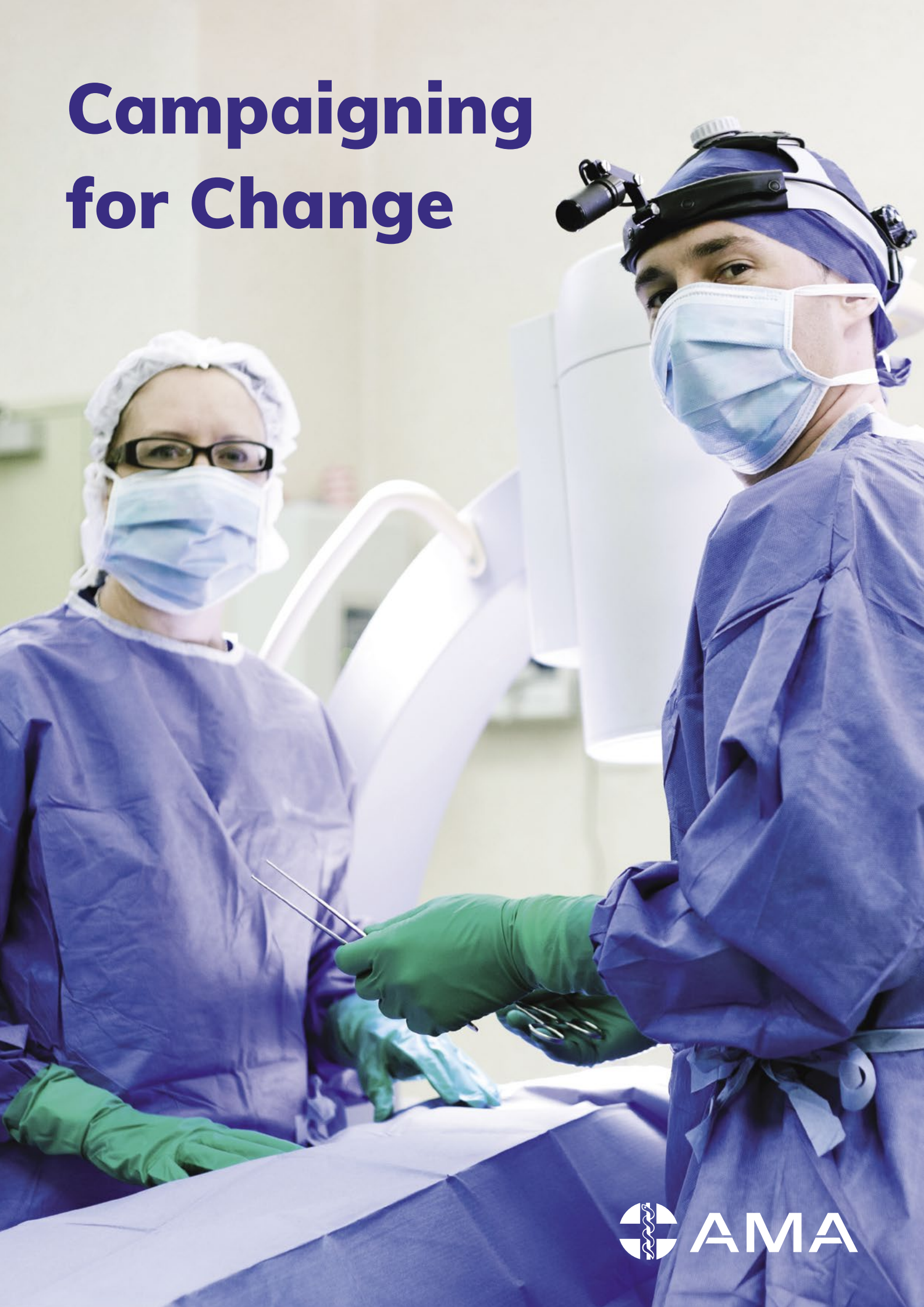
Campaigning for Change



AMA

> **Taking action on these issues will relieve financial pressure and demand on the healthcare system while improving the lives of the most vulnerable in our society.**

Deep and detailed reform is required across the entire system as outlined in our *Vision for Australia's Health*, however we can, and should, take several immediate steps to address urgent problems for a measurable and lasting impact.

Drawing on the five pillars of policy reform, the AMA has identified four priorities for immediate action. These are 'big picture' issues that require critical thought and action now to prepare for a future health system that is sustainable and effective.

The AMA represents doctors that work in every sector of the health system and is uniquely positioned to identify and understand cross-cutting issues that impact on the sustainability and quality of healthcare. These campaign priorities represent a bold but pragmatic vision for what needs to be done right now.

