## Australian Medical Association

# Federal Budget Submission 2011-12

AMA

Health – the best investment that governments can make

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# Health – the best investment that governments can make

When economic and fiscal conditions are difficult, governments and households tend to restrict their investment in health care.

This pattern is not unique to Australia. During the global financial crisis, it occurred in wealthy and poor countries alike.

When health expenditure is restricted, investment in preventive health measures often falls to even more inadequate levels. This means that potential better health outcomes and cost savings through preventive health are lost.

There is a strong and valid argument that health investment should increase or at least be maintained in tough economic times or times of crisis such as the recent floods. The health impacts from these events, especially mental health, are significant.

Health care is an investment in the social fabric of the nation and in the productivity of the workforce. It is an excellent investment. When done well, it can generate a return of immeasurable value in terms of a healthy, happy and productive population.

Many Australians enjoy access to a very large number of high quality health services at a very modest cost. But for some time Australia has been under-investing in health care.

For example, our public hospitals are under very intense workload pressure and are not providing all patients with appropriate and timely access to emergency services and elective surgery.

The mental health system is not even reaching many patients and it is failing too many others.

And Aboriginal and Torres Strait Islander peoples are experiencing health status that is, at best, on a par with some of the poorest countries on the planet.

While we have areas of excellence in our health system, we also have many areas where we should and could be doing a lot better. It requires commitment, targeted financial investment, and investment in the health workforce.

Australia can afford to do a lot better in health. We weathered the global financial crisis with less economic and financial pain and less social dislocation than any other advanced economy.

The AMA welcomes the fact that the Federal Government has recognised at least some of the deficiencies in health care and that it has identified second-term priorities including mental health, aged care, and a national disability insurance scheme.

However, the AMA is not convinced that all Australian governments fully understand the scale of investment that will be required to maintain Australia's health system as one of the better systems in the world and to meet the challenges of an ageing population.

If we are able to keep older people well and independent longer into their retirement, we will get more from every dollar we spend on health – but only if we make the appropriate investments at the outset.

The AMA Budget Submission identifies areas where additional investment in health care and health infrastructure is needed and should be considered in the forthcoming Federal Budget.

Each of these investments, if adopted, would generate great returns to the Australian community.

Each of these investments, if neglected, implies a cost to the Australian community.

The AMA does not suggest that the answer to every question is to spend more. We have identified areas where the Government can spend more effectively.

There are ways to improve the management and the functioning of our public hospitals and major programs such as the MBS and the PBS, and there are ways to further improve outcomes from chronic disease management, prevention and early intervention.

We have identified the areas that Australia needs to address right now in order to have a high quality health system into the future - in particular, investments in health workforce and health and medical research.

The AMA is fully aware of the demands on the Federal Budget from global economic pressures and the massive recovery and reconstruction programs following floods and fires and cyclones.

But we believe strongly that spending on health is an investment that will underpin the rebuilding and restoration of productivity, cohesion and confidence in the Australian population.

**Dr Andrew Pesce**
President

# Public hospitals

## Background

A capable and safe public hospital system is a core requirement for the delivery of high-quality, safe and accessible health services.

The public hospital system currently has insufficient capacity to ensure that patients are treated in the emergency department or admitted into hospital within safe, clinically appropriate timeframes. The AMA estimates that across Australia 3,870 additional beds are needed for the public hospital system to operate at a safe 85 per cent average bed occupancy rate.

Research and development are key parts of the mission of the public hospital system. Support for research, development and training ensures that we can continue to improve patient care and training for future generations of doctors. Most public hospitals also undertake research and training as part of their normal functions.

Doctors working in public hospitals can contribute essential expertise to the management and operation of the hospitals. Local knowledge from local doctors is essential to improve clinical care and decisions about strategic planning, budgeting and resource allocation.

## Key issues for patients

Public hospitals must have the capacity to meet the demands of a population that is growing and ageing, and experiencing chronic conditions that inevitably require acute care.

Monitoring hospital performance against service delivery targets and standards of care informs the community about how well public hospitals are performing. But we need to ensure that targets and standards do not interfere with decisions about the best care for patients. Such targets are not useful unless public hospitals have the resources that are required to meet them, as well as the flexibility to use resources to the greatest clinical effect.

Patients will continue to experience inappropriate waits in emergency departments and for elective surgery and other specialist medical care unless capacity in all areas of public hospitals is expanded to allow more patients to be treated and admitted within clinically recommended times.

## Key issues for the Government

While the Government's health reform agenda should ensure that all health care resources are used efficiently and effectively, the rejuvenation of public hospitals – through better targeting of the additional health reform funding and better governance arrangements – is a priority.

Unless public hospitals are properly funded and governed they cannot deliver the acute care services that communities need, nor can they meet expected national standards for quality and timely access to hospital care.

Public hospital financing arrangements must accommodate future growth in the demand for public hospital services.

Hospitals need to be supported to deliver a range of services and perform a range of functions to high standards. Performance standards and monitoring are important but must not introduce perverse incentives that compromise good patient care.

Doctors involved in patient care can make a significant contribution to the effective and efficient management of public and private hospitals. Doctors can contribute to better management of health costs while ensuring quality patient care and outcomes by being involved in decisions about resource allocation and the purchasing of services for the provision of patient care.

The management of hospitals works best when doctors are engaged in clinical and corporate governance.

# AMA POSITION

## Public hospital beds

Every public hospital must have sufficient capacity to operate at an average bed occupancy rate of 85 per cent. Expanding the capacity of the public hospital system will result in more timely access into hospital for patients, and safe occupancy rates once patients are in the hospital.

There must be a transparent mechanism for tracking whether or not any new funding commitments by the Commonwealth actually result in an increased capacity in public hospitals to meet the demands of the community. The Government needs to:

- commission a monitoring system called *Bedwatch* to report publicly on the number of new and existing beds available in public hospitals;
- ensure that *Bedwatch* also monitors important factors related to hospital occupancy rates such as access block in emergency departments; and
- require the State and Territory Governments to report the number of available beds for each public hospital, and their average occupancy rates, as part of their obligations to report against performance benchmarks.

