Australian Medical Association

2022 Federal Election Statement

OVERVIEW

Australia's health system is one of the best in the world. In 2021, the highly regarded Commonwealth Fund rated Australia as having the third best health system when ranked among eleven similar high-income countries. In its report, Australia was placed at number one with respect to both healthcare outcomes and equity.

Australia however performed less well on other key measures including access to care. On that measure, Australia placed eighth, meaning that Australia was considered below average when it came to the affordability and timeliness of care. In relation to measures of preventive care, safe care, coordinated care, and engagement and patient preferences, Australia was ranked in the middle.

While we have a very good health system, we know that it falls short in a number of areas and that there is more Australia needs to do, particularly in the areas of access to care, prevention, and coordination.

In 2021, the AMA released its Vision for Australia's Health. Despite the impact of COVID-19, this document is as relevant today as it was 12 months ago. It proposed sensible and targeted initiatives that would help fix our health system, including addressing those issues identified by the Commonwealth Fund. Our reform ideas focus on five pillars - general practice, public hospitals, private health, a health system for all, and a health system for the future.

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GENERAL PRACTICE

International studies prove what general practitioners have known for generations – a strong GP-led primary healthcare system keeps people well and saves lives.

The studies also show that a strong GP based system not only improves the health of our patients but is also a very efficient means of utilising scarce health dollars. It delivers substantial bang for the health buck.

Studies however show that the high quality of general practice in Australia also serves to reduce health inequalities across the system.

Despite this, consecutive Commonwealth Governments have failed to provide adequate funding for general practice, leaving the specialty to struggle with a growing workload as the community ages and patients' healthcare needs become more complex.

This election is an opportunity for both major parties to commit to modernising Medicare through reform and the provision of additional funding that will future proof general practice and enable more care to be delivered in the community by GPs in collaboration with other healthcare professionals, keeping people healthier and out of hospital.

Policy proposals

Supporting better healthcare through voluntary patient enrolment (VPE)

85 per cent of Australians visit a GP every year, 76.3 per cent of Australian's have a usual GP, and almost 95 per cent have a usual practice. The AMA believes that now is the time for Australia to formalise and strengthen this relationship by supporting patients to enrol with a GP or general practice of their choice.

The introduction of VPE in Australia will support improved care for patients. It will encourage more patients to develop a long-term relationship with a GP or local general practice and provide the foundation for every Australian to have their own 'medical home.'

International evidence shows that having a long-term relationship with a GP leads to lower mortality, fewer acute hospital admissions, lower use of after-hours care, lower use of Emergency Departments, a more trusted relationship between patient and GP, improved patient satisfaction, and improved patient engagement in preventive healthcare measures.

Supporting patients to spend more time with their GP

Medicare was introduced in 1984 and, when it comes to funding a visit to the GP, is becoming increasingly out of date. It is failing to support those patients with more complex care needs that require more time with their GP as part of a comprehensive approach to care.

Current Medicare GP attendance items are structured to support shorter consultations with a GP rather than the more comprehensive care that some patients need. While GPs continue to provide the best possible care they can for patients, out of date funding arrangements are putting increasing pressure on practice viability.

Medicare must support GPs to spend more time with patients, something that was stressed in the Government's own review of Medicare. We need a new Medicare consultation item that encourages and supports GPs to spend more than 15 minutes with those patients that need more time. This will help to keep people healthier and, for those complex patients at risk of hospitalisation, ensure that their conditions are well controlled.

Delivering the care patients' need in general practice – all under one roof

Most general practices in Australia employ a practice nurse, who works with GPs to deliver care for patients. Practice nurses support GPs in a variety of areas including immunisation, wound care, health assessments and chronic disease management.

General practices are increasingly looking to employ other health professionals as part of a modern team-based approach to delivering comprehensive care for patients. These teams may include practice nurses, pharmacists, dieticians, physiotherapists, podiatrists, Aboriginal Health Workers, or a range of other allied health workers. This is convenient for patients and will strengthen general practice as the medical home for all Australians.

To support this model of care, the Workforce Incentive Program needs to be reformed, including easing the current caps on subsidies and introducing annual indexation so that the subsidies can keep pace with wages growth and give practices greater capacity and flexibility to employ the range of clinical staff that best supports the care needs of their patients.

This should be supported by targeted infrastructure grants for general practices to ensure that the provision of multidisciplinary services is not constrained by existing infrastructure limitations.

