

Australian Medical Association  
Federal Budget Submission  
**2013-14**



**AMA**

Health – the best investment that governments can make

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## Let's Make Every Health Dollar Count



It may be an election year, but it is highly unlikely that we will see an old-fashioned, big-spending election year Budget that is designed to buy a few extra votes in marginal seats.

The combination of minority Government and an economy under constant pressure would indicate that the Budget will be big on rhetoric, but little in terms of significant new spending.

The health reform process that commenced under Kevin Rudd has slowed to a crawl and the big picture is now much smaller. This has come about through a combination of the Gillard Labor Government having to survive with the support of Independents, the changing political hue of State and Territory Governments, the global economic downturn, policy timidity, and some bad advice in key reform areas.

Nevertheless, the Federal Government has put more money into health - through current public hospital funding under the National Healthcare Agreement, and future funding under the National Health Reform Agreement and other more targeted Agreements, all of which have been signed by all governments.

What we are now seeing, however, is retreat and reversion to the blame game between the Commonwealth and the States in regard to health policy and health funding. We have seen it all before.

It is important in this environment to get back to basics. We must protect and support the fundamentals of the health system.

The 2013-14 Health Budget must look at getting the priorities right.

If new funding is limited, then it must go towards building on the things that work.

We must build capacity in our public hospitals. Funding must be better targeted, patient-focused, and clinician-led. This will require unprecedented cooperation between the Federal and State Governments.

The complete pipeline of medical training needs to be properly funded to ensure we have a medical workforce in sufficient numbers to meet future community need. This will involve some long-term vision and planning, not stopgap year-by-year solutions.

Money should be going to GP Infrastructure Grants, not GP Super Clinics. The Grants are delivering real benefits to general practices and their local communities. The Super Clinics are a bad idea that is getting worse and wasting valuable health dollars.

Planning is needed to allow primary care, led by general practice, to cope with the growing demands of chronic disease in the community.

The Government has announced major policies in the areas of aged care and mental health. Where there is evidence that things can be done better, the Government must take the advice of clinicians at the front line and shift or re-prioritise funding accordingly.

This same principle should be applied to e-health.

The AMA supports the PCEHR – it can make a real difference to the continuity of care for patients.

But the legal framework for the PCEHR has imposed additional red tape on practices. The Government can alleviate this by assisting practices to navigate the complex pathways and requirements necessary for them to participate.

We must also proceed consultatively on the National Disability Insurance Scheme (NDIS). The priority must be on timely quality care, not litigation. The AMA has some concerns that are still to be resolved.

The Government must preserve and build on its commitment to improving Indigenous Health outcomes.

The AMA Federal Budget Submission 2013-2014 provides sensible and affordable recommendations for a stronger health system.

We may not have the environment for significant new health funding, but we have an urgent need for some smarter thinking on how precious health dollars are allocated and spent. The funding must find its way to the patient.



Dr Steve Hambleton  
AMA Federal President

## Medical workforce and training

It is widely acknowledged that there are shortages in Australia's medical workforce, particularly in outer metropolitan, rural and remote areas.

In response, the Government has moved to significantly increase the number of medical students. The number of medical graduates has grown sharply in the last decade and is set to expand even further, from 1287 in 2004 to a projected 3970 in 2016 – an increase of more than 200 per cent.

Increasing the number of medical school places is only one step towards training sufficient doctors to meet the nation's health needs. It must be accompanied by a focus on maintaining the quality of medical training for which Australia is renowned, and a matching expansion in the number of medical training places beyond medical school.

Graduates go on to complete one to two years of generalist (prevocational) training and then three to eight years of specialty training in one of a range of specialties, including general practice.

Increasing the number of medical school places will be ineffective in addressing medical workforce shortages unless there is a coordinated increase in:

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

Some steps have already been taken towards meeting these challenges.

In 2008, the Council of Australian Governments (COAG) announced a \$1.64 billion package to support undergraduate clinical training for the health workforce. In 2010, the Federal Government committed \$640 million to support a significant expansion in prevocational and vocational GP training positions, as well as additional specialist training positions in the private sector.

