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RACP Pre-Budget Submission 2019-2020 – Promoting systems reform, equity, prevention and sustainability

February 2019

Executive Summary

The Royal Australasian College of Physicians (RACP) trains, educates and advocates on behalf of more than 25,000 physicians and trainee physicians across Australia and New Zealand.

The RACP represents a broad range of medical specialties who work at both the individual and population level and at all stages of the lifecycle from infancy and childhood through adolescence and adulthood to old age and the end of life, including paediatrics and child health, cardiology, respiratory medicine, neurology, oncology, public health medicine, occupational and environmental medicine, palliative medicine, sexual health medicine, rehabilitation medicine, geriatric medicine and addiction medicine.

Beyond the drive for medical excellence, The RACP is committed to developing policies, programs and initiatives which will improve the health of communities. Not only must we ensure that patients have access to an integrated and well-coordinated health system, but policies must take a whole-of-government approach to reduce the likelihood of poor health outcomes and support governments in addressing the social determinants of health.

This is especially important because we know that the health and wellbeing of individuals can be significantly impacted by circumstances over which they have no direct control, such as early childhood experiences or trauma, socio-economic status, and access to suitable housing, education and employment.

The RACP therefore makes the following recommendations for the 2019-20 Federal Budget currently being developed by the Australian Government.

Recommendation Summary

Integrated Care

- Facilitate scalable evidence-based care for people with chronic conditions that is inclusive of specialist care by:
    - Funding and fostering a model of care for management of patients with comorbid chronic health conditions. The proposed model of care would:
        - expand the interdisciplinary composition of primary care teams beyond GP services to encompass long-term roles for specialist physicians, nurses and allied health practitioners
        - introduce flexibility in the scope of practice of non-physician team members (e.g. nurse specialists)
        - move away from the ‘one problem per visit basis’ and other inbuilt and often unintended mechanisms that isolate practitioners and prevent collaboration and
        - be evaluated as a two-year trial, with ongoing monitoring, evaluation and reporting on the trial’s outcomes.
    - Consider reforms to the Medicare Benefits Schedule (MBS) or other financial incentives to better incentivise direct communications between general practitioners (GPs) and specialists in the management of chronic disease patients. Supported communications could include provision for:
        - case conferences to include more than one specialist (not of the same specialty)
        - enabling specialists to modify and have specific input into chronic care management planning and
        - direct health professional communications (with and without the patient present) outside of case conferences.

- Explore at the next Council of Australian Governments (COAG) meeting the Productivity Commission proposal for joint Commonwealth and state contributions from their respective shares of hospital activity-based funding to a Prevention and Chronic Condition Management Fund (PCCMF) in each local health district.

Digital Health and Telehealth

- Make available 'provider readiness' incentives comparable to those currently provided to GPs (i.e. the Practice Incentives Program e-health incentive) to hospital and community-based specialist physicians to sign up and participate in My Health Record.
- Deliver the funding needed to progress the National Digital Health Strategy project to develop minimum interoperability standards, with the goal of an agreed vision and roadmap for interoperability between all public and private health and care services in Australia.
- Remove the distance requirement from the MBS items supporting specialist telehealth consultations.

Child Health

- Immediately reinstate the Australian Health Ministers' Advisory Council (AHMAC) subcommittee on child and youth health.
- Commit to new investment in paediatric child health services that are universally available, but with a scale and intensity that is proportionate to the level of disadvantage so that health policies, programs and initiatives funded by the Australian Government can begin to address inequities in child health.
- Fund expanded home visit programs, particularly in rural and remote areas, in order to overcome barriers to access that can affect the health and wellbeing of children.
- Establish annual public reporting from relevant departments against the Australian Institute of Health and Welfare's (AIHW) Children's Headline Indicators.
- Develop Equitable Access Indicators in relation to child health that are reported on annually by the AIHW and provide additional funding to address specialist service access issues identified from this reporting.
- Commit funding to establish and maintain an *Inequities in Child Health Alliance*, in conjunction with several leading Australian universities, policy groups and health services, to:
    - build the evidence base on responses to inequities in child health
    - assist in the development of equitable access indicators in relation to child health on which governments will report
    - collect and publish data from various jurisdictions on inequities in child health and
    - provide paediatricians with an easily accessible, reliable and rigorous source of current evidence in relation to inequities in child health and how it can be addressed in their practice.
- Conduct and publish evaluations on the implementation and effectiveness of:
    - The National Framework for Child and Family Health Services - secondary and tertiary services (2015)
    - Healthy, Safe and Thriving: National Strategic Framework for Child and Youth Health (2015).