This information should be included on the *MyHospitals* website.

## Secure funding for research and training in public hospitals

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

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

## Public hospital governance

Doctors must be genuinely involved in decision-making at the local level. Governments must ensure that:

- local doctors are represented on the governing councils of Local Hospital Networks;
- members of Local Hospital Networks are selected using an open and transparent process that is free from political interference;
- the Local Hospital Networks have the power to hire and fire the CEO of the hospital; and
- decisions made by Local Hospital Networks are transparent and publicly available.

The roles and functions of the bodies that are established to oversee hospital performance, financing and governance should be complementary - and there should be a minimum of duplication.

## Public hospital funding

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

- hospitals are paid on the basis of the effective cost of care rather than an arbitrary 'efficient price'. This will require more funding for public hospitals, not less;
- the effective price is indexed annually at a rate that recognises real increases in operating costs, such as wages and equipment;
- the effective price allows variation for local flexibility and incorporates sufficient loadings and adjustments to reflect the variable geographic and other circumstances of individual hospitals;
- the effective price does not compromise or limit clinical decisions that doctors make for their patients;
- effective pricing is available to cover the real cost of care; and
- funding models support the maintenance of outpatient services to ensure comprehensive patient care in the most appropriate clinical setting and provide access to this essential component for teaching and training of medical students and future specialists.

# Mental health

## Background

Many Australians experience a mental illness at some time in their lives. Several Federal Parliamentary Senate inquiries, the National Health and Hospitals Reform Commission, the National Advisory Council on Mental Health, and the Mental Health Council of Australia have all pointed to the need for increased mental health funding and reform of mental health service delivery arrangements. To date, responses from the Government have been inadequate. In particular, there continue to be significant problems with community-based mental health services that have not been appropriately structured or funded since the Burdekin reforms that moved much of the care and treatment of people with a mental illness out of institutions and into the community.

## Key issues for patients

All Australians with a mental illness deserve to have ready access to quality mental health care based on their particular needs. This requires a significant expansion of services, intervention and support across the whole continuum of care, including a focus on destigmatisation, prevention and early intervention, community-based care, subacute care, acute care, crisis and outreach services, specific services for special needs groups, and better ways to address the social, environmental and economic factors that impact on mental health.

People are still frequently unable to gain access to the mental health care they need, when they need it. Care in the community is especially deficient, both after hospitalisation for an acute episode and for people who could be treated in the community, including by a GP or psychiatrist in a community-based setting, thus preventing the need for acute hospitalisation. Many people with mental illness, especially those with less significant psychoses and psychiatric illness, are able to be appropriately diagnosed and cared for in respect of their physical and mental health problems by general practitioners in the community. It is imperative that care provided in the community by general practitioners for those with mental illness is enhanced, supported, properly funded and better coordinated, and that there are more community-based support services for GPs to which they can refer their patients as part of managing and treating their condition.

## Key issues for the Government

Some recent measures to improve early identification and intervention for youth have been announced. But there continues to be significant unmet need in mental health care and major gaps in service provision that the Government must address in this Budget. The AMA is calling for a significant investment in an extensive range of areas over the next four years (as outlined below) to ensure that mental health care is accessible, affordable and effective.

## AMA POSITION

The AMA calls on the Government to provide $5 billion over four years to expand health and social support services to ensure that all people with mental illness are properly supported. In 2011, the AMA will be releasing a detailed plan outlining what is required in all of these priority areas to assist the Government meet its commitment to making mental health a successful second-term priority. This plan will include calls for the Government to provide support in the following areas.

- Prevention, destigmatisation and community understanding, including through sustained national community awareness campaigns to increase mental health literacy and reduce stigma; public education campaigns for prevention and a reduction in substance abuse; and promotion of good health and resilience in young people at school and in the community.
- Early identification and intervention, including through support for more online and phone counselling and support services, comprehensive information about local referral pathways to ensure that patients get linked to the right service at the right time, more child-, adolescent- and youth-friendly services, and mental health screening for infants, children, and adolescents to identify symptoms as early as possible.
- Community-based care, including through improved Medicare Benefits Schedule (MBS) rebates and streamlined MBS arrangements to improve access to psychiatrists and GPs for patients treated in community-based settings; improved access to mental health assessment facilities and mobile outreach; access to specialised community-based programs to treat specific clinical conditions including eating disorders, perinatal depression, personality disorders, suicide and self-harm; improved access to specialised mental health assessment and care and dementia care services for the elderly in residential aged care; and improved access to community-based mental health care services in rural and urban communities to meet local needs.
- Subacute care, including through more capital and recurrent funding for subacute beds for long-stay patients and for residential rehabilitation; step-up and step-down residential care as an alternative to inpatient admission, or for a period of transition after hospital discharge; and more respite care for people with mental illness and their families.
- Acute care, including through funding to open and continue to operate additional acute care beds in public hospitals; increased access to public patient mental health outpatient services; specialised mental health and dual diagnosis spaces in public hospital emergency departments; and additional capacity to provide patients with the option of being treated in single sex mental health wards in public hospitals.
- Crisis and outreach care, including through increased investment in crisis and outreach care, particularly for those with severe mental illness and/or those at risk of suicide; and the establishment of a rapid-response outreach team for every acute mental health service.

- Support and services for special needs groups through improved access to specialised mental health services, including people in Indigenous communities, people with disabilities, those with significant drug and alcohol issues, older people, the homeless, and those people from culturally and linguistically diverse backgrounds, prisoners, and people in detention centres.
- Measures to address the social, environmental and economic determinants of mental health through improved access to education, supported community-based housing, public housing, social support including services to prevent neglect and sexual abuse of children, vocational rehabilitation, employment support and post–placement employment support; and a social service system that links to community mental health services to enable appropriate clinical support, especially for those with severe and/or chronic mental illness.
- Expanded mental health workforce including by increasing the number of funded psychiatrist trainee places; increasing the number of training opportunities for other mental health workers; providing further continuing professional development and competency training opportunities for the primary health care workforce who want it; and more debriefing services for mental workers and doctors.
- Improved coordination and access including through additional funding for mental health coordinators to assist with transition in and out of acute and subacute care; increased online support and access to telemedicine and e-health technology; improved coordination, information and communication flows; and reducing access gaps and improving referral pathways at the local level between acute care and community-based services and between the public and private sector providers working in them.
- Research, including by funding more mental health research in the areas of neuroscience, clinical treatment and translational research to ensure that mental health services are evidence-based and continuously improve.