Health Workforce Australia (HWA) has published Health Workforce 2025 (HW2025), with volumes one and three providing clear evidence that Australia faces significant bottlenecks in medical training due to projected shortages of intern, prevocational and specialist training places.

HW2025 also shows that in order to meet future community health needs and reduce our reliance on international medical graduates, Australia must ensure that all local medical graduates have the opportunity to progress to full specialist qualification.

Health Ministers have already had to deal with a critical shortage of intern positions for 2013. In the absence of concrete planning and action, they will face the same problem in the years beyond, not only in relation to interns, but also prevocational and specialist training places.

We cannot afford to continue with an ad hoc approach that relies on crisis management and fails to take a long-term view of the health system and the needs of the community.

## AMA POSITION

In November 2012, HWA released its response to HW2025. This outlines nine steps to address health workforce shortages and includes the establishment of a National Medical Training Advisory Network (NMTAN) to improve the coordination of the medical training pipeline.

The AMA will work with HWA to ensure the NMTAN can play an effective role in improving the overall coordination of medical training. However, it is important that the work of the NMTAN is informed by clear targets and backed by high-level Government support.

The AMA calls for the 2013 update to HW2025 to set out the number of intern, prevocational, and specialist medical training positions required to match the increased output of medical schools and, following this, for the Government to convene a specific COAG meeting to:

- reach agreement on the number of quality intern, prevocational, and specialist medical training places needed, based on the analysis provided by HWA;
- reach agreement on the respective financial contribution of each government;
- agree on robust performance benchmarks to measure achievement against HW2025 targets and COAG commitments, with regular reporting by HWA on progress against these targets; and
- commit to the development, in consultation with the profession, of performance benchmarks to ensure that the quality of medical training is sustained.

The AMA also notes that the Federal Government generally has responsibility for the funding of medical training places in general practice and in non-traditional settings such as the private sector. In this regard, the AMA calls on the Government to:

- increase the Practice Incentive Payment for teaching medical students to \$200 per teaching session so that it better reflects the costs to general practice of teaching medical students;
- commit to the ongoing funding of at least 100 intern places a year in expanded settings, including private hospitals;
- increase the number of places in the Prevocational GP Placements Program to 1500 places a year by 2016, supporting more junior doctors to have a quality general practice experience;
- increase the GP training program intake to 1500 places a year by 2016; and
- expand the Specialist Training Program, which is currently oversubscribed, so that it provides 1500 places a year by 2016.

## Public hospitals

The public hospital system is one of the fundamental foundations for the provision of high-quality, safe and accessible health services.

But the public hospital system does not have sufficient capacity to ensure that patients are either treated in emergency departments or admitted into hospital within safe, clinically appropriate timeframes. This is despite additional Federal Government funding in recent years.

The number of public hospital beds per capita, which is the most robust measure of capacity, is stagnant.

The addition of new beds in the system is barely keeping pace with population growth. Even though 872 new beds were opened across the country in 2010-11, the number of public hospital beds per 1000 people remained anchored at 2.6. Bed capacity is worse if taken in the context of the population aged 65 and over, who have more hospital episodes with longer admissions than young people. The number of public hospital beds for every 1,000 people over the age of 65 continues to fall.

Linked to the shortage of beds, many patients are not being treated quickly enough. In 2011-12, the proportion of emergency department patients classified as *urgent* who were seen within the recommended 30 minutes was 66 per cent, well short of the 2013 target of 80 per cent.

In the same year, 64 per cent of all emergency department visits were completed in four hours or less, well short of the 2015 target of 90 per cent. Several States failed to meet even the baseline performance target, let alone the incremental target for the first year of this new performance measure.

The AMA estimates<sup>1</sup> that, in 2011-12, the percentage of Category 2 elective surgery patients seen within the clinically recommended time of 90 days was 81 per cent. At the same time, the national median waiting time for elective surgery was 36 days.

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

General practitioners experience the capacity problems of the public hospital system when they try to get sick and elderly people into public hospitals for treatment.

Official elective surgery waiting list figures hide the true extent of delays facing patients waiting to be treated in the public hospital system. The time that patients wait, from when they are referred by their general practitioner to a surgeon for assessment, is not counted. It is only after patients have seen the surgeon that they are added to the official waiting list.