- Fund the provision of a minimum schedule of universal preventative health care interventions, to be delivered at point of vaccination to both babies and mothers, including links to the relevant maternity and immunisation registers and MBS items designed to be used at the time of immunisation.
- Fund research into further opportunities for universal preventative health initiatives in early childhood.

Adolescent and Young People's Health

- Expand the eligibility of the MBS health assessment items 701, 703, 705 and 707 to include adolescents and young adults aged 10-24 year to facilitate early identification of risks and needs.
- Invest in the development of specialised adolescent health services which address the unique physical, mental and sexual health challenges of adolescence and build the capacity of adolescents to self-manage chronic disease.
- Fund and support prevention and treatment services through new and existing networks and services, such as child and family health, community services and other mental health services for children, adolescents and young adults.
- Fund regular national surveys of children's and young people's mental health to monitor indicators of child and adolescent health, as well as their economic and social determinants.
- Commit to secure, long-term funding for accessible adolescent sexual and reproductive health services, including funding for clinical education and training to support the delivery of these services.
- Greater access to bulk-billed Sexually Transmitted Infections (STI) screening for children and young people through:
    - Ensuring children and young people can receive a full rebate for short GP consultations, regardless of their location and
    - Funding full-service sexual health clinics in underserved areas.

Aboriginal and Torres Strait Islander Health

- Legislate for guaranteed long-term funding to progress the strategies and actions identified in the National Aboriginal and Torres Strait Islander Health Plan (NATSIHP) Implementation Plan commensurate with the burden of disease.
- Commit to secure, long-term funding for the Rural Health Outreach Fund (RHOF) and Medical Outreach Indigenous Chronic Disease Program (MOICDP) commensurate with the burden of disease.
- Commit to sustained, secure funding for the evidence-based, locally-delivered Tackling Indigenous Smoking program to address the number one modifiable risk factor in the burden of disease in Indigenous communities.
- Build and support the capacity of Aboriginal and Torres Strait Islander health leaders by committing secure long-term funding to the Indigenous National Health Leadership Forum.
- Reinstate funding for a clearinghouse modelled on the previous *Closing the Gap* clearinghouse, in line with the recommendations of the Fifth National Mental Health and Suicide Prevention Plan.
- Commit to secure, long-term funding for primary health care, community-led sexual health programs and specialised sexual health services to deliver Sexually Transmitted Infections (STIs) and Blood Borne Viruses (BBVs) services, and to ensure timely and

culturally supported access to specialist care in all regions, to achieve low rates of STIs and good sexual health care for Indigenous Australians.

    - Within this framework explore with state and territory governments reciprocal funding arrangements whereby Commonwealth contributions are reciprocated with commitments by state and territory governments to fund specialist services to complement, augment and support primary health care in the provision of sexual health services.

- Invest in and support a long-term multi-disciplinary sexual health workforce and integrate with primary healthcare to build longstanding trust with communities.
- Fund the implementation plans of the National Blood Borne Virus and Sexually Transmissible Infection Strategies to ensure the implementation plan activities are delivered and targets achieved.

Silicosis and Occupational Lung Disease Prevention and Management

- Commit to secure, long-term funding to establish a national occupational lung disease registry, currently being considered by COAG.
- Establish a national occupationally-acquired respiratory disease surveillance and registry program.

End of Life

- Provide secure, long-term funding to improve the volume, co-ordination and delivery of community specialist palliative care services across the life span, in ways which support integration with hospital services and are delivered in conjunction with equitable access to flexible and rapidly responsive social and community services.
- Commit to secure, long-term funding to develop and implement models of care which improve the availability of palliative and supportive care services (including paediatric palliative care services), with a focus on non-cancer services in hospitals and in non-hospital settings such as residential aged care facilities, in people's homes and in rural and remote communities and among other underserviced populations.
- Substantially expand the Comprehensive Palliative Care in Aged Care package to fund additional specialist doctors and nurses across Australia to meet the unmet needs of patients who would benefit clinically from the delivery of high-quality palliative and end-of-life services in residential aged care settings.
- Endorse population-based palliative and supportive care, including end-of-life care, as a COAG priority.