Taking action on these issues will relieve financial pressure and demand on the healthcare system, while improving the lives of the most vulnerable in our society. This is a pragmatic plan, taking into account everything that has happened in 2020-21 so far, and what the political realities of the next few years will be. It acknowledges the need to relieve pressure on the public hospital system, address systemic disadvantage in the population, and improve the quality of care we provide for older Australians.

This involves addressing the social determinants of health – the inequalities stemming from the circumstances in which people grow up, work and live, and the systems available to them. Significant variation in socioeconomic status, including education, employment and income, is responsible for up to one-half of the health gap between Aboriginal and Torres Strait Islander peoples and non-Indigenous Australians[1]. As a profession, it is clear that there is a role to be played in the moral determinants of health – the shared commitment and solidarity to ensure the basic rights and circumstances to live healthy lives.

The AMA will campaign on these priorities from 2021:

- Introducing a tax on sugar-sweetened beverages (with associated community education) to reduce their excessive consumption and take a clear step to tackling obesity, while also raising much needed funding for preventative health initiatives;
- Working with the Aboriginal community-controlled health sector to understand workforce needs and increase the number of medical practitioners and specialists working with and providing services for Aboriginal and Torres Strait Islander communities. At the same time redoubling efforts to increase the number of Aboriginal and Torres Strait Islander people in the medical workforce;
- Rebuilding the value and sustainability of private practice in Australia; and
- Implementing urgent reforms to how public hospitals are funded, to supplement the current focus on activity-based funding and ensure sufficient focus on positive improvement, increased capacity, and reduced demand, while putting an end to the blame game.

Campaign successes:

- In early 2021, the AMA campaigned for fundamental reform to the aged care system, to ensure it is working in harmony with the medical system. The Government's response to the Aged Care Royal Commission committed to key reforms that the AMA has been calling for for years.

Please be aware that this document may contain images or names of deceased persons.

Sugar-Sweetened Beverages

The preventative health agenda in Australia is the story of a few wins and many failed attempts. We have seen some wins – the introduction of food star ratings, while not perfect, has led not only to better health literacy and healthier purchases by consumers, but in some cases reformulation by industry. But we have seen major campaigns considered, commenced and then abandoned. Too often for policy makers the short-term nature of budget cycles and long-term payoff of prevention come into conflict. The inability to coordinate and deliver successful preventative health strategies across local, State and Federal jurisdictions is one reason why Australia lags behind comparable nations in health outcomes and disease prevention.

It is for this reason the AMA will campaign on a clear, concrete policy – a tax on sugar-sweetened beverages (SSBs).

Obesity, diabetes, poor vascular health and cancer are responsible for a huge burden on our health system. High sugar intake is a large contributor to this. Australians drink more than 2.4 billion litres of SSBs each year[2], and these products are marketed in such a way that it can be cheaper to purchase two litres than a 200ml or 600ml container – encouraging greater consumption. Sadly, in some remote Aboriginal and Torres Strait Islander communities these drinks can be viewed as the safer option to the community's water supply – clearly requiring action[3].

In 2021 the AMA launched a report – *A tax on sugar-sweetened beverages: Modelled impacts on sugar consumption and government revenue* – which estimated that, if the Government introduced a tax which raised the average price of select supermarket SSBs by at least 20 per cent, sugar consumption from soft drinks would reduce by 12 to 18 per cent and the Government would raise annual revenue of $749 million to $814 million[4].

Some estimates have found that an SSB tax that increases the retail price by 20 per cent would, over a 25-year period, see 16,000 fewer cases of type 2 diabetes, 4,400 fewer cases of heart disease and 1,100 fewer cases of stroke. It is estimated that 1,600 more Australians would be alive in 25 years, with millions of dollars saved in healthcare costs[5].

The benefits of a tax on SSBs extend beyond a price signal to consumers – it generates funds that can be used for additional, preventative health measures without needing to impact primary and acute health budgets.

Unlike other products that contain sugar, certain SSBs offer no nutritional value. They are unnecessary for the human diet, and in some communities, have wreaked havoc. By targeting SSBs only, we are also ensuring that we are not increasing the cost of living for Australians through their grocery bills, where some everyday staple foods do contain added sugar. Such a tax will need to be carried out alongside measures to ensure that in rural and remote areas, there is reliable, safe access to water and affordable hydration beyond SSBs.

Governments are unique in their capacity to influence purchasing behaviour on a large scale. Price signals – in the form of taxes and levies – are one way that governments can reduce harm from the sale of unhealthy products. Increases in the retail price of SSBs will reduce consumption – we know it works through our experience with tobacco, where Australia has been a world leader. With SSBs, there has been confirmed success already in a number of countries, including the United Kingdom, Mexico, France, Chile, Catalonia (Spain), and in some US jurisdictions, where robust evaluations have shown a drop in consumption following the tax.[6] It is also a policy position recommended by the World Medical Association, as well as many others. Australia need only take the experience and apply it to our own market to begin reaping the benefits.