The publicly available elective surgery waiting list data understate the real time that people wait for elective surgery.

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<sup>1</sup> The Australian Institute of Health and Welfare no longer reports the percentage of elective surgery patients admitted within clinically recommended times, citing an 'apparent lack of comparability of clinical urgency categories among jurisdictions'. The AMA has estimated a national average using individual State and Territory published hospital statistics, not all of which cover the entire 2010-11 or 2011-12 periods.

State and Territory Governments have committed to arrangements that provide greater transparency regarding the flow of funding to hospitals, and hospital performance.

As the managers of the public hospital system, the State and Territory Governments are squarely responsible for ensuring that public hospital funding is sufficient to ensure they have the capacity they need to meet access and quality targets set by COAG.

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

## AMA POSITION

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### Public hospital beds

The Performance and Accountability Framework<sup>2</sup> should include bed numbers and average bed occupancy rates as critical indicators of public hospital capacity. The National Health Performance Authority should track bed numbers to ensure that additional Federal funding provided to State and Territory Governments actually results in the opening of new beds, and that new beds are not offsetting bed closures.

### Elective surgery waiting lists

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

### Public hospital funding

The goal of hospital funding systems should be to support effective health care services, rather than the cheapest services. The national efficient price has been set using cost data from the under-performing hospital system of 2009-10. In the price setting process, the complexity of hospital services across different hospitals and different geographical areas may have been underestimated and oversimplified. As a result, the new funding arrangements could have the following adverse impacts:

- a real reduction in the number of services provided – because the funding amount does not cover the cost of providing timely and effective care;
- a change in the types of services provided – with a focus on the more ‘lucrative’ activities;
- a reduction in the quality of care; and
- a diminution in the number of training places, and the quality of the training experience for junior doctors – with a focus on higher throughput in order to attract more funding for activity.

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<sup>2</sup> National Health Reform Agreement, pgs 44-45, Schedule C

These impacts must be carefully monitored in real time so that adjustments can be made in order for public hospitals to meet the demand for their services. Medical practitioners must be involved in this process.

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

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

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## Secure funding for teaching, training and research in public hospitals

Teaching, training and research 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 teaching, training and research undertaken in public hospitals;
- medical practitioners are involved in determining how this funding is distributed and used at the local level;
- funding for teaching, training and research in public hospitals is linked to transparently reported and independently audited performance indicators; and
- funding for rural and remote hospitals reflects the cost of providing services in those locations.

## Health and medical research

A robust program of health and medical research is essential to an efficient and properly functioning health system. The AMA supports the vision of *'Better health through research'* that has been endorsed by the McKeon Strategic Review of Health and Medical Research.

Increased support for health and medical research in areas such as child health, chronic disease, primary care, clinical trials, and basic epidemiological and laboratory research is essential if Australia is to gain the maximum benefit from the expertise that exists in our hospitals, universities, and the community.

The Government needs to make a more substantial investment in health and medical research. With our general prosperity, strong economy, and track record in innovation, Australia should be aiming to be an international leader in investing in health and medical research.

### AMA POSITION

The Government must increase its support for health and medical research by at least 10 per cent each year over the next four years. This should provide additional funding to:

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

Funding of research within hospitals is often lost because it is not separated out from the cost of clinical care (and can be used to fund clinical care). Funding for research is also not appropriately coordinated across areas of need when it is allocated at hospital level.

To avoid these problems, the Government must:

- explicitly identify the research component within the cost of health care, and
- establish a health system-wide process for distributing such funding so that it has maximum impact.

## Aboriginal and Torres Strait Islander health

The gap in health and life expectancy between Aboriginal peoples and Torres Strait Islanders and other Australians remains wide.

The AMA recognises the early progress that is being made to close the gap, particularly in reducing early childhood mortality rates, and in addressing major risk factors for chronic disease, such as smoking.

This momentum must be maintained for the long term, particularly through increased resources for culturally appropriate primary care and the health and medical workforce for Aboriginal and Torres Strait Islander health.

### AMA POSITION

The AMA believes the Federal Government should renew its commitment to a COAG *National Partnership Agreement on Closing the Gap in Indigenous Health Outcomes* for a further five years from 2013, with the same level of funding allocation as provided in 2008.