# Aboriginal and Torres Strait Islander health

## Background

The gap in life expectancy between Indigenous and non-Indigenous Australians remains one of the most compelling health problems confronting Australia today. The higher prevalence of a range of chronic and communicable diseases and social and emotional health problems among Indigenous peoples is unacceptable. There is a limited health and medical workforce providing culturally appropriate primary care services for Indigenous Australians, and a range of social, environmental and economic factors act to entrench health problems. A concerted effort is needed to improve the access of Indigenous Australians to high quality health care if the gap in life expectancy is to be closed within a generation.

## Key issues for patients

The very poor health status of Australia's Indigenous peoples is a disaster for them and an indictment of the nation as a whole. With the right support and access to appropriate health care, Indigenous people can develop practical solutions and preventive approaches to some of the health-related problems in their communities. It is important to engage Indigenous people in their own health care solutions.

## Key issues for the Government

Australia's health system is undergoing major reform, including the creation of regionalised primary health care organisations that have potential to promote best practice and continuity of care for Aboriginal and Torres Strait Islander peoples. COAG's agreement for the Federal Government to take 100 per cent funding responsibility for GP, primary care and aged care services provides an opportunity for one level of government to ensure that funding is channelled to where it is most needed.

## AMA POSITION

The AMA welcomed and supported the 2008 COAG National Partnership Agreement on Closing the Gap in Indigenous Health Outcomes, then funded at $805 million over four years. The AMA calls on the Government to develop and implement in partnership with Indigenous people a long-term national strategic plan to improve the health of Indigenous people, with tangible intermediate goals. In addition, the AMA calls for further funding to be included in the forthcoming Budget for the following immediate priorities:

- expansion of the workforce for Indigenous health, through additional grants to enhance infrastructure and services, to allow Aboriginal Medical Services to offer mentoring and training in Indigenous health in Indigenous communities to Indigenous and non-Indigenous medical students and vocational trainees, and offer salary and conditions for doctors working in Aboriginal Medical Services that are comparable to those of State salaried doctors;
- development of a network of Centres of Excellence in Indigenous Health across Australia to act as training and research hubs for medical professionals seeking high quality practical experience and accreditation in Indigenous health;
- $10 million per annum over 10 years to fund grants to NGOs and community groups for health-related capacity building in Indigenous communities throughout Australia; and
- measures to improve urgently all of the social determinants of health in Indigenous communities.

It is an imperative that the transfer of 100 per cent of primary health care funding responsibility to the Federal Government does not disadvantage community-based Aboriginal and Torres Strait Islander health services, and that the Federal Government fully replaces funding that was provided to those services from other sources, such as State governments and local councils.

# Health financing

## Background

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

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

High rates of participation in private health insurance are supported by measures such as Lifetime Health Cover, the Medicare levy surcharge and the private health insurance rebates.

Most out-of-hospital medical services are provided by private medical practitioners and Medicare rebates assist patients with the costs of these services. The real value of Medicare rebates for patients has not kept pace with the increasing cost of running medical practices because successive Governments have failed to index the Medicare schedule fees in line with other indices such as CPI and average weekly earnings. In the year to September 2010, the Labour Price Index increased by 3.2 per cent and the CPI by 2.7 per cent. In contrast, some MBS items were indexed by a very modest 1.8 per cent and rebates for services provided by non-vocationally registered GPs, pathology and diagnostic imaging items have not been indexed at all for more than a decade. Consequently, out-of-pocket costs for patients are increasing.

Instead of increasing Medicare rebates, the Extended Medicare Safety Net (EMSN) was introduced to assist patients with high out-of-pocket costs for medical services provided out of hospital. The EMSN structure helps share these costs between patients and the Government. In 2009, the Government shifted more of the burden of the costs on to patients by introducing a cap on the total EMSN benefits paid for some medical services.

## Key issues for patients

Patients want the choice of affordable access to private hospital services, especially for elective surgery. And they want a strong viable private sector so that the public hospital sector can be there for those who really need it.

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

Government subsidies for private health insurance premiums and the EMSN alleviate the financial pressure faced by many people in receiving private hospital treatment and private medical services in the community.

## Key issues for the Government

The private hospital system is now the dominant provider of elective surgery. Private health insurance also provides financial support for various preventive health services.

It is a good investment for the Government to support private health insurance because high participation maintains the balance of the hospital sector. High private health insurance membership brings private dollars into the health system and, in turn, means that the government funding required is less than it otherwise would be.

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

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

Though 80 per cent of GP services are bulk billed, there is cross-subsidising of these services by patients who incur a gap, and their gap is increasing. Only 26.7 per cent of specialist consultations are bulk billed and, for patients who are not bulk billed by their specialist, the average out-of-pocket cost is $46. Patient out-of-pocket costs for pathology and diagnostic imaging services are also rising because the Government's rebates are not keeping up with the cost of providing these services.

Poor or no MBS indexation, cuts to existing rebates, and caps on EMSN benefits by the Government simply shift costs to patients and make medical services less accessible.

The Government is reviewing funding for pathology services. If changes to pathology funding are being considered as a result of this review, it is essential that there is consultation with pathologists to ensure that changes in funding arrangements do not negatively impact on the availability and quality of pathology services, and to ensure the ongoing viability of training and research in the pathology sector.

# AMA POSITION

## Support for private health insurance

The existing measures that encourage private health insurance participation are effective and must be maintained to ensure that membership remains at levels that ensure that there is no shift of the burden from the private to the public hospital sector. The AMA does not support any change to private health insurance that risks reducing the private health insurance participation rates. Further, any reduction in private health insurance participation for any reason must be offset by a sufficient increase in funding for the public hospital sector to ensure that it can meet increased demand from increased numbers of public patients.