Aboriginal and Torres Strait Islander Health

The AMA has always seen its role to be part of the solution to Australia's health challenges, especially in critical areas of need, including Aboriginal and Torres Strait Islander health. Aboriginal and Torres Strait Islander peoples have disproportionately higher levels of chronic disease, including type 2 diabetes, cancer and cardiovascular disease. The life expectancy gap between Aboriginal and Torres Strait Islander peoples and other Australians is significant. With a large portion of the health gap being attributed to the social and cultural determinants of health, and with funding levels for the much higher health needs of Aboriginal and Torres Strait Islander peoples being inadequate, Aboriginal and Torres Strait Islander health forms a critical component of our focus for lasting reform.

Australia's medical workforce must be well equipped to meet the unique health and cultural needs of Aboriginal and Torres Strait Islander patients. Central to this is working with ACCHOs to increase the cultural safety of care provided by doctors and health professionals and supporting more Aboriginal and Torres Strait Islander peoples to become doctors. Critical to this will be enhanced cultural awareness training to ensure cultural competence for the vast majority of the medical profession who are from non-Aboriginal and Torres Strait Islander backgrounds.

The AMA will campaign on two specific issues: getting more medical practitioners and specialists to work in Aboriginal and Torres Strait Islander communities and health organisations to deliver culturally safe services; and increasing the number of Aboriginal and Torres Strait Islander peoples in the medical workforce.

Working with Aboriginal and Torres Strait Islander Communities

Cultural safety in the delivery of health services is paramount for Aboriginal and Torres Strait Islander peoples. Aboriginal and Torres Strait Islander peoples must feel welcome and safe to seek medical attention, where there is no challenge to one's culture or identity, and where patients can be confident that the service will be free of racism and discrimination. Healthcare services for Aboriginal and Torres Strait Islander peoples are delivered by a mix of Aboriginal community-controlled health organisations (ACCHOs), government-managed clinics or private General Practice. Within these, the workforce consists of Indigenous and non-Indigenous people in clinical and non-clinical roles.

ACCHOs are key examples of culturally safe health service models for Aboriginal and Torres Strait Islander peoples. The AMA recognises that ACCHOs are a source of strength and community for Aboriginal and Torres Strait Islander peoples and they have shown to be more effective than other health services at improving health outcomes for Aboriginal and Torres Strait Islander patients. This is achieved through the provision of comprehensive primary care, including but not limited to: home and site visits, medical, public health and health promotion services, allied health, transport assistance, drug and alcohol services and providing help with income support. The cultural safety in which ACCHOs provide their services is a key factor of their success.

ACCHOs have played an important role during the pandemic, successfully providing tailored public health messaging about COVID-19 to Aboriginal and Torres Strait Islander peoples, and working closely with Government on preparedness, response and recovery planning[7]. This is a pertinent reminder of the important space ACCHOs hold in the health landscape.