The renewed COAG Agreement should include funding for improved infrastructure capacity for primary health care in the Aboriginal Community Controlled service sector to enable these services to:

- provide mentoring and training opportunities to Indigenous and non-Indigenous health and medical students and vocational trainees; and
- provide a comprehensive core set of primary care services to patients, including through outreach services and community visiting.

The COAG Agreement should also include funding to develop a network of Centres of Excellence in Aboriginal and Torres Strait Islander Health across Australia, to act as training and research hubs for medical professionals seeking high-quality practical experience and accreditation in Aboriginal and Torres Strait Islander health.

Linking and coordinating services is important to maintaining high quality and continuous care. The Government should facilitate systematic engagement between Aboriginal community-controlled services and mainstream general practices within Medicare Local regions.

Getting a healthy early start in life is crucial to health later in life. Aboriginal and Torres Strait Islander children are particularly susceptible to risks and stressors that lead to poor outcomes later in life.

The Government needs to focus greater funding on best practice programs in early childhood development that evidence shows are meeting with success.

There is also great need for a new COAG National Partnership Agreement to include targets and corresponding funding relating to Aboriginal people and the criminal justice system.

The rate of incarceration of Aboriginal people and Torres Strait Islanders across Australia is totally unacceptable, and must be addressed through a national commitment based on specific goals backed with adequate resources.

In some communities, alcohol abuse has a major effect in undermining family wellbeing and the healthy development of children. The AMA encourages the Government to ensure that:

- communities are empowered to inclusively develop effective alcohol management plans to address the particular harms and risks of excess alcohol use; and
- funding is provided to enable action to recognise and prevent foetal alcohol spectrum disorder.

## Priorities in preventive health

Rates of chronic cardiovascular conditions remain high in Australia, and the number of Australians who are overweight or obese continues to increase, including among children.

Harmful alcohol use and inappropriate diet are strong contributors to this situation.

To stem the rising tide of chronic conditions, individuals need to have the best opportunities to make healthy choices about their lives.

Properly resourced and evidence-based approaches to preventive health can be effective in providing these opportunities.

There have been significant steps taken by the Government to lower smoking rates, but more definitely needs to be done to tackle excess alcohol use and obesity.

### AMA POSITION

The AMA calls on the Government to support the following measures to tackle harmful alcohol use and excess weight:

- make it easier for doctors to provide the best health and medical advice and interventions to patients at risk of overweight and obesity by making it a priority for the Australian National Preventive Health Agency to sponsor research on best-practice interventions and support for doctors treating patients who are overweight or obese;
- prohibit the targeted marketing of alcohol products to adolescents and teenagers, and ban the sponsorship of sporting events by alcohol manufacturers;
- mandate pricing arrangements for the sale of alcohol (through volumetric taxation and/or minimum floor pricing) to help reduce excessive alcohol consumption;
- prohibit the broadcast advertising of energy-dense and nutrient-poor food products (i.e. junk food) to children, particularly at child television viewing times;
- target a reduction in the national consumption of sugary carbonated beverages through a restriction on advertising and a review of applicable taxation; and
- implement a system of simple and informative nutritional labelling on food products that evidence shows will encourage behavioural change in consumers toward choice of healthy products.

## Mental health

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 reducing stigma, prevention and early intervention, community-based care, sub-acute 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 affect mental health.

People are still frequently unable to get the mental health care they need, when they need it.

Care in the community continues to be especially deficient, both after hospitalisation for an acute episode, and for people who could be treated in the community.

Such care, including that provided by a GP or psychiatrist in a community-based setting, could prevent the need for acute hospitalisation or readmission.

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 GPs for those with mental illness is enhanced, supported, properly funded and better coordinated, and that there are more community-based support services to which GPs can refer their patients as part of managing and treating their condition.

### AMA POSITION

Support for all people with mental illness must be multifaceted and provided in the following ways:

- prevention, reducing stigma and enhancing 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;
- sub-acute care, including through more capital and recurrent funding for sub-acute 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; and
- 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.

## Aged care

Demand for health care services to meet the needs of older Australians is growing rapidly.