Delivering better care for people suffering from chronic wounds

It is estimated that 450,000 Australians currently live with a chronic wound, with hard to heal wounds costing the health system around $3 billion a year. This cost, wound healing times, infections, long-term complications, amputations, and hospitalisation could be significantly reduced if patients could access best practice wound care through their general practice. While GPs will often supply dressings at no cost to patients, the costs of these are not covered by the government and this makes it difficult for patients to access the most appropriate dressing for their needs.

To provide better care for many of these patients, a wounds consumables scheme should be implemented to subsidise the costs of the dressings provided in general practice. This would mean that GPs could provide patients with the most clinically suitable dressings, reduce patient out of pocket costs and improve their quality of life. Such a scheme should focus on ensuring those most at risk can access the care they need, targeting:

- Patients with diabetes who have a diabetic foot ulcer or diabetic leg ulcer;
- Patients with a venous or arterial leg ulcer; and
- Patients 65 years of age and over.

Supporting better care for people in aged care

Healthcare for people in Residential Aged Care Facilities (RACFs) is getting more complex. People are entering RACFs with multiple chronic diseases and their care is increasingly complex. Positioning GPs at the centre of healthcare provision in aged care is central to improving the health outcomes and quality of life for older people, as well as reducing avoidable hospitalisations.

Unfortunately, too few GPs currently visit aged care facilities as the current Medicare funding does not properly recognise the time and complexity involved in providing GP services to patients in RACFs. This means RACF residents are not always able to access the care they need when they need it. As a result, their condition may deteriorate, and they often end up being transferred to a public hospital. This fragmented approach to care is costly, puts more strain on our public hospitals, and leads to poorer health outcomes.

Improved incentives for GPs to attend RACFs must be implemented, including establishing a new funding model that makes it sustainable for GPs to deliver increased and continuing services in RACFs, including via telehealth with RACF staff in circumstances where patients are unable to effectively communicate due to underlying health conditions.

Improving access to after-hours GP services

People get sick outside of business hours, and our 24/7 economy also means that people cannot always visit their GP during the day. When patients need medical care outside of normal hours, they prefer to access this through their usual GP or general practice. The current Medicare arrangements discourage GPs from offering in-clinic services after 6pm on weeknights as well as after 12pm on Saturdays. This means that patients are often diverted to an Approved Medical Deputising Service (AMDS) or choose to visit a local emergency department.

Accessing services through these alternative models is expensive, with the average cost of an ED attendance being around $540. To change this, the AMA believes that Medicare rules should be revised so that Medicare rebates for in clinic GP after hours services are available from 6pm on weeknights and from 12pm on Saturdays.

Supporting general practices to stay open for longer into the evening will save money, ease pressure on our public hospital system, and support the delivery of comprehensive care to patients.

Encouraging more doctors to work in general practice

Despite record numbers of graduates from medical schools around the country, interest in GP training is declining. Medical graduates are turning to other specialty areas and the growth in the non-GP specialist workforce continues to outpace growth in the GP workforce.

The Australian General Practice Training Program has fallen short of its recruitment targets every year since 2017. The number of medical graduates applying for GP training has fallen as has the number of acceptances. This has long term implications for the GP workforce and community access to GP services.

While general practice remains a rewarding career, the reality is that other specialties are proving more attractive to medical graduates. One of the key reasons for this is the significant loss of pay and conditions that trainees incur when they leave their salaried position in a public hospital to train in general practice. Many trainees also never have the opportunity to experience general practice early in their career when they are deciding on their specialty choice.

To address the problem and encourage recruitment into general practice, future policy needs to deliver:

- Parity of working conditions for GP registrars, implemented via a 'single employer model' of GP training that is funded to deliver these conditions; and
- A Community Residency Program to provide doctors in training with more opportunities to undertake prevocational training in general practice and give more doctors an understanding of general practice and primary care.

PUBLIC HOSPITALS

The Australian public hospital system is in crisis, with patients caught in logjam. Chronic underfunding at both state/territory and Commonwealth level has led to declining performance, with delays in access to care for patients leading to unnecessary suffering and, in some cases, poorer health outcomes.

Since 2008 we have lost 6 public hospital beds for every 1000 persons over the age of 65. Whereas 30 years ago we had over 30 beds in our public hospital system per 1000 people over the age of 65, we now have less than 15.

At the same time our population is ageing. We expect that by 2035 over one million people will be older than 85, almost double what it is today. If we want to save our public hospital system, we must act now.