## Extended Medicare Safety Net

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

## Appropriate indexation of the MBS

MBS indexation must be brought closer in line with increases in the Labour Price Index and the CPI so that rebates keep pace with the real increases in the cost of providing medical services and running medical practices. This will ensure that the Government provides appropriate financial assistance to patients to maintain affordability of medical services provided outside the hospital setting. In addition, MBS indexation must be applied to all medical services on the MBS, including pathology and diagnostic imaging services. The AMA estimates that appropriate indexation of these services would add $266 million to annual outlays.

# Long-term care and disability support

## Background

There are high levels of unmet demand for disability services in Australia. However, disability services across the country are often poorly resourced, ill-coordinated and inadequate to the long-term health care and support needs of individuals with serious disabilities. The disability care system also does not reflect the goals of enhanced social and economic participation that underpin the National Disability Strategy. The community has historically relied on informal care arrangements, which have substantially shifted costs on to families, but there is expected to be a decline in the number of people who are willing or able to provide long-term care for family members with a disability.

Disability services are poorly resourced and not sufficiently coordinated to meet the long-term health care and support needs of individuals with serious disability. There is little national consistency in the access that people with a disability have to appropriate levels of care and aids.

## Key issues for patients

Individuals with a disability and their families are entitled to have access to long-term essential care and support based on their level of need. Lack of access to services results in poor health outcomes, less full and effective participation and inclusion in society, and a reduction in dignity, autonomy and the ability to be independent.

## Key issues for the Government

There is a significant need for reform to the funding and financing of the disability service system, to ensure that equitable access to long-term essential care and support is reliably available to those who need it.

## AMA POSITION

The Government should introduce a system of comprehensive care and support that includes a coordinated package of services such as accommodation support, employment support, rehabilitative care, aids and appliances, and respite care, access to which should be underpinned by individual decision-making and choice.  Long-term care and support should be provided to individuals with a disability to a level that ensures that their health and medical welfare does not deteriorate as a result of inadequate care.  The current Productivity Commission Inquiry provides a significant opportunity to design a world-class national disability insurance scheme. It is important that the appropriate groundwork is laid in advance for the future implementation of any national insurance scheme.

The Government must prepare for the staged implementation of a national disability insurance scheme as per the forthcoming recommendations of the Productivity Commission, when it reports in mid-2011. A priority will be agreement on, and establishment of, models for sustainable financing that can reliably meet need into the future.

The Government must also set aside sufficient funds in the forthcoming Budget for the significant expansion of the disability service system, so that Australia is ready to meet the substantially increased demand for disability services that will result from the introduction of a national disability and support scheme.

# Workforce and training

## Background

Australia has a poor record when it comes to medical workforce planning. For far too many years, policy rested on an assumption that Australia had too many doctors. We now know that this was wrong and, following strong lobbying by the AMA and the medical profession, steps are being taken to address this situation.

Careful planning is essential to ensure that the boom-bust medical workforce cycles of the past are avoided and that the community gets access to the high-quality medical care that it deserves. Planning for workforce requirements and training remains inadequate.

Since 2004, the Commonwealth has responded to medical workforce shortages by taking several steps to increase significantly the number of medical school places across the country. As a result, by 2014, there will be around 3,800 graduates from Australian medical schools compared with 1,500 in 2004. The AMA has welcomed these increases, but medical training takes many years and increasing the number of medical school places will not address medical workforce shortages unless there is an associated increase in intern, prevocational and vocational training places.

## Key issues for patients

A key to the success of Australia's health care system is that patients have access to a highly skilled and motivated medical workforce employed in general practice, community and hospital settings.

Medical training in Australia is underpinned by rigorous, independently-set professional standards that require students and junior doctors to work in accredited, supervised training positions to enable them to get the experience they need. Australia must ensure that the resources are in place to enable the increasing number of medical school graduates to complete their medical training.

## Key issues for the Government

It is essential for the future of the health system that the Commonwealth and State and Territory Governments deliver more resources to support the training of the medical workforce. Reliable data on the full medical workforce supply and demand requirements, including prevocational and vocational training places needed to meet future workforce demand, are not available.

## AMA POSITION

The Government must introduce a framework that delivers the right number of medical practitioners to the community, working in the disciplines and regions where they are needed so that the community's needs are properly served.  This will require significant commitments and funding, better planning and coordination and better utilisation of private and community settings, all underpinned by a transparent accountability framework so that progress can be accurately measured and monitored.

To do this, the Government should implement the recommendations of the 2010 AMA Medical Training Summit Joint Statement, which include:

- the establishment of a specific Medical Workforce Planning Advisory Committee to analyse community demand for medical services in the context of the current supply of medical practitioners coming through the system and make recommendations on the number of medical school, prevocational and vocational medical training places required;
- Federal and State health ministers to adopt the recommendations of this Committee and provide funding and resources to implement the required training places;
- the Federal Government to make its 60 per cent funding contribution to teaching in public hospitals conditional on the States and Territories funding and delivering the required training places;
- the Medical Training Review Panel be commissioned to monitor the expansion of the recommended additional prevocational and vocational training places and conduct a biennial review of clinical training places across the spectrum of medical training to identify any unanticipated new gaps emerging between supply and demand;
- revised funding arrangements for undergraduate medical training so that the quality of training of medical students is not reliant on the income that universities get from overseas students;
- ensuring that funding provided to States and Territories for teaching in public hospitals includes a component to cover the costs of protected teaching time for doctors; and
- continuing to support more training in general practice, the private sector, and other community settings.

# Health and medical research

## Background

Australia has a proud record of achievement in health and medical research, and this must be maintained. Health and medical research, including that funded through the National Health and Medical Research Council (NHMRC), is crucial to maintaining best-practice, high quality health and medical care in Australia. An investment in health and medical research also generates social and economic benefits to the community. The health system needs to be efficient, and a central part of this is having best-practice knowledge and techniques available to medical practitioners and patients. An efficient health service system also needs to deliver effective health outcomes, particularly in primary care settings, and manage patients through complex care pathways.

## Key issues for patients

All Australians benefit from investment in health and medical research in the longer term because it helps ensure that doctors have access to the best evidence-based therapies and treatments informed by well-funded world-class research. If the appropriate investments are not made, Australia's ability to offer its citizens high quality health care will be impaired.