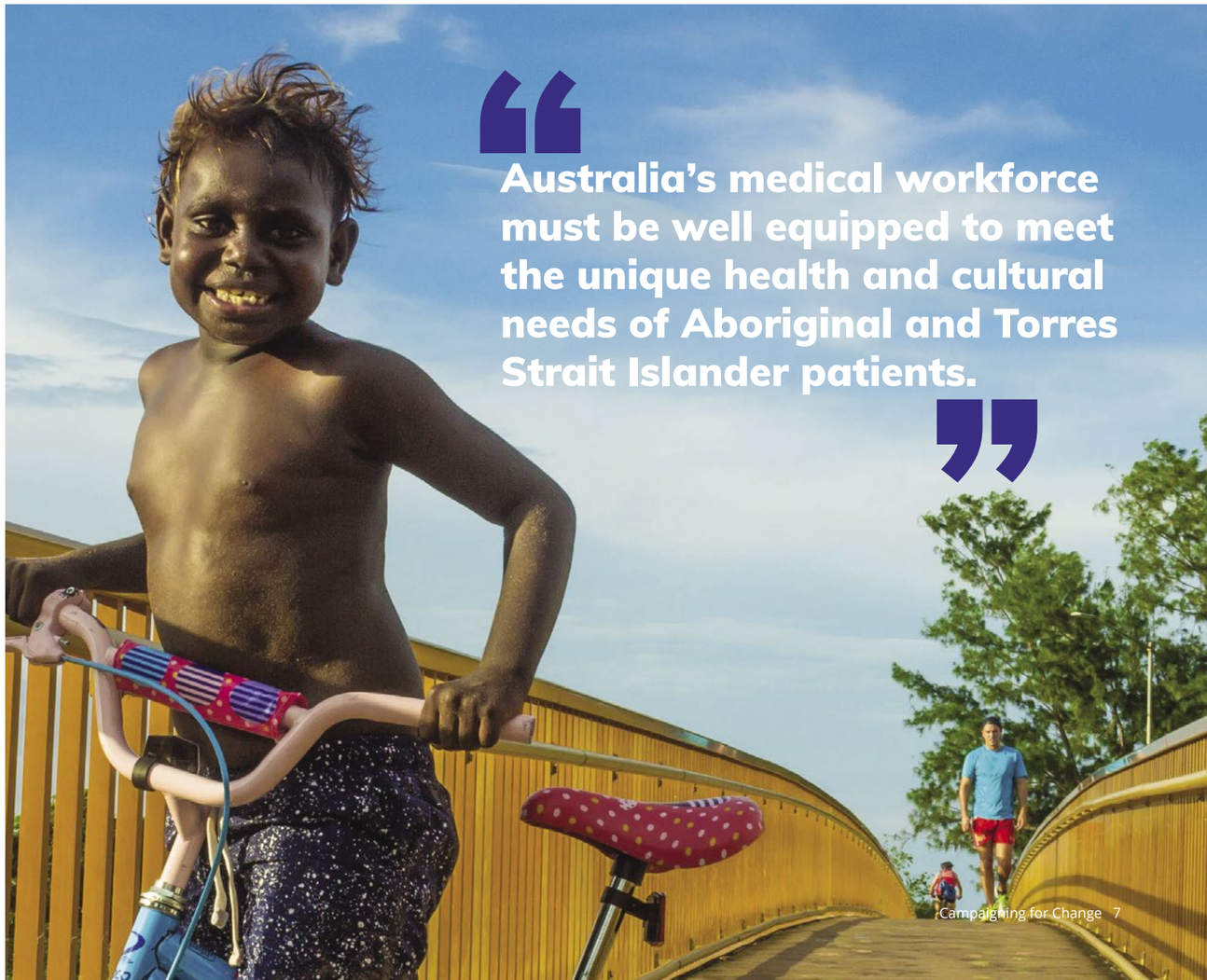
Despite proof of their effectiveness, many ACCHOs are underserved across all parts of Australia. The AMA will campaign for its members and the wider medical profession to take up opportunities to work with Aboriginal and Torres Strait Islander communities, ACCHOs and other Aboriginal and Torres Strait Islander health organisations. This will not only enhance the cultural safety of the medical workforce but will contribute to better workforce distribution according to community need and allow for effective multidisciplinary care.

Increasing the Aboriginal and Torres Strait Islander Workforce

Through its Indigenous Medical Scholarship, the AMA is playing its part by supporting Aboriginal and Torres Strait Islander medical students to become doctors. As the Australian Indigenous Doctors' Association has highlighted, "Aboriginal and Torres Strait Islander doctors have a unique ability to align their clinical and socio-cultural skills to improve access to services, provide culturally appropriate care"[8], and ultimately improve health outcomes for Aboriginal and Torres Strait Islander patients.

Over recent years, there has been a steady increase in the number of Aboriginal and Torres Strait Islander students graduating from medical programs, but more Aboriginal and Torres Strait Islander doctors are needed. In 2019, there were 519 registered medical practitioners in Australia that identified as Aboriginal or Torres Strait Islander, representing 0.44 per cent of the workforce, which is a number well below population parity.[9] The AMA will campaign for effective support of Aboriginal and Torres Strait Islander registrars in training and will seek a 10 per cent acceleration in parity of Aboriginal and Torres Strait Islander GP and non-GP specialists within two years.

Growing the Aboriginal and Torres Strait Islander medical workforce is crucial, but it will be a long-term process that will require change at all stages of the medical education and training continuum. This will include, but is not limited to, consideration of medical workforce distribution and need, a culturally appropriate medical curriculum, alternative education and training pathways for Aboriginal and Torres Strait Islander medical students and doctors, and reliable workforce data and modelling.



A Valued Private Health System

For too long now the private health system has been the focus of negativity – stories about declining insurance membership, people experiencing gaps and increasing premiums, complexity in insurance policies, and peak groups fighting each other, rather than fixing the system.

Sadly, this negativity overshadows the positive stories that our private practitioners see each and every day. Stories of people having their mobility returned; stories of people being treated by their choice of doctor; of healthcare delivered on time; and of reduced pressure on our public hospitals.

The AMA has already released a detailed policy blueprint for private health insurance, calling on Government to revisit and refine many of the existing policy levers, while also introducing some new ones. The AMA believes that this is the critical stage of reform to slow the decline of the insured population, and the detailed analysis has already been completed by the AMA for Government to implement[10].