Our public hospital capacity must be increased to meet the demands of a population that is increasing in size, age and suffering from multiple chronic health issues. If the Commonwealth continues to not pay its fair share of public hospital funding and governments continue to blame each other, the problems were are seeing will only get worse.

This will come at a cost to patients and to taxpayers. Delayed care has a real impact, often leading to loss of quality of life and the further deterioration of health along with long term costs to the health system and the economy.

Policy proposals

Adequate hospital funding arrangements with the Commonwealth paying a fair share

Under current arrangements, the Commonwealth provides 45 per cent of funding for public hospital activity and has a cap of 6.5 per cent on funding growth. Public hospital finances are being squeezed, as cost growth (inflation) plus demand growth for public hospital services start to exceed government funding growth.

To address this, a new funding hospital funding agreement is needed with the states and territories that:

- Removes the cap on funding growth;
- Lifts the Commonwealth share of public hospital funding to 50 per cent;
- Binds the states and territories to invest the freed up additional five per cent of funding in quality improvement and expanded capacity; and
- Reintroduces select pay-for-performance targets, and funding for increased capacity, with the goal of at least reversing the decline in public hospital performance. This Commonwealth funding would be in addition to, and separate from, activity-based funding.

Connecting and integrating with general practice

Too many patients are presenting to Australian hospitals with preventable illnesses, with complications from a chronic condition that could have been managed in the community, or are being readmitted to hospital due to a poor discharge. These are costly and unavoidable.

General practice can play a stronger role in improving the performance of our hospitals, however the current funding arrangements are lacking. Through improved communication between general practices and hospitals, people with chronic diseases can be better managed in their communities, not their hospitals.

Targeted funding to improve discharge summaries and integrating them across clinical settings will prevent avoidable admissions and readmissions.

Adapting and improving outpatient care

The hidden waiting list is the poorly reported on waiting list for outpatient appointments, before being placed on the elective surgery waiting list. This hidden waiting list is a major problem for our health system, and it is challenging for government to address as the data for each state and territory is inconsistent.

Alternative options for delivering outpatient care should include broad adoption of digital health technologies, expanded hospital in the home models, and stronger integration with general practice and aged care facilities to limit hospital presentations and lead to better management of chronic health issues.

PRIVATE HEALTH

The unique balance between the public and private sectors makes the Australian health system one of the best in the world. The AMA supports a system where the public and private sectors work side by side to provide high quality healthcare for Australians.

Many Australians however are cancelling their private health insurance (PHI) policies, and too many of the new members are older and more likely to make substantial claims. To increase the uptake of PHI and make premiums more sustainable, Australians need to see genuine value.

At the same time, private health insurers are increasingly looking to pursue US style managed care initiatives that give them greater control over the care that their members receive. This extends to the direct provision of health services, secretive contracting arrangements with healthcare providers, and the part ownership of health services and infrastructure.

While there have been several attempts to reform private health insurance in Australia, they have largely tinkered around the edges and failed to adequately restore private health insurance to the levels of membership seen 20 years ago.

We need a reinvigorated and resilient private health system, which complements the public hospital system by providing high-quality, timely and affordable care in a sustainable way. Australians want affordable access to a private hospital, choice of practitioner, and to know that the care they receive is something that they discuss and agree on with their doctor and not the product of arbitrary decisions by private health insurers.

Policy proposals

Improving the value proposition of private health insurance

Restoring the PHI rebate to 30 per cent for targeted groups will make private health insurance affordable for younger Australians and those in the workplace on lower incomes. Improving the promotion of existing government youth discounts on PHI will also support this.

Mandating a minimum return amount of 90 per cent to the health consumer for every premium dollar paid would demonstrate real value. There needs to be a standardised return that is higher than the current PHI industry average.

Updating the Medicare Levy Surcharge and Lifetime Health Cover

Originally introduced in July 1997 for income earners over $50,000, the Medicare Levy Surcharge (MLS) aimed to encourage those that could afford it to take up private health insurance membership. At the time an income of $50,000 was the threshold for the highest income bracket of taxation. The MLS threshold now cuts in at the same income bracket as the 30 per cent marginal taxation rate, much closer to the average wage than what is considered to be a 'high income earner'.

Lifetime Health Cover (LHC) started on 1 July 2000 and was designed to encourage people to take out hospital insurance earlier in life and encourage them to maintain it. More than 20 years on, there are legitimate concerns that the MLS and LHC are no longer having their intended impact. There are perverse outcomes from applying the MLS to people at a lower income than originally intended, and LHC now applies at an age when private health insurance will be unaffordable for many people.