## Key issues for the Government

The Government needs to increase the funding commitment to health and medical research to improve the evidence base, not only for cutting-edge hospital procedures, but also for preventive medicine and chronic disease management.

## AMA POSITION

The AMA supports the medical research community's call for additional funding (totalling $850 million over 3-4 years) to maintain Australia's position as a global leader in health and medical research. In particular, the additional funding is required for the following:

- a four per cent real annual growth in funding for the NHMRC from 2011 to fund research to address rising rates of conditions such as diabetes, cancer and dementia, as well as ways to build workplace productivity and to address population ageing;
- building health research as an enabler of health reform to provide evidence to drive excellence and continuous improvement in the health system; and
- funding to help innovative ideas and new technologies make it to market.

# Aged care

## Background

Demand for health care services to meet the needs of older Australians is growing rapidly. Between 2010 and 2050, the number of older people (65-84 years) will more than double, from 2.6 million to 6.3 million, and the number of very old (85 and over) will more than quadruple, from 0.4 million to 1.8 million.

## Key issues for patients

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

Many older people are transferred into residential aged care facilities from hospital after a long and complex hospital stay, and have multiple and complex health care needs that require ongoing medical care and management. We can expect this trend to continue.

## Key issues for the Government

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

Further, properly-funded medical care in appropriate settings will help provide older people with quality care as they reach the end of their lives, and have the added bonus of freeing up acute care beds.

## AMA POSITION

MBS rebates for services provided by doctors and practice nurses must reflect the time and complexity of providing ongoing medical and dementia care to older people living in aged care facilities and in the community. The current MBS rebate for these services should be at least doubled. This would require the Government to invest an additional $150 million per annum for these services.

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

A specific aged care accreditation standard for medical care must be introduced to ensure that access to medical care is monitored and scrutinised under aged care accreditation arrangements like other important quality, service, and care arrangements.

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

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

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

# GP infrastructure

## Background

The Government initially committed $280.2 million over four years for the construction of 36 GP Super Clinics in Australia. In 2010-11, the Government committed a further $370.2 million over four years for the construction of a further 28 GP Super Clinics, including $122 million for 425 GP infrastructure grants for existing GP practices nationally. The average grant per GP Super Clinic is $8.25 million and the average GP infrastructure grant is $287,000.

To date, the Government has announced the location of approximately 60 GP Super Clinics, although only a handful are operational at this point. Many GP Super Clinics have been opposed by the local doctors, as there is no shortage of GPs or health services in the area and the GP Super Clinic, when it is established, will compete with existing general practices. Further, there is no persuasive economic case for providing such enormous additional health care subsidies for GP Super Clinics when the same outcome could be achieved for a much lower level of investment.

## Key issues for patients

Patients want access to doctors and medical services and through them to necessary allied health and nursing services. The GP Super Clinics program will give them access to new buildings but not necessarily to doctors. Doctors who are attracted to a GP Super Clinic may be drawn from an existing GP practice resulting in no net gain to the community. Measures that can bolster the capacity of existing general practice services in needy communities are highly valued by patients.

## Key issues for the Government

Though the Government cannot easily back away from previous commitments, in those communities where there is resistance to the establishment of a GP Super Clinic, there is scope for change. The Government should meet its obligations to these communities by shifting the budget for the Super Clinic into GP infrastructure grants for existing practices that have a track record in the community of delivering good health services but who could do better with small infrastructure grants to expand services to patients.

In addition, since the applications for previous and current grant rounds have been, and are likely to continue to be, oversubscribed, the Government's should commit to additional funding for the GP infrastructure grants program in 2011-12. This would maximise the effectiveness of the Government infrastructure expenditure, be quicker to implement, and support services that are already valued by the relevant communities.

## AMA POSITION

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

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

# Chronic disease management

## Background

The recent AIHW *Australia's Health 2010* report confirms that GPs are increasingly treating older patients with more complex care needs. The management of chronic and complex disease is a key part of general practice, with at least one chronic problem managed in 42 per cent of all visits to a GP.

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

Australia needs a comprehensive approach to the management of chronic and complex illness, not just a focus on single diseases as in the current Government's proposed plan for diabetes.

The medical profession was not properly consulted on the Government's proposed program to deliver GP care for patients with diabetes. This program relies on patient enrolment with the practice and, once enrolled, limits patient choice. It interferes with the doctor-patient relationship and requires patients to surrender their entitlement to Medicare rebates.

Though the AMA supports the Government's recent decision to defer the implementation of its Coordinated Care for Diabetes reforms until the results of a pilot program are available, it continues to call for the Government to implement the AMA's plan for improving the management of chronic and complex disease.

## Key issues for patients

As highlighted earlier, research commissioned by the AMA shows that patients want to spend more time with their GP. The current structure of the MBS does not support more time with the doctor, with patients on average spending about 15 minutes with their GP each time they visit.

Improved access to GP-referred allied health and other support services can improve the management of chronic and complex disease and enhance people's quality of life.

At the same time, the health system must also encourage individual patients to take some responsibility for their own health and wellbeing, based on the advice they receive from their GP, including on secondary prevention measures.

## Key issues for the Government

GPs could keep more patients with chronic and complex disease out of hospital if they could obtain better support for their patients. This would save the health system money and relieve some pressure on the hospital system.

In addition, governments should have a strong health prevention focus as part of their health care policy. Providing patients with an MBS rebate structure that supports longer consultations would ensure that patients with chronic and complex conditions get the time that they need with their doctor.

# AMA POSITION

The AMA has a comprehensive plan to manage chronic and complex disease by improving GP-coordinated access for their patients to multidisciplinary care and other important support services. The plan can be found on the AMA website at www.ama.com.au/node/5519

The AMA plan builds on what works and has the overwhelming support of GPs. Under this plan, existing fee-for-service Medicare arrangements would be enhanced so that patients would have streamlined access to GP-referred allied health services and a range of other support services, such as mobility aids. The plan focuses on patients' clinical needs and ensures that more support is available to those patients who need it. Unlike the Government's proposed program, the AMA's plan does not require patients to surrender their right to Medicare rebates.