Between 2010 and 2050, the number of older people (those aged between 65 and 84 years) will more than double, from 2.6 million to 6.3 million, and the number of very old (those aged 85 years or more) will more than quadruple, from 400,000 to 1.8 million.

In the future, older people are likely to have more complex health needs and expect a higher quality and level of service.

There will be an increasing preference by older Australians to live and be cared for in the community wherever possible, and for as long as possible. The demand for quality dementia and palliative care in all settings will increase.

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

At the same time, the medical workforce is finding it increasingly difficult to provide medical care to older Australians living in residential aged care in the context of their day-to-day surgical practice.

An AMA survey of medical practitioners working in the aged care sector shows that the medical workforce is ageing and individuals are starting to cut back their visits, and that younger doctors are not moving in to fill the gap.

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

Further, properly funded medical care provided to residents will help provide older Australians with quality care in appropriate settings as they reach the end of their lives.

## AMA POSITION

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

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

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

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

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

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

Community care, including domiciliary services for older people, is of crucial importance. Services should be matched to the needs of each individual, be comprehensive, linked to the medical services received by the patient, and coordinated at the practice level.

## Tackling chronic disease

The Bettering the Evaluation and Care of Health Report, *General Practice Activity Australia in 2010-11*, confirms that GPs are increasingly treating older patients with more complex care needs.

The management of chronic and complex disease is a key part of general practice, with chronic conditions making up more than one third of all problems managed.

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

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

### AMA POSITION

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

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

The AMA also supports a more proactive approach to the coordinated management of patients with chronic and complex disease. The Department of Veterans Affairs (DVA) has initiated the Coordinated Veterans Care (CVC) program that provides additional funding support for GPs to provide comprehensive planned and coordinated care to eligible veterans, with the support of a practice nurse or community nurse. This program is designed to reduce avoidable hospital admissions and deliver overall savings to the health system.

The DVA CVC program was developed with strong clinical input and has broad stakeholder support. The AMA supports the development of a broad coordinated care program to tackle chronic and complex diseases based on the model of care and funding arrangements developed for the CVC program.

## GP infrastructure

The Government has committed to develop 64 GP Super Clinics in locations across the country.

The GP Super Clinic program is expensive, and is failing to reach the vast majority of the community, including those patients who are living in areas with poor access to health services.

In contrast, the smaller and more modestly funded Primary Care Infrastructure Program has been evaluated by the Australian National Audit Office and has been shown to be making good progress, with many projects completed or underway.

Overall, it is likely that the program will support around 450 practices to expand services for patients and become more involved in teaching and training the next generation of GPs.

Rather than focusing excessive subsidies on a very small number of practices, the Government could achieve much more for patients by providing reasonable grant funding to a larger number of existing practices to improve their facilities and expand available services and opportunities for teaching and training.

### AMA POSITION

The Government should provide for an additional 600 GP infrastructure grants at current funding levels (on average, approximately \$300,000 each) enabling a third round of GP infrastructure grants.

## Private health insurance coverage of coordinated care

The care needs of Australians are becoming more complex with the ageing population and increasing incidence of chronic disease. Increasingly, patients are suffering from multiple chronic conditions, which complicate their care needs.

Existing Medicare-funded chronic disease management arrangements are too limited, cumbersome, difficult for patients to access, and are wrapped up in red tape and bureaucracy.

The current arrangements also mean that more people end up in hospital to have their conditions managed. The AMA has proposed changes to these arrangements and these are outlined in the Tackling Chronic Disease section of this submission.

Private health insurers understand this issue. They have introduced wellness and prevention programs that provide their members with access to services such as exercise physiologists, dieticians, and physiotherapists to better manage their chronic conditions.

However, these programs often work in isolation of, and sometimes against, the management plan that the member's medical practitioner has put in place. In addition, members also use their private health insurance general treatment cover to self-select a wide range of allied health services.

Medical practitioners are well placed to coordinate and improve access to coordinated multidisciplinary care for privately insured people with chronic conditions.

Improved coordination would reduce the number of avoidable hospital admissions and generate long-term savings for health insurers and the health system.

### AMA POSITION

Private health insurance should extend to primary care coordination services provided by medical practitioners.