But there is more work to be done into the future. The only way to save private health insurance long term is to improve its affordability, while ensuring it offers value for patients. While the first round of reforms in 2018-2020 dealt with making insurance easier to understand and more consistent across products, it did nothing to address the underlying affordability issues. The next stage of reform must involve all the key stakeholders: the private hospitals, the private health insurers, the medical device manufacturers, the doctors and of course, the patients.

Now is not the time for timid reform – we need significant change to the system. New treatments, improved clinical outcomes and more cost-effective care need not be adversaries – there are real reforms we can make to reduce costs in the system, without reducing care or outcomes. There is an opportunity to instil greater value in private health insurance through greater returns to patients. It is possible to maintain the choice that is the hallmark of the private system, while standardising costs and contracts between hospitals, doctors, and insurers, and making them more transparent. We must also continue reforms to ensure that we have competitive prices for prostheses, without losing the critical ideal of choice or burdening patients with exorbitant out-of-pocket costs. There is no point making insurance affordable if patients do not see the *value* in the system.

Vital to achieving this reform will be the ability of each of the key players to move away from the combative debates of the past, and work together. Refining the system, without using the opportunity to exert greater insurer-led control over clinical pathways or introduce managed care by stealth; embracing new models of care in the community while recognising the need to ensure hospital sustainability; maintaining patient choice of doctor and hospital while simplifying arrangements; increasing transparency of policies and out-of-pocket costs without creating a system that prioritises the cheapest price over a quality outcome.

It will not be easy. However, continuing the current arguments will only devalue the amazing work and care provided by our private system.

The AMA will be campaigning on the value of the private health system, and in particular, the work of our private practitioners. We will campaign to show patients the life-changing care that the private health system provides, while also educating all Governments on their critical roles in improving population health outcomes and taking pressure off state-run public hospitals.

In addition to having developed a detailed policy prescription for the Federal Government on the reform of private health insurance policy settings, the AMA will convene a summit of the key peak groups – recognising that solutions to the current crisis must come from the whole sector. Through this campaign the AMA will drive a roadmap for reform. Working together we can make insurance affordable, sustainable and demonstrate to the public the true value of a strong, vibrant private system alongside our public hospitals.

Public Hospitals in Crisis

In the first half of 2021, we have heard stories of people dying waiting to be seen in public hospitals that are operating at breaking point, and ambulance ramping outside public hospitals because there aren't enough beds and staff to cope with demand.

There are both human and financial costs to our public hospitals operating in crisis mode. Access block and emergency department (ED) overcrowding appear to be getting worse, and this is associated with increased mortality, morbidity and length of hospital stay.[11]

The AMA has been calling out the declining performance of public hospitals for several years. The *2020 AMA Public Hospital Report Card* showed that performance is stagnant or declining across all five areas covered in the Report Card. Patients are waiting longer for ED treatment and elective surgery, and the number of available hospital beds per 1,000 residents aged ≥65 years – an important measure of public hospital capacity – has been in persistent decline for decades.[12]

2014-15 marked a turning point for the performance of public hospitals – after several years of year-on-year improvements across some measures, this trend was reversed around the time significant reforms were made to public hospital funding. These changes significantly stripped funding from public hospitals and abolished the National Health Performance Authority and performance-related funding.[13]