The Government must:

- implement the AMA plan to manage chronic and complex disease in consultation with the medical profession; and
- increase the Medicare patient rebate for level C and D consultation items in the MBS to support improved care for patients with chronic and complex conditions. This will improve patient access to longer consultations. Funding allocated to the current Government's diabetes plan should be redirected and used for this purpose.

# Other GP priorities:

## [after-hours services; practice nurse funding; GP-referred MRI; and Point-of-Care Testing (PoCT)]

### Background

The Government has already committed funding to reform the provision of after-hours care and practice nurse funding. In respect of after-hours GP services, from 2013-14 the Government has proposed that the role of the newly-established Medicare Locals will include the funding and coordination of GP after-hours face-to-face consultations on referral from the after-hours call centre service, *healthdirect* Australia.

In terms of practice nurse funding, the Government has proposed that there will be annual incentive payments of $25,000 per full-time GP for a registered nurse and $12,500 per full-time GP for an enrolled nurse, capped at five incentives per practice. This new program will replace current Government PIP funding for practice nurses, which includes a limited number of 'for and on behalf of' MBS items and PIP subsidies that apply in certain geographic areas.

There is also a need to institute funding for GP-referred MRI scans to assist GPs in the diagnosis and treatment of their patients, and for Point-of-Care Testing (PoCT) in general practice to assist GPs in the management of chronic disease, particularly in the areas of optimising therapy, engaging patients in their self management, and providing regular follow-up.

### Key issues for patients

Access and affordability are important to patients, particularly those in rural and remote locations. Any new after-hours service must be adequately resourced to ensure that patients need not travel long distances for a face-to-face consultation. Patients whose GP currently provides after-hours services want to continue to be able to be treated after hours by their own GP. And patients who need to be referred to another doctor after hours need to be reassured that there are mechanisms for the record of their after-hours consultation to be promptly forwarded to their regular GP to facilitate any follow-up treatment and for continuity purposes.

Patients will also benefit from improved access to care as a result of more practice nurses in general practice if additional funding for practice nurses is properly implemented so that it leads to an expansion of practice nurses in general practice.

Current arrangements under the MBS that restrict patient access by limiting MRIs to patients referred by a specialist or consultant physician result in delays for patients in obtaining access to specialists and the appropriate diagnostic test in a timely manner, diagnosis, and the appropriate treatment or

management plan.  Patients could also receive less informative or higher risk tests (such as CT scans) than clinically indicated and bear the additional costs of potentially unnecessary specialist attendances or rebate-exempt MRIs.

PoCT is highly convenient for patients.  It encourages ongoing compliance in follow-up attendances and adherence to medication and management strategies.  Patients with chronic conditions can be tested at the time of consultation using PoCT to enable GPs to act on an immediate result and engage patients in the management of their condition.

## Key issues for the Government

New after-hours funding arrangements must not create a disincentive for practices currently providing after-hours services to continue to do so and must encourage those who are not currently providing after-hours services to do so.

The Government must ensure that the design and implementation of new practice nurse funding arrangements are undertaken with full input by, and consultation with, the medical profession and other relevant stakeholders to ensure that there is an expansion of practice nurse services rather than a contraction as a result of detrimental changes in funding arrangements.

GPs would be better supported to deliver the right service, in the right place, at the right time if the Government provided MBS rebates for clinically-indicated GP-referred MRIs and PoCT.  The short-term costs of funding these initiatives would be offset in the long term by less wastage and duplication of services, more timely clinical decisions and action, and improved patient outcomes. Providing access to these services through general practice would demonstrate the Government's commitment to supporting improved personal responsibility for health care management, improved management of chronic disease, and improved patient outcomes, while avoiding the long-term costs to the health system from the inability of patients to have easy and affordable access to appropriate care.

## AMA POSITION

The AMA believes that any new after-hours and practice nurse funding arrangements must not disadvantage any general practice currently providing after-hours care or practice nurse services or deter them from continuing to provide these services for their patients. Any new funding arrangements for these programs must be carefully developed and designed, in consultation with the profession, so as not to disadvantage any individual general practice currently providing these services for their patients.

GPs should also be supported in caring for their patients with appropriate access to the best available diagnostic tests. This requires the Government to introduce MBS rebates for patients for MRI scans when patients are referred by a GP where clinically appropriate and for PoCT testing undertaken by GPs.

The AMA calls for GP-referred MRIs to be funded for the following conditions:

- first seizures;
- cervical spine trauma with abnormal neurological findings;
- low back pain;
- acute knee injury (not chronic pain);
- suspected cervical radiculopathy; and
- chronic headache in a young person.

To ensure that the introduction of MBS-funded GP-referred MRI items does not increase waiting times for a scan – as existing licensed MRI machines are already operating at capacity (and in the interests of timely and affordable access) – clinically-indicated scans should be funded under Medicare from unlicensed machines that meet the appropriate safety and quality standards.

The AMA also calls for PoCT in general practice to be included in the MBS and that the rebates for these items are the same as for relevant MBS pathology items. The key PoCT tests required in general practice are INR, troponin, and BSL. Any cost to the Government would be in line with the recommended services under disease management guidelines and would therefore be negligible, because individual existing pathology tests would simply be replaced with PoCT.

# Non-vocationally registered GPs

## Background

The Government introduced vocational registration in 1989 to recognise general practice as a discipline in its own right, improve professional standards and to reward high-quality practice.

Between 1989 and 1995, medical practitioners already practising in general practice who met the eligibility criteria could apply to be grandfathered on to the Vocational Register. The grandfathering period for the Vocational Register ended in November 1996.

The introduction of the Vocational Register effectively created two classes of GPs: those who were vocationally registered (VR GPs) and had access to higher A1 Medicare rebates, and those who were not (the Non-VR GPs) and only had access to lower value A2 Medicare rebates. The A2 rebates were set initially at 93 per cent of the A1 rebates but have never been eligible for annual indexation and so are proportionally worth much less than A1 rebates over time.