Obesity

- Prioritise obesity prevention by:
    - Implementing an effective tax on sugar-sweetened beverages to reduce consumption and using generated revenue to facilitate access to healthy diets and culturally relevant initiatives to improve health equity.
    - Committing appropriate funding to develop and implement the national strategy on obesity recently announced by COAG which would focus on primary and secondary prevention and social determinants of health, especially in relation to early childhood and rural and regional issues and would do so over an extended period.
    - Establishing a national taskforce including sustained funding, regular and ongoing monitoring and evaluation of key measures and regular reporting on targets. This recommendation is aligned with a recommendation of the December

2018 final report of the Select Senate Committee on the obesity epidemic in Australia.

  - Committing to secure, long-term funding for evidence-based prevention measures for overweight and obesity and ensuring primary prevention interventions focus on those most affected by overweight and obesity.
  - Allocating funding to the development, implementation, update and monitoring of comprehensive and consistent national guidelines on diet, physical activity and weight management, with a focus on critical periods in the life course.

- Provide hospital funding to state and territory governments specifically geared towards delivering equitable access to bariatric surgery for public hospital patients.

Preventative Health Agency:

- Prioritise prevention by re-establishing a national preventative health body to set nationwide goals, directs strategic investment, coordinate implementation of initiatives and evaluate the evidence for the cost-effectiveness of population-wide preventative health interventions.

Drug and Alcohol Policy

- Introduce a volumetric taxation system for all alcohol products and abolish the Wine Equalisation Tax (WET) and rebate.
- Allocate a proportion of the increased revenue raised from volumetric taxation to funding alcohol and other drug treatment and prevention services as part of a coordinated national response to alcohol and other drug use disorders.
- Substantially increase funding for alcohol and other drug treatment system reform, including for appropriate and multidisciplinary workforce development, capital works to improve the physical infrastructure and the development of appropriate needs-based planning models and suitable models of care to address unmet demand for treatment.
- Increase funding for prevention services to reduce the incidence of alcohol and other drug use disorders.

Climate Change and Health

- Establish a national healthcare sustainable development unit. The unit would draw on local best practice as well as leading international models, such as the Sustainable Development Unit in the UK. The first tasks of the unit would be to:
  - consult with stakeholders
  - establish appropriate metrics and measure the total carbon footprint of the health sector in Australia
  - work with health stakeholders to develop an environmental sustainability strategy and
  - support health services to implement the strategy.

- Develop a national climate change and health strategy for Australia, including meaningful mitigation and adaptation targets, effective governance arrangements, professional and community education, effective intergovernmental collaboration and a strong research capacity.

Refugee and Asylum Seeker Health

- Immediately reinstate the Status Resolution Support Service payments to those asylum seekers who have been removed from the program due to changes in eligibility criteria in 2018.

- Reverse the changes to the eligibility criteria and discontinue the removal of people already accessing the program.

Integrated Care

There is an urgent need to reconfigure health services, given that an increasing proportion of the community are living with multiple chronic conditions (i.e. multi-morbidities).[1] [2] [3] This is because care for chronic conditions cannot be confined to one part of the health sector – these increasingly prevalent conditions often require care at various times in each of the primary, secondary and tertiary sectors. Better communication and interaction between practitioners across these sectors will benefit both the health care providers and consumers for whom the health care system has been established[4].

Fundamental to this goal is 'system supported connectivity' between primary care and specialist services and a genuine placement of patients at the centre of the care design. The College therefore recommends funding for a model of comprehensive care for patients with multi-morbidities (that goes beyond Health Care Homes). This should be underpinned by a broader set of reforms to the existing health service delivery framework, particularly with respect to the role of healthcare professionals in the care management of chronic disease patients.

Specialists are an integral part of the primary health care treatment system, yet specialist expertise has not historically been included in recent federal funding approaches to patients with chronic conditions. Ideally, specialists should have a role to play in primary care and community settings in diagnosing and managing patients with chronic conditions and preventing chronic disease exacerbations. This would require, among other things, more opportunities for specialists to collaborate with general practitioners (GPs) in an ambulatory care setting, whether this is through actual physical spaces for devolved hospital services or by virtual collaborations supported by technology[5].

