endorses the World Medical Association Statement on Child Abuse and Neglect , which states that the rights of children to be free of abuse and neglect take priority over any rights of adults.

The AMA recognises the need to view child abuse and neglect as a serious public health issue.

The AMA calls upon the Government to form a national policy for child abuse and recovery that is accepted by all States and Territories.

The AMA calls upon the Australian Government to ensure that children in immigration detention receive the same level of health and welfare services as all Australian children.

4.10 Childhood Immunisation

Background

The rate of fully-immunised Australian children rose from 52 per cent in 1995 to over 85 per cent in 2002 due mainly to Australian Government incentives to parents and general practitioners for fully immunising children according to the Australian Standard Vaccination Schedule (ASVS). The vaccines in this schedule were fully funded by government.

In September 2003, three additional vaccines (conjugate pneumococcal, varicella and inactivated polio) were added to the ASVS as recommended by the Australian Technical Advisory Group on Immunisation (ATAGI) and approved by the National Health and Medical Research Council (NHMRC).

The Australian Government did not fund these additional vaccines so that there are now two immunisation schedules in Australia – the ASVS, which is currently not fully funded, and the National Immunisation Program that does not include varicella or inactivated polio vaccine.

Key Issues for Patients

Parents who wish to fully immunise their children as per ASVS must pay for the unfunded vaccines themselves.

Conjugate pneumococcal vaccine was funded in June 2004, and thus added to the ASVS, after much lobbying by the AMA and other groups. Previously parents of children not deemed to be in high-risk groups have had to pay a total of $450 for the three doses of pneumococcal vaccine.

Key Issues for Governments

The current situation of two schedules is confusing for parents and GPs who are the main immunisation providers. Centrelink, which is responsible for administering the Maternity Immunisation Allowance and the payment of Child Care Benefit – which are dependent on evidence of 'full immunisation status' – is also confused.

The immunisation rate has declined.

AMA Position

The AMA is committed to working with governments and with all others involved in the care of children, to ensure the universal uptake of childhood immunisation.

The AMA calls upon the Australian Government to fund all childhood immunisations listed on the Australian Standard Vaccination Schedule. These vaccines are all recommended by ATAGI and approved by NHMRC.

The AMA calls for easy to understand information regarding childhood immunisation be universally available to parents and caregivers.

The AMA supports the time extension of the Immunisation Incentives (GPII) Scheme.