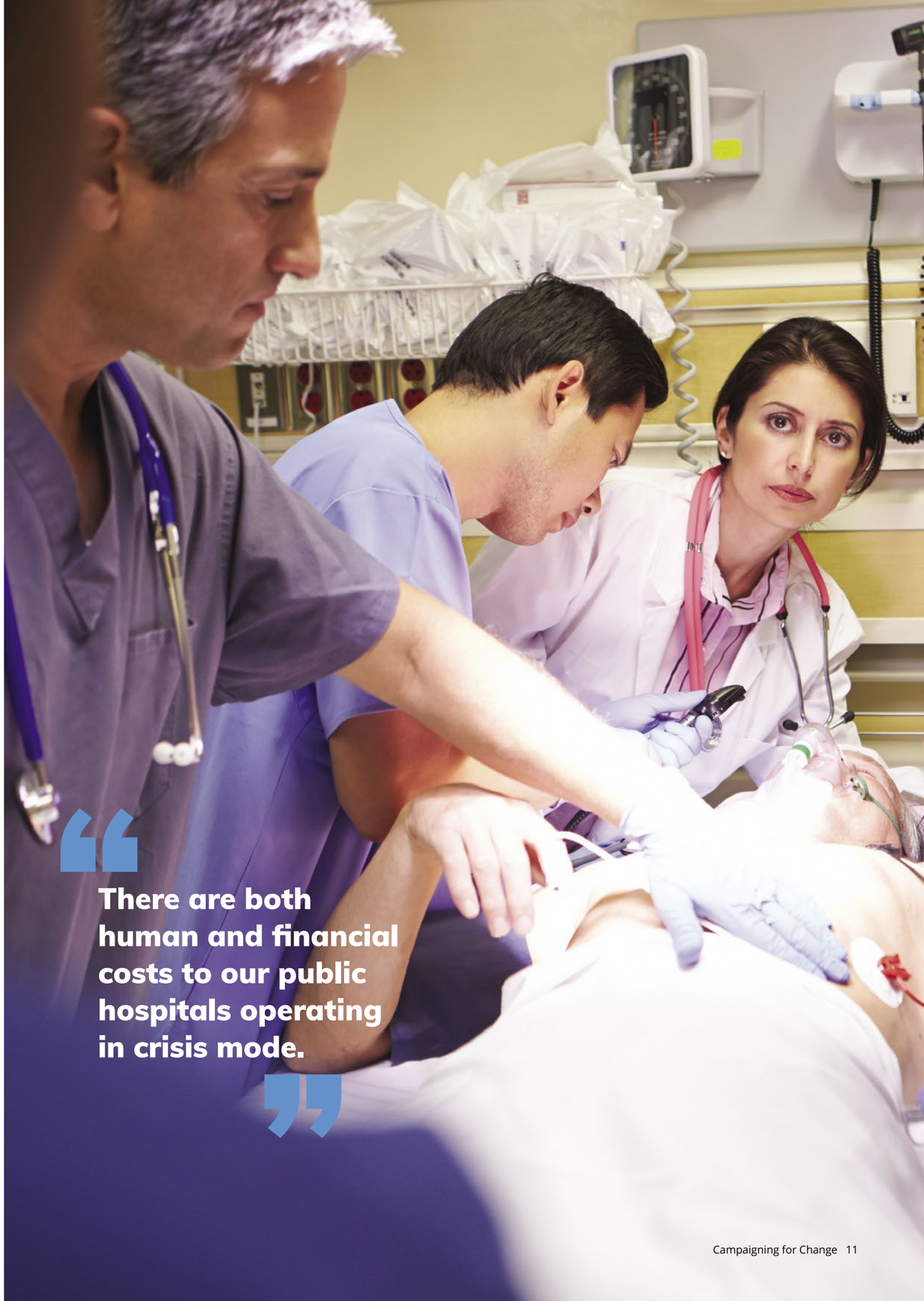
The latest Addendum (2020-2025) to the National Health Reform Agreement is, by and large, a continuation of the same Commonwealth funding formula that has produced the long waiting times for public hospital services to date. More of the same will not help improve patients' timely access to public hospital treatments.

Without reform, public hospital performance will only get worse as demand increases. Australia's population is growing and ageing, and the burden of chronic and complex disease is increasing. Meanwhile, ED presentations are increasing, as is the urgency of treatment required when patients arrive at the ED.

The AMA's vision is for a new funding approach to supplement the current focus on activity-based funding – one that includes funding for positive improvement, increased capacity, and reduced demand, and puts an end to the blame game.

While broader reform is needed in the long term, the AMA will campaign for targeted reforms that are needed right now to stem the public hospital crisis. This includes the Commonwealth increasing its contribution to 50 per cent for activity (as per current COVID-19 partnership agreement), with States and Territories to use the 5 per cent of 'freed-up' funds on improvement. The Commonwealth Government has also saved a lot of money from insufficient indexation of its contribution under the current funding arrangement, as well as through the current 'cap' on growth. This should be addressed going forward. These savings should be reinvested as a first step, alongside introduction of new models of partnership funding between the Commonwealth and the States and Territories.

Our public hospitals need funding to buy extra beds and to focus on improving their performance. Funding is also needed for alternative out-of-hospital care so that people whose needs can be better met in the community can be treated outside hospital. This is what is needed now to steer public hospitals out of crisis mode.



Building a Healthy Aged Care Sector

Older people have the same right to quality healthcare as any Australian. Sadly, this right is often not realised, as the Royal Commission into Aged Care Quality and Safety has shown. High quality and coordinated healthcare is not the experience of many older people in the aged care system.

Meanwhile, healthcare for older people is getting more complex, not less. Increasing life expectancy and an ageing population means greater complexity of medical care in old age and increased demand for aged care and healthcare services now and in the future.

The Government has not been doing enough to improve the situation in aged care or anticipate and prepare for the growing numbers of people entering aged care. The AMA and its membership have been advocating for years for reforms needed to improve the situation.

More recently we have seen aged care bear the tragic brunt of the COVID-19 pandemic. It is clear nursing homes were under-resourced, short staffed and ill-prepared for the pandemic. Around 75 per cent[14] of deaths from COVID-19 have involved those living in nursing homes.