With few notable exceptions, Commonwealth-funded Primary Health Networks (PHNs) and state government local health and hospital networks have relatively immature linkages. These linkages should be strengthened, providing the means for jointly planned and localised regional healthcare. The most sustainable means to strengthen such linkages to achieve better integrated care for patients with multi-morbidities is through funding reforms to better pool Commonwealth and state healthcare funding streams. The Productivity Commission has proposed that both tiers of government (Commonwealth and state) direct a modest share (2 to 3%) of their current activity-based funding for hospitals into a Prevention and Chronic Condition Management Fund in each local health district to be jointly managed by the Local Hospital Network and Primary Health Network. [6]

The RACP recommends that the Australian Government:

- Facilitate scalable evidence-based care for people with chronic conditions that is inclusive of specialist care by:
    - Funding and fostering a model of care for management of patients with comorbid chronic health conditions. The proposed model of care would:
        - expand the interdisciplinary composition of primary care teams beyond GP services to encompass long-term roles for specialist physicians, nurses and allied health practitioners
        - introduce flexibility in the scope of practice of non-physician team members (e.g. nurse specialists)

[1] Australian Institute of Health and Welfare (AIHW). Chronic Disease Overview. Canberra: AIHW; 2018 https://www.aihw.gov.au/reports-statistics/health-conditions-disability-deaths/chronic-disease/overview

[2] Caughey GE, Vitry AI, Gilbert AL, Roughead EE. Prevalence of comorbidity of chronic diseases in Australia. BMC Public Health. 2008;8(1):221.

[3] Harrison, C., Henderson, J., Miller, G. and Britt, H., 2016. The prevalence of complex multimorbidity in Australia. *Australian and New Zealand journal of public health*, *40*(3), pp.239-244.

[4] Sampson, R., Barbour, R. and Wilson, P., 2016. The relationship between GPs and hospital consultants and the implications for patient care: a qualitative study. BMC Family Practice, 17(1), p.45.

[5] In Ontario such virtual networks, that include GPS and specialist physicians have demonstrated impacts on hospitalisation rates. Rahman, F., Guan, J., Glazier, R.H., Brown, A., Bierman, A.S., Croxford, R. and Stukel, T.A., 2018. Association between quality domains and health care spending across physician networks. *PloS one*, *13*(4), p. e0195222.

[6] Productivity Commission 2018, Shifting the Dial: 5-year productivity review.

- move away from the 'one problem per visit basis' and other inbuilt and often unintended funding mechanisms that isolate practitioners and prevent collaboration and
- be evaluated as a two-year trial, with ongoing monitoring, evaluation and reporting on the trial's outcomes.

- Consider reforms to the Medicare Benefits Schedule (MBS) or other financial incentives to better incentivise direct communications between GPs and specialists in the management of chronic disease patients. Supported communications could include provision for:

    - case conference to include more than one specialist (not of the same specialty)
    - enabling specialists to modify and have specific input into chronic care management planning and
    - direct health professional communications (with and without the patient present) outside of case conferences.

- Explore at the next Council of Australian Governments (COAG) meeting the Productivity Commission proposal for joint Commonwealth and State contributions from their respective shares of hospital activity-based funding to a Prevention and Chronic Condition Management Fund (PCCMF) in each local health district.

Digital health and telehealth

Digital health is about electronically connecting the points of care so that health information can be shared securely. It is therefore fundamental to facilitating integrated care. Strategic use of digital health and telehealth can help address major challenges to the health system, such as inequitable access, an ageing population, the gap in Indigenous health outcomes, chronic disease and workforce issues.[7]

The My Health Record (MHR) initiative is the Australian Government's major investment in digital health. However, among clinicians, incentives are currently only provided to general practitioners (GPs) to sign up and participate in MHR.

The quick and efficient sharing of patient information between GPs and specialists would constitute one of the benefits of the MHR. However, this benefit is unlikely to be achieved without better engagement and buy-in from specialist physicians. Comparable incentives to these currently provided to GPs should also be available to community-based physicians (many of whom are also engaged in the public hospital sector) if the goal is to maximise broad clinician uptake and fully leverage the benefits of MHR.