## Key issues for patients

The difference in rebates coupled with non-indexation means that patients who attend Non-VR GPs now receive a significantly-reduced Medicare rebate, in comparison to patients who attend VR GPs. These patients also potentially face higher out-of-pocket expenses, making access to their GP less affordable.

For example, the rebate for a 15-minute consultation for the patient of a Non-VR GP is $21, compared to that for a similar (Level B) A1 consultation of $34.90.

## Key issues for the Government

The Government should act on the recommendation of the 2005 Biennial Review of the Medicare Provider Number Legislation and provide one more opportunity for doctors who meet the necessary criteria to be grandfathered on to the Vocational Register. This is particularly important given that a number of these medical practitioners, while eligible, were excluded from the Vocational Register because at the time of their application they were on maternity leave, raising a family, undertaking further training, or overseas, and missed the opportunity to apply.

Having recently increased the number of GP training places to help address shortages in the GP workforce, the Government could further enhance the immediate availability of experienced medical practitioners to the GP workforce by addressing the longstanding anomalies that exist in funding and recognition of Non-VR GPs.

## AMA POSITION

Non-VR GPs should be recognised for their considerable experience in both general practice and other areas of medicine. Grandfathering these practitioners will help retain and increase their numbers in the general practice workforce and encourage them to increase their hours.

Specifically, the AMA calls for a final round of grandfathering for all of the Non-VR GPs who had access to GP Medicare rebates prior to 1 November 1996 and have predominantly been in general practice for a minimum of five years since that date.

In addition, in order to further reduce the inequity in rebates for any remaining Non-VR GPs, after this grandfathering opportunity, the A2 rebates should be increased to reflect the differential that existed when the vocational recognition structure was introduced. For those practitioners who are not eligible for grandfathering to the vocational register, A2 rebates should be increased to 93 per cent of the A1 rebates and indexed appropriately on an annual basis. This would address the inequity in these fully-qualified medical practitioners receiving a rebate similar to, and in the future potentially less than, that received by lesser-trained health providers such as nurse practitioners.

Based on 2005 Department of Health and Ageing figures, there are around 2,500 Non-VR GPs, including 1,500 currently accessing A1 rebates through various incentive programs. Those already having access to A1 rebates will not represent any increase in expenditure for the Government. Of the remaining 1,000, it is estimated that fewer than 20 per cent would qualify for the final round of grandfathering, with the rest eligible for rebates at 93 per cent of A1 rates. This would represent a $22 million increase in expenditure for the Government.

# Rural health

## Background

The shortage of medical practitioners in rural and remote Australia has been a problem for a long time. Through many useful interventions, a serious worsening of the situation has been prevented, but there has been no improvement. The shortages are not only in medicine, but these are some of the most critical shortages. They contribute to the lower health status and life expectancy of Australia's non-metropolitan population.

There are significant concerns over the sustainability of the rural medical workforce, with obvious adverse implications for the health of rural people. The AMA and the RDAA contend that urgent intervention is required to attract Australian-trained doctors to rural areas. Despite extensive measures over many years, the rural medical workforce crisis persists.

It is estimated that 50 per cent of the rural medical workforce have been recruited from other countries. These practitioners have provided an essential and appreciated contribution to the health needs of rural communities but it is not a sustainable situation in the long run. We need to attract doctors interested in a career in rural medicine. Given that most medical specialties are not viable in smaller communities, we need rural generalist doctors with advanced skills training to meet the health needs of these communities.

In addition, we need incentives and assistance programs for doctors working in rural areas. In 2010, the Government adopted the ASGC-RA classification as the basis for determining many of its rural incentive payments. The ASGC-RA replaced the outdated RRMA. The Government implemented the ASGC-RA classification on a grandfathered basis, so the full extents of its implications are not yet known, but there are some geographic anomalies that need to be rectified.

## Key issues for patients

The Australian Institute of Health and Welfare (AIHW) reports that rural people generally rank below people who live in major cities on a wide range of health status measures. For example, death rates in regional, rural and remote areas are significantly higher than urban areas.

Health services in rural areas are also being rationalised, which is making access to health care more difficult for rural patients. Since 1995, around 50 per cent of maternity units alone have been closed across the country.

Rural communities are finding it ever harder to recruit and retain doctors. Up to 50 per cent of doctors in some parts of rural Australia are now overseas trained – well above the 25 per cent average across the country. Even with the contribution of overseas-trained doctors, at least 1,700 additional doctors are needed to fill current vacancies.

Quality health care in rural communities depends on a well-distributed and well-trained medical workforce that works in effective collaborative arrangements with other health care professionals. Given that other specialist services require larger populations than are available to be viable, more comprehensively trained rural generalist doctors with advanced skills training are necessary.

The introduction of the new ASGC-RA classification as the basis for determining rural incentive payments which encourage and support rural health services contains some obvious anomalies that may have the effect of reducing the availability of services for patients in some rural locations. Some towns that are manifestly less well-placed to attract medical staff are in the same or a lower classification than those who are not as badly off. These towns will find it even harder to attract medical staff, and services for patients will be reduced. For example, Tumut, Gundagai, Dalby and Camperdown are in the same classification as Hobart, Wagga Wagga, Port Macquarie and Bendigo.

## Key issues for the Government

The shortage of medical practitioners in rural and remote Australia is an issue that will not be solved by expecting rural and remote people to accept a lower level of health care than their metropolitan counterparts. There is an over-reliance on overseas-trained doctors working in rural and remote locations that is not fair and not sustainable in the long run.

Better rural generalist training needs to be introduced across the country to produce appropriately trained doctors for the work required in rural areas. A comprehensive rural generalist pathway has been introduced in Queensland and appropriate models need to be developed and funded for the rest of Australia.

In addition, the AMA and RDAA have proposed a range of policy initiatives that will directly benefit rural patients. These include more funding for rural hospitals, a rural health obligation, more support for patient transport schemes, expanded specialist outreach services, and training strategies. These are important, but they are not enough to fix the problems in rural Australia once and for all. The Government needs to commit to a significant initiative that gives a clear signal that doctors currently working in the country are valued and that moving to the country is an attractive option.