In the lead up to the Government's response to the Royal Commission, the AMA launched a report – *Putting health care back into aged care* – and a supporting campaign 'Care Can't Wait'. We called for clear investment and change to ensure that aged care and healthcare are integrated and that older Australians receive the same high quality healthcare as anyone else.

Our report included new modelling, which estimated that if Governments invested sufficiently in health and aged care, over four years (2021–22 to 2024–25) $21.2 billion could be saved in public and private healthcare from avoidable hospital admissions, presentations and stays from older people in the community or in nursing homes.

These avoidable hospital visits could be prevented primarily by putting more doctors and nurses back into nursing homes. So the AMA partnered with our hard-working nurses – the backbone of the aged care sector – to campaign for a mandatory minimum staff-to-resident ratio that reflects the level of care needs and ensures 24-hour on-site registered nurse availability. Following the Royal Commission, the Government has committed to a mandatory minimum staff-to-resident ratio and improved availability of registered nurses. From October 2023, providers will be required to meet a mandatory care time standard of an average 200 minutes for each resident, including 40 minutes of registered nurse time. In addition, nursing homes will be required to have a registered nurse on site for a minimum of 16 hours per day. This is a good first step, however there are residents in nursing homes now who are in desperate need of staffing ratios. They cannot wait until 2023. And registered nurses are needed 24 hours a day; care needs do not fit conveniently into 16 hours a day.

The AMA also campaigned for significant investment in funding models that better support the delivery of GP services in nursing homes, because there are considerable health benefits to people maintaining a treatment relationship with their usual GP. In the 2021-22 budget the Government committed to a modest investment to improve access to primary care for senior Australians, including funding for the Aged Care Access Incentive and for Primary Health Networks to provide enhanced healthcare in aged care settings. This is an important step forward and the AMA hopes to see a step change in the scale of investment in future years.

It is also time to see medical care innovation in nursing homes. The AMA campaigned for Government to ensure interoperability between GP clinical and aged care software systems, including My Aged Care and the My Health Record. Interoperability is essential to ensure safe and joined up healthcare. The Government has committed to the use of My Health Record in aged care to better support transition of aged care residents across care settings. The AMA will continue to push for interoperability between different clinical systems as an essential pre-requisite for person-centred healthcare.

We can and should support older Australians to live in their own homes and communities for as long as they feel comfortable. In the 2021-22 budget the Government announced 80,000 new home care packages over two years. This is a step in the right direction that will significantly reduce, but not fully eliminate, the home care packages waiting list. Investment in home care will need to continue over the coming years, to keep up with the demand created by the growing and ageing population.

The AMA stands ready to work with Government over the next few years as it implements its reform package in response to the Royal Commission.

Endnotes

[1] Department of Health. *Investments in the social determinants of health*. Retrieved 22/01/2021 from: https://www1.health.gov.au/internet/publications/publishing.nsf/Content/natsihp-companion-toc~invest-socialdeterminants

[2] Australian Medical Association (2021). *A tax on sugar-sweetened beverages: Modelled impacts on sugar consumption and government revenue*. Forthcoming - available at www.ama.com.au

[3] Thurber, K.A. et al (2020). Sugar-sweetened beverage consumption among Indigenous Australian children aged 0–3 years and association with sociodemographic, life circumstances and health factors. *Public Health Nutrition* 23(2), 295–308. Doi: 10.1017/S1368980019001812; Rajapakse, J. et al (2019). Unsafe drinking water quality in remote Western Australian Aboriginal communities. *Geographical Research* 57(2), 178–188. Doi:10.1111/1745-5871.12308.

[4] Australian Medical Association (2021). *A tax on sugar-sweetened beverages: Modelled impacts on sugar consumption and government revenue*. Forthcoming - available at www.ama.com.au

[5] Veerman, J.L., Sacks, G., Antonopoulos, N. & Martin, J. (2016). The impact of a tax on sugar-sweetened beverages on health and health care costs: A modelling study. *PLoS ONE* 11(4), e0151460. Doi: 10.1371/journal.pone.0151460

[6] Teng, A.M., Jones, A.C., Mizdrak, A., Signal, L., Genc, M. & Wilson, N. (2019). Impact of sugar-sweetened beverage taxes on purchases and dietary intake: Systematic review and meta-analysis. *Obesity Reviews* 20, 1187-1204. Doi: 10.1111/obr.12868

[7] Finlay, S. & Wenitong, M. (2020). Aboriginal Community Controlled Health Organisations are taking a leading role in COVID-19 health communication. *Australian and New Zealand Journal of Public Health* 44(4), 251-252. Doi: 10.1111/1753-6405.13010; Crooks, K., Casey, D. & Ward, J.S. (2020). First nations people leading the way in COVID-19 pandemic planning, response and management. Medical Journal of Australia 213(4), 151-152.e1. Doi: 10.5694/mja2.50704.