The College also supports initiatives such as the National Digital Health Strategy project to develop minimum interoperability standards, with the goal of an agreed vision and roadmap for interoperability between all public and private health and care services in Australia. At present, lack of such interoperability is a significant barrier to better connected care.

In recent years, telehealth has increased patient access to specialist medical advice. Medicare specialist telehealth service items have increased by 12.6% between the 2016 and 2017 calendar years; from 106,769 to 120,271[8].

However, telehealth has been restricted to patients who live within a 15 km distance from a specialist service. There would be significant benefits – for patients, health services and

[7] Wilson, L., 2017. National Digital Health Strategy. https://conversation.digitalhealth.gov.au/australias-national-digital-health-strategy
[8] Estimate based on statistics on the following item numbers 99, 112, 113, 114, 149, 288, 384, 389, 2799, 2820, 3003, 3015, 6004, 6016, 13210, 16399, 17609

healthcare providers as well as for government budgets – in removing the current MBS item limitation on telehealth services. This restriction, which has not been amended since 2012, unnecessarily limits the provision of specialist care when there may be valid reasons for a telehealth consultation within a 15 km distance from a service. Removal of the restriction might benefit people with chronic conditions, those with carer responsibilities, ambulatory limitations, transport difficulties, time limitations and condition-related impairments.

Telehealth has the additional benefit of minimising disruption within the home, school or work, (for example, families with high care responsibilities, people with work responsibilities and children at school). The use of telehealth could be further supported within the palliative care and pain management specialties as part of an integrated model of care.

The RACP recommends that the Australian Government:

- Make available 'provider readiness' incentives comparable to those currently provided to GPs (i.e. the Practice Incentives Program e-health incentive) to specialist physicians to sign up and participate in the MHR.
- Deliver the funding needed to progress the National Digital Health Strategy project to develop minimum interoperability standards, with the goal of an agreed vision and roadmap for interoperability between all public and private health and care services in Australia.
- Remove the distance requirement from the MBS items supporting specialist telehealth consultations.

Child Health

All children, no matter where they live or who they are, should have the same opportunity to fulfil their potential. Child health inequities are differential outcomes in children's health, development and well-being that are unjust, unnecessary, systematic and, most importantly, preventable. In Australia, this means that a large number of children will not have the same health, wellbeing and developmental outcomes as their more socially advantaged peers.

Many inequities start early in childhood and increase along a clear social gradient. This means that the greater a child's disadvantage, the worse their health, development and well-being. These gaps widen as children progress across the life trajectory, resulting in adverse adult health, educational and vocational outcomes and increased subsequent mortality and morbidity. This can have an intergenerational effect with inequity passed on to the next generation. Health inequities also have high costs to society - the cost of inaction on the social determinants of health on productivity and expenditure in Australia has been estimated to be as high as $14 billion per year.[9]

By tackling health inequities, societies achieve better health overall and the social gradient flattens with a 'spill over' effect on non-health outcomes such as social, educational and workforce inclusion and crime reduction. Significant economic benefits flow from providing strong and truly universal child health and education services that are proportionate to a population group's needs, with those children most at need having the greatest access to quality services.

Children also have a right to a universal package of preventative health care, and some children in Australia are still unable to access a regular schedule of services including immunisation, health and development checks. The 2011 Australian Health Ministers' Advisory Council (AHMAC) report for National Framework for Universal Child and Family Health Services recommended that the schedule of contacts be based on:

- Alignment to immunisation schedules to encourage participation in both programs

[9] Brown L, 2012: The cost of inaction on the social determinants of health. University of Canberra: National Centre for Social and Economic Modelling. https://www.cha.org.au/images/CHA-NATSEM%20Cost%20of%20Inaction.pdf

- Critical periods of child development
- Opportunities to identify families at risk and offer timely family support services
- Opportunities for targeted anticipatory guidance (parental advice) and
- Aligning contacts with the child's birthday (particularly over 18 months).

Australia has implemented robust policies to ensure that all children are immunised but there are few policy provisions in place to ensure that pregnant women, infants and children receive the other components of the minimum preventative health care package. Policy approaches such as the USA Women Infant and Child incentive programme have been shown to increase the uptake of essential preventative health care and could be investigated further for ensuring universal coverage of woman and child focussed support.

The RACP's Position Statement – *Inequities in Child Health*[10], calls on all governments to take sustained and meaningful action to achieve fairer access to healthcare and more equitable health outcomes for all Australian children.