In terms of existing funding and support for medical services in rural areas, the Government has a clear interest in resolving anomalies in the classification of geographic locations so that communities that are already disadvantaged in terms of access to medical services are not further disadvantaged. The anomalies ought to be able to be resolved without jeopardising the integrity of the ASGC-RA.

## AMA POSITION

The Government must include support for the following rural health initiatives in the forthcoming Budget.

- Developing and implementing improved and expanded rural generalist training, with Federal Government leadership and resources, which would attract and train the appropriate number of doctors necessary for rural practice. This would require guaranteed training places at the pre-vocational and vocational levels including in advanced skills training.
- Attracting and retaining the medical workforce during and after completion of vocational training, including implementing the AMA/RDAA Rural Workforce Package, which would provide enhancements to rural isolation payments and rural procedural and emergency/on-call loadings to encourage more doctors to work in rural areas and boost the number of doctors in rural areas with essential obstetrics, surgical, anaesthetic or emergency skills.
- Reviewing the ASGC-RA classification in order to address the more obvious anomalies.

It is estimated that this investment in rural health care would be of the order of $300 million to $400 million annually.

# E-health

## Background

An e-health system that connects patient information across health care settings - and to which treating doctors and other health workers have access, and to which they can contribute - will improve the safety and quality of medical care in Australia.

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

Australia has made significant progress in developing technical specifications and standards for e-health systems. The time has come to build the overarching infrastructure to make e-health a reality.

## Key issues for patients

Health care of the patient is best served when the medical practitioner has access to the full health record.

Personally controlled electronic health records can empower and encourage individuals to take responsibility for their own health, but for medical practitioners their use may be severely limited because of problems with the accuracy and comprehensiveness of the information they contain.

A secure electronic medical record, in the first instance containing pathology and diagnostic imaging results, discharge summaries and information on medications dispensed, is needed in addition to any personally controlled health record in order to improve the safety of patient care.

## Key issues for the Government

The Government must drive and fully fund the development and implementation of a shared electronic medical record, starting with a record that provides basic information critical to patient care.

## AMA POSITION

The Government should concentrate all its efforts on getting pathology results, diagnostic imaging results, hospital discharge summaries, and information on medications dispensed on to an electronic medical record across the whole health system, both public and private.

The Government must fund and implement a shared electronic medical record that:

- contains reliable and relevant medical information about individuals;
- aligns with clinical workflows and integrates with existing medical practice software;
- is governed by a single national entity; and
- is fully funded by the Government, supported by appropriate incentives, education and training.

# Climate change and health

## Background

The world's climate is changing because of greenhouse gas emissions and global warming. These changes are likely to pose significant challenges to the health and wellbeing of Australians. These health impacts will place increasing demand on the health system over time. People of all ages need to be confident that they can continue to receive good quality, timely access to their family doctor and other health and medical professionals. This will be especially important in emergencies, where good communication and organisation in the health sector are paramount.

## Key issues for patients

Extreme weather events such as storms, floods, heatwaves and fires, as well as longer term changes, such as drought and changes to the food and water supply, will all have serious health implications for Australians. These include nutritional disorders from changes in food production, deaths from heatwaves, mental health problems from geographical dislocation, food- and water-borne diseases, increased vector-borne diseases, possible chemical exposures, and fatalities and injuries from extreme weather events.

## Key issues for the Government

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

## AMA POSITION

A National Strategy for Health and Climate Change should incorporate:

- strong communication linkages between hospitals, major medical centres and emergency response agencies, to maximise efficient use of health resources in extreme weather events;
- localised disaster management plans for specific geographical regions that model potential adverse health outcomes in those areas;
- nationally-coordinated surveillance measures to prevent exotic disease vectors from becoming established in Australia; and
- the development of effective interventions to address mental health issues arising from extreme events, including those involving mass casualties and from longer-term changes, including drought.

# Health prevention priorities

## Background

A growing number of Australians are at high risk of serious diseases and premature death because of excess weight, alcohol use, and smoking. These conditions account for nearly one-third of all illness in Australia. They reduce people's life expectancy by five years on average. Rates of overweight and obesity are also unacceptably high among Australian children. Preventive health measures can be effective in addressing these risks, and should be an integral part of the health care system.

## Key issues for patients

Poor health outcomes are a matter of great concern to patients. Too often, however, the health risks are not well enough understood in the community.

## Key issues for the Government

Key issues for the the Government are how to make it easier for individuals of all ages to make healthy choices about their lifestyle and behaviours through having a greater range of healthy options in the community, and less promotion of unhealthy choices and behaviours.

Strategic, long-term and properly-resourced population-based approaches to prevention can be effective. There is increasing evidence to support a range of educational, fiscal, regulatory and individual measures that can be taken at a society-wide level to ensure that healthier choices are the easier ones for people when it comes to eating, physical activity, smoking and alcohol use. There has been progress in government policy responses to tackle smoking rates, but there are gaps in community-level measures to address overweight and obesity, as well as excess drug and alcohol use. These continue to be major health risks, and particularly for young people. Targeted programs should be aimed at reducing trauma, a leading cause of death in young Australians.

# AMA POSITION

The Government must support the following community-level measures, which can be readily implemented, and especially effective in tackling harmful alcohol use and obesity in the community.

- Restricting alcohol advertising and promotion in publications and at specified locations and times so as to minimise the influence on people under the age of 18.
- Phasing out alcohol sponsorship of sporting events and youth music events, and prohibiting alcohol sponsorship of junior sports teams, clubs or programs.
- Applying taxation to alcohol beverages in proportion to the volume of alcohol contained in the beverage.
- Prohibiting the broadcast advertising of energy-dense and nutrient-poor food products and beverages (ie, junk food) to children, particularly in children's television viewing times.
- Mandating simple and informative nutritional labelling on food products.

While individuals must take more responsibility for making the right choices, the Government must also support them by including health literacy as a core component of the National Curriculum for both primary- and secondary-level schooling.

The Government must also make it easier for doctors to provide the best health and medical advice and interventions to patients at risk of overweight and obesity. To facilitate this, an initial priority for the new National Preventive Health Agency should be to sponsor research on best-practice interventions and support for doctors treating patients who are overweight or obese.