[8] Australian Indigenous Doctors' Association (2019). *Policy statement: Federal election 2019 – Aboriginal and Torres Strait Islander Medical Workforce*. Retrieved 22/01/2021 from: https://www.aida.org.au/wp-content/uploads/2019/05/AIDA-Position_Federal-Election-2019_FINAL.pdf

[9] Department of Health. National Health Workforce Dataset. Retrieved 06/05/2021 from: https://hwd.health.gov.au/

[10] See: Australian Medical Association (2020). A*MA Prescription for Private Health*. Retrieved 22/01/2021 from https://ama.com.au/articles/ama-prescription-private-health

[11] **Mortality:** Javidan, A.P., Hansen, K., Higginson, I., Jones, P., Petrie, D., Bonning, J., ...& Lang, E. (2020). *White Paper from the Emergency Department Crowding and Access Block Task Force*. International Federation for Emergency Medicine. Retrieved 10/05/2021 from: https://www.ifem.cc/resources/white-paper-from-the-ifem-emergency-department-crowding-and-access-block-task-force-june-2020/; Paton, A., Mitra, B. & Considine, J. (2018). Longer time to transfer from the emergency department after bed request is associated with worse outcomes. *Emergency Medicine Australasia* 31(2), 211-215. Doi: doi.org/10.1111/1742-6723.13120; Sprivulis, P., Da Silva, J., Jacobs, I.G., Frazer, A.R.L. & Jelinek, G.A. (2006). The association between hospital overcrowding and mortality among patients admitted via Western Australian emergency departments. *Medical Journal of Australia* 184(5), 208-212. Doi: 10.5694/j.1326-5377.2006.tb00203.x

Morbidity: Pines, J., Pollack, C., Diercks, D., Chang, A.M., Shofer, F.S. & Hollander, J.E. (2009). The Association Between Emergency Department Crowding and Adverse Cardiovascular Outcomes in Patients with Chest Pain. *Academic Emergency Medicine* 16(7), 617-625. Doi: 10.1111/j.1553-2712.2009.00456.x; Bernstein, S., Aronsky, D., Duseja, R., Epstein, S., Handel, D., Hwang, U. ...& Society for Academic Emergency Medicine, Emergency Department Crowding Taskforce. (2009). The Effect of Emergency Department Crowding on Clinically Oriented Outcomes. *Academic Emergency Medicine* 16(1), 1-10. Doi: 10.1111/j.1553-2712.2008.00295.x; Mullins, P.M., Pines, J.M. (2014). National ED crowding and hospital quality: results from the 2013 Hospital Compare data. *The American Journal of Emergency Medicine* 32(6), 634-639. Doi: 10.1016/j.ajem.2014.02.008; Innes, G., Sivilotti, M., Ovens, H., McLelland, K., Dukelow, A., Kwok, E., ...& Chochinov, A. (2019). Emergency overcrowding and access block: A smaller problem than we think. *Canadian Journal of Emergency Medicine* 21(2), 177-185. Doi: 10.1017/cem.2018.446

Length of inpatient stay: Richardson, D.B. (2002). The access-block effect: relationship between delay to reaching an inpatient bed and inpatient length of stay. Medical Journal of Australia 177(9), 492-495; Liew, D., Liew, D. & Kennedy, M.P. (2003). Emergency department length of stay independently predicts excess inpatient length of stay. *Medical Journal of Australia* 179(10), 524-526. Doi: 10.5694/j.1326-5377.2003.tb05676.x

[12] Australian Medical Association (2020). *Public Hospital Report Card 2020*. Retrieved 26/05/2021 from: https://ama.com.au/articles/ama-public-hospital-reportcard-2020

[13] For Budget changes see: The Commonwealth of Australia (2014). *Budget 2014-15, Budget Paper No2 2014-15*. pp126, 137. Retrieved 27/05/2021 from: https://archive.budget.gov.au/2014-15/bp2/BP2_consolidated.pdf; Parliament of Australia (2018). *Recent developments in federal government funding for public hospitals: a quick guide*. Retrieved 27/05/2021 from: https://www.aph.gov.au/About_Parliament/Parliamentary_Departments/Parliamentary_Library/pubs/rp/rp1819/Quick_Guides/FundingPH

[14] Department of Health (2021). Coronavirus Covid-19 at a glance, 23 May 2021. Retrieved 24/05/2021 from: https://www.health.gov.au/sites/default/files/documents/2021/05/coronavirus-covid-19-at-a-glance-23-may-2021.pdf

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