## Medicare rebates for GP video consultations

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

The delivery of health services to Indigenous populations in remote Australia is almost exclusively through remote health centres.

Medical care is provided by specialised GPs who reside in urban centres such as Darwin or Alice Springs. These practitioners could enhance their face-to-face care of Indigenous populations with video consultations from urban centres to remote locations.

The AMA has highlighted problems with ongoing access to medical care for residents of aged care facilities for many years.

The Federal Government's telehealth initiative provides incentives for aged care providers to set up video conferencing facilities. It is extremely inefficient for these facilities to be used only for referred specialist consultations. Medicare rebates for GP video consultations with residents of aged care facilities would improve the efficiency of providing follow-up care by GPs, and ensure full use is made of existing Government-funded video consultation facilities in aged care centres.

Similarly, there are rural, remote and outer metropolitan patients who have difficulty attending general practices because of mobility problems or because of distance.

Medicare rebates for GP video consultations to these patients would improve the efficiency of providing follow-up care by GPs, and ensure full use is made of the video consultation infrastructure funded by the Government.

### AMA POSITION

Extending MBS telehealth items to GP consultations for remote Indigenous Australians, aged care residents, people with mobility problems, and rural people who live some distance from GPs would considerably improve access to medical care for these groups.

## Climate change

Australians are not immune from the potential effects of climate change - including floods, heatwaves, fires and drought, as well as long-term changes to the food and water supply.

These potential changes will affect people's health, and place increasing and unpredictable demands on Australia's health system.

All Australians need to have their access to family doctors and other health and medical professionals maintained, particularly in emergencies, when good communication and organisation in the health sector is paramount.

### AMA POSITION

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

This National Strategy should incorporate:

- strong communication links between hospitals, major medical centres, general practitioners, and emergency response agencies to maximise efficient use of health resources in extreme weather events;
- localised disaster management plans for specific geographical regions that model potential adverse health outcomes in those areas;
- nationally-coordinated surveillance measures to prevent exotic disease vectors from becoming established in Australia;
- development of effective interventions to address mental health issues arising from extreme events, including those involving mass casualties and from longer-term changes, including drought; and
- a register of recently retired competent medical practitioners who are willing to assist in providing medical services during a national emergency.

The AMA also believes that climate change is a health and medical research priority, and should form a core part of a National Strategy for Health and Climate Change, supported by strong, long-term funding grants.

## National Disability Insurance Scheme

The AMA supports the establishment of a National Disability Insurance Scheme (NDIS) that is 'no fault' and provides comprehensive care and support for people with serious disabilities.

The AMA supports this because it recognises the importance of appropriate support for people with serious disabilities.

People with a disability and their families have a right to participate in the community and be supported to do so.

A scheme that provides fairness and equity, and a better quality of life for Australians with serious disability and their families, will ensure this right is achieved.

A 'no fault' system of disability support will allow disabled people and their families to access timely care and support based on need, rather than fault.

A founding principle of any long-term care scheme for disabled people should be to reduce the reliance on litigation to access funding for care and support. A 'no fault' approach to a national disability support scheme would negate the (usually) high cost of accessing funding through litigation.

Unfortunately, under clause 104 of the *National Disability Insurance Scheme Bill 2012*, the Chief Executive Officer of the National Disability Insurance Scheme Launch Transition Agency can require a participant or a prospective participant in the NDIS to take action to claim or obtain compensation.

### AMA POSITION

Clause 104 of the *National Disability Insurance Scheme Bill 2012* does not facilitate an Australian system of disability support based on need.

The clause works against generating a cultural shift by which Australians with disabilities and their families are supported by the community and do not need to pursue compensation for the costs of care and support.

The National Disability Insurance Scheme Bill 2012 should be amended to ensure the NDIS is truly an insurance-based approach to provide and fund care and support for Australians with disabilities and their families.

## e-Health

### Shared Electronic Health Records

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

The benefits of e-health in making the best use of existing health care services and avoiding errors, duplication and waste are well known.

For medical practitioners, e-health means being able to access all of the clinically relevant medical information about a patient at the time of diagnosis or treatment.