Reform is needed to ensure that the MLS and LHC settings are appropriate and encourage people to take up membership early in life and maintain it through to old age.

A Private Health System Authority

The regulatory environment that underpins the interaction between private health insurers, hospitals, and patients must promote the effective and efficient supply of health services. Private health insurance has specific features that make the design of an efficient regulatory environment especially complex, and current regulatory arrangements are not fit for purpose.

Australians should also be wary of American-style managed care coming to Australia. The great benefit of the Australian private healthcare system is that it is driven by patient choice and treatments are determined by doctors, not insurers.

Now is the time to commit to the establishment of an independent, well resourced, statutory body to oversee the private health system and protect patient choice and clinical autonomy. The Private Health System Authority would create a platform for genuine reform of our private healthcare system, ensuring that appropriate safeguards are in place to protect the core principles that our system is built upon.

A HEALTH SYSTEM FOR ALL

Our proud system of equality in Australian healthcare should be defended and maintained. Our vision is for a sustainable health system, achieved via policy and funding reform, where prevention is the foundation of healthcare planning and design. Emphasis should be placed on environmental, social and moral determinants of health.

Access for all Australians remains a key feature of our system, including identifying and filling service gaps for Aboriginal and Torres Strait Islander peoples, people with mental health needs, people living in aged care settings and other vulnerable groups, in conjunction with the National Disability Insurance Scheme.

Policy proposals

Preventive Health

Investing in preventive health helps mitigate the onset of chronic illness, affords people longer and healthier lives, and reduces pressure on the health system. Prevention must become a foundation of healthcare planning and design including:

- Pursuit of the National Preventive Health Strategy 2021-2030, including the commitment to allocate 5 per cent of health expenditure to prevention activities in the life of the strategy; and
- Implementation of a tax on sugary sweetened beverages, as a first step towards tackling obesity and other preventable chronic diseases.

Aboriginal and Torres Strait Islander health

The AMA supports the National Agreement on Closing the Gap. This partnership gives Aboriginal and Torres Strait Islander leaders an equal seat at the table with all governments, and is designed to ensure Indigenous voices are prioritised in policy, budget and direction setting for policy across a broad range of areas.

Even so – the health gap remains persistent, and more effort is needed to ensure equity of access to culturally safe, response, affordable and accessible healthcare for Aboriginal and Torres Strait Islander peoples including:

- Funding for Aboriginal and Torres Strait Islander health services is allocated according to need and under the advice of Aboriginal and Torres Strait Islander expertise, including towards the unimplemented parts of the National Aboriginal and Torres Strait Islander Health Plan 2013-2023;
- Expanding and investing in successful community-controlled health service delivery models, to allow Aboriginal and Torres Strait Islander organisations to deliver culturally safe and appropriate health services to their own communities;
- Investing in evidence-based strategies to grow the Aboriginal and Torres Strait Islander medical workforce; and
- Ensuring cultural safety training is embedded across the medical profession.

Mental Health

Before the pandemic, we already knew that one in five Australians would experience mental ill-health at some point in their lives. In the aftermath of COVID-19 we have seen a significant increase in prevalence of mental ill health, especially amongst young people who have been isolated from the normal freedoms and opportunities that define this significant time in life.

A comprehensive government response is needed over the long term to rebuild and reshape the Australian mental health system, and respond to a growing demand for services in the years to come, including:

- Investment in mental health services delivered through general practice, offering comprehensive care to patients, and reducing fragmentation of care. This includes mental health nurses, social workers and other support services embedded within general practices to provide responsive mental healthcare;
- Increased MBS rebates for GPs providing mental healthcare to have parity with other chronic illness consultations;
- Expanding community mental health services to take pressure off other parts of the health system including emergency departments; and
- Expanding outreach telehealth services to support rural mental health service delivery and continuation of telehealth for psychiatrists.

Climate Change

The health sector makes a significant contribution to Australia's carbon emissions – around 7 per cent each year. The AMA is committed to a net zero target for the healthcare sector by 2040, with an interim target of 80 per cent by 2030.

To achieve this target, we need to see national leadership, with the Commonwealth working with the states and territories to:

- Establish a national sustainability development unit to oversee carbon emissions in the Australian health sector;
- Develop a national strategy for health and climate change; and
- Incorporate waste reduction strategies as a requirement in hospital accreditation.

Child Health

Climate change, poverty, a poor diet, and unstable housing can have a huge impact on a child's health. Social determinants have a direct impact on health and wellbeing, and the AMA believes that a commitment to equity must underpin fiscal, social, and economic policy.