The RACP recommends that the Australian Government:

- Immediately reinstate the Australian Health Ministers' Advisory Council (AHMAC) subcommittee on child and youth health.
- Commit to new investment in paediatric child health services that are universally available, but with a scale and intensity that is proportionate to the level of disadvantage so that health policies, programs and initiatives funded by the Australian Government can begin to address inequities in child health.
- Fund expanded home visit programs, particularly in rural and remote areas, to overcome barriers to access that can affect the health and wellbeing of children.
- Establish annual public reporting from relevant departments against the Australian Institute of Health and Welfare's Children's Headline Indicators.
- Develop Equitable Access Indicators in relation to child health that are reported on annually by the AIHW and provide additional funding to address specialist service access issues identified from this reporting.
- Commit funding to establish and maintain an *Inequities in Child Health Alliance*, in conjunction with a number of leading Australian universities, policy groups and health services, to:
    - build the evidence-base on responses to inequities in child health
    - assist in the development of equitable access indicators in relation to child health on which government will report
    - collect and publish data from various jurisdictions on inequities in child health and
    - provide paediatricians with an easily accessible, reliable and rigorous source of current evidence in relation to inequities in child health and how it can be addressed in their practice.
- Conduct and publish evaluations on the implementation and effectiveness of:
    - The National Framework for Child and Family Health Services - secondary and tertiary services (2015) and
    - Healthy, Safe and Thriving: National Strategic Framework for Child and Youth Health (2015).
- Fund the provision of a minimum schedule of universal preventative health care interventions, to be delivered at point of vaccination to both babies and mothers,

[10] Royal Australian College of Physicians (2018), Position Statement: Inequities in Child Health, https://www.racp.edu.au/docs/default-source/advocacy-library/racp-inequities-in-child-health-position-statement.pdf

including links to the relevant maternity and immunisation registers and MBS items designed to be used at the time of immunisation.

- Fund research into further opportunities for universal preventative health initiatives in early childhood.

Adolescent and Young People's Health

Without a commitment to adolescent and young adult health we risk forfeiting hard won improvements in infant and early childhood health. Adolescence presents an opportunity for health professionals to positively influence young people's health for the rest of their lives. The onset of puberty begins a period of profound physical growth and neurological development. Establishing healthy habits in adolescence, when health behaviours related to non-communicable diseases are adopted, contributes to significantly improved health outcomes and reduced health costs throughout adulthood.

Funding and support for prevention services are particularly important for young people, as is investing in their capacity to self-manage chronic disease. Expanded access to GPs and paediatricians will allow adolescents and young adults to have their needs and risk factors identified early. This will help facilitate decreased risk-taking, reduce incidence of chronic disease and substance abuse and improved mental health.

Young people have the right to information, education and clinical care that supports healthy sexual development and informed choices and minimises the risk of coercion, unplanned pregnancy, sexually transmitted infection and other unwanted or unintended consequences, including emotional, psychological, social and cultural consequences. Sexual and reproductive health care for young people is delivered in a range of settings including primary care, community and hospital-based adolescent and young adult health services, community-controlled Aboriginal Health Services, sexual health centres and family planning clinics, school-based services and justice health services. Optimal care is culturally, age and developmentally appropriate and delivered from a youth-friendly perspective.

The RACP recommends that the Australian Government:

- Expand the eligibility of the MBS health assessment items 701, 703, 705 and 707 to include adolescents and young adults aged 10-24 year to facilitate early identification of risks and needs.
- Invest in the development of specialised adolescent health services which address the unique physical, mental and sexual health challenges of adolescence and build the capacity of adolescents to self-manage chronic disease.
- Fund and support prevention and treatment services through new and existing networks and services, such as child and family health, community services, sexual health and other mental health services for children, adolescents and young adults.
- Fund regular national surveys of children's and young people's mental health to monitor indicators of child and adolescent health, as well as their economic and social determinants.
- Commit to secure, long-term funding for accessible adolescent sexual and reproductive health services, including funding for clinical education and training to support the delivery of these services.
- Greater access to bulk-billed sexually transmitted infections (STI) screening for children and young people through:
    - Ensuring children and young people can receive a full rebate for short GP consultations, regardless of their location and
    - Funding full-service sexual health clinics in underserved areas.