Personally controlled electronic health records (PCEHR) empower and encourage individuals to take responsibility for their own health, but their usefulness for medical practitioners may be limited by concerns regarding their accessibility, content and accuracy, and the comprehensiveness of the information they contain.

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

Medical practitioners want to use the PCEHR to enhance clinical care.

However, the PCEHR legislation and its participation requirements are complex and introduce new and significant obligations on medical practices.

There are substantial penalties for non-compliance with the complex legal requirements.

Medical practices will have to devote substantial administrative and information technology resources to meet these new requirements.

International experience has shown that:

*“... those who create the data often bear the most significant costs, whereas those who use the data gain the benefit. Therefore, funding models need to reflect this difference.”<sup>3</sup>*

If the PCEHR is to make a significant difference to the health care system in Australia, the Government must support implementation by medical practices.

In addition, implementation, evaluation and adjustment must be overseen and informed by practising clinicians - the medical practitioners and other health practitioners who will create and use the information in the PCEHR.

<sup>3</sup> *Concept of Operations: Relating to the introduction of a Personally Controlled Electronic Health Record System.* Australian Government Department of Health and Ageing and National E-Health Transition Authority. September 2011 release, page 132.

## AMA POSITION

Shared Electronic Health Records must:

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

The Government should provide a single set of standardised template policies and protocols detailing what is required to participate in the PCEHR, which medical practices can adjust to suit their own practice arrangements.

This would save significant administrative time and resources for medical practices that would otherwise have to prepare these documents from scratch. Government funding should be provided to an entity that understands the clinical and administrative operations of medical practices to prepare these template documents.

The Government should provide a standardised step-by-step toolkit to streamline the processes that medical practices will have to put in place to meet the administrative and technological requirements of the PCEHR.

A clinical advisory group that represents the views of practising clinicians should be established to oversee and advise the Government on the practical implementation of the PCEHR and its use in clinical practice.

The clinical advisory group should also work with the Systems Operator on the technical adjustments that need to be made to the system, based on experience with its use in clinical practice.

## PBS authority prescriptions

There are around 100 medicines on the Pharmaceutical Benefits Scheme (PBS) that require medical practitioners to obtain authority from the Department of Human Services to prescribe them.

To obtain this 'authority', medical practitioners can choose to:

- call the Department of Human Services' Authority Freecall service;
- post an Authority Prescription Form to the Department of Human Services; or
- use the Department of Human Services' PBS authorities website.

The most frequently used method is the Authority Freecall service, where an administrative officer decides if the medical practitioner can have the necessary authority.

In 2008-09, 6.4 million calls were made to the Authority Freecall Service, of which only 2.8 per cent did not result in an authority being provided<sup>4</sup>.

But doctors using the service have been plagued by lengthy delays. In an online survey conducted by the AMA in October and November 2012, 35 per cent of medical practitioners reported spending up to four minutes a day waiting for calls to be answered; 35 per cent reported spending between five and nine minutes a day waiting; and 30 per cent reported spending 10 minutes or longer.

Time spent by medical practitioners waiting on a phone line is time stolen from patient care.

The Productivity Commission has identified the PBS authority system as an unnecessary administrative burden for medical practitioners, and has recommended it be removed (Review of Regulatory Burdens on Business: Social and Economic Infrastructure Services 2009).

A Department of Health and Ageing review demonstrated there was no impact on prescribing behaviour from moving PBS authority medicines to streamlined arrangements. The review stated:

*"... there were no substantial changes relative to historical growth trends observed in either total script volume or total PBS outlays for streamlined authority medicines for the first year of operation." (Streamlined Authority Initiative Review 2009).*

This report shows that dropping the authority requirement for a medicine does not increase the risk that it will be prescribed outside PBS guidelines. The Department of Health and Ageing has not provided evidence to demonstrate that the PBS authority policy deters medical practitioners from prescribing PBS medicines outside the PBS restrictions<sup>5</sup>.

## AMA POSITION

The Government can make a significant improvement to the productivity and efficiency of the medical workforce in Australia by removing the PBS Authority system.

<sup>4</sup> Senate Community Affairs Committee, Answers to questions on notice, Health and Ageing Portfolio, Question: E09-187, 21 October 2009.

<sup>5</sup> Ibid.