This is why in 2022, we along with other expert peak organisations support the establishment of a child health taskforce within 6 months of the Federal election.

Matching the medical workforce to community needs

To avoiding the boom-bust cycle that has characterised medical workforce planning, we must ensure that medical school intakes are linked to workforce planning and community need. While we have seen an explosion in medical student numbers in Australia since 2004, this has not solved problems of maldistribution and specialty shortages.

The growth in full fee-paying student places encourages medical graduates to pursue specialty areas that are better remunerated, and these are typically areas of subspecialist practice located in large metropolitan centres.

We need to see a better system where there is regulation of all medical school places, including domestic and overseas full fee-paying places, so that medical school intakes are matched to community need, with clear limits on the number of full fee-paying students.

Investing in the rural medical training pipeline

To improve access to medical care for regional/rural areas and disadvantaged communities, we need to develop clear training pathways and solutions to rural medical workforce needs and distribution. This requires an increased focus on generalism within the specialist workforce, improved access to specialist services in rural Australia, and development of a rural training pipeline which takes students all the way through to the completion of specialist fellowship training. The achieve this we need to see:

- The expansion of the Commonwealth Government's Specialist Training Program (STP) to 1700 places over the next term, giving priority to rural areas, generalist training and specialties that are under-supplied;
- Investment in regional teaching hospitals to ensure they have sufficient capacity to host STP-funded non-GP specialist registrars;
- Implement the National Rural Generalist Pathway nationally, and a commitment to ongoing funding;
- Encouragement of end-to-end rural medical training programs, with a view to ensuring they provide positive rural exposure and lead to retention of rural medical practitioners;
- Expansion of capacity for remote learning (training and educational opportunities, especially for trainees in regional/rural sites, and potential remote supervision); and
- Promotion of regional training and research teaching hospital hubs to grow non-GP specialist capacity outside metropolitan areas.

A HEALTH SYSTEM FOR THE FUTURE

Building a health system for the future will require us to embrace new technology and innovation, consolidate the gains from COVID-19 reforms such as telehealth and e-prescribing, and build upon these gains to facilitate better access for all patients.

Used appropriately, data and technology can aid diagnosis, clinical audit, and patient engagement, and can provide solutions to deliver care in circumstances currently not possible. Key to consideration of a future health system are the opportunities offered by new innovative models of care, integrated care at a lower cost, and value-based healthcare – that is, sustainable system redesign.

Policy proposals

Building a health system that incorporates new technologies

The pandemic response saw years of healthcare reforms enacted in days. Telehealth and e-prescribing will remain, yet there are other advances we should still make. For example, there needs to be funding for innovations in rural health and technological infrastructure to ensure doctors are more accessible to patients.

The benefits of telehealth need to be expanded beyond the simple doctor-patient dynamic, with options for telehealth between clinicians to improve the outcome of a patient consultation, funded through Medicare.

Remote monitoring technology can facilitate equitable healthcare, in particular for private medical practices in rural and remote areas, yet there are no appropriate funding mechanisms that exist to encourage this. Medical practices can invest in these technologies, however practices struggle to justify this without a means of funding, despite the benefit to the patient.

Genuinely interoperable health systems

Right now, clinical software in a hospital and in a general practice or RACF do not communicate properly. This is inefficient and can lead to duplication and errors. Building interoperability into clinical software will ensure that each person involved in care has current information about the patient to enable provision of the best possible quality care.

We need a national focussed attempt to improve digital maturity through workforce training initiatives, eliminating fax use, and promoting secure messaging uptake through directed improvement payments or grants.

We need to continue to pursue better interoperability of clinical software so that all healthcare providers can easily and securely share data where necessary.

Empowering patients to track their health data

My Health Record is a valuable but underused resource. We need to encourage widespread use and adoption, with a specific focus beyond general practices. Patients should be supported with education for, and access to, digital health and assistive technologies to receive high-quality care where they need it.

Coordinated approaches to disease control

Infectious diseases are a serious global health issue. Australia must play a global role in the prevention of epidemics, pandemics and other health threats. Currently, disease threats are managed by disjoined state and Commonwealth structures. The COVID-19 pandemic has demonstrated that coordinating rapid and effective public health responses to manage communicable diseases and outbreaks requires a national approach. The establishment of an Australian National Centre for Disease Control (CDC) will provide a national approach to addressing current and emerging health threats, with a focus on engaging in global health surveillance, health security, epidemiology, and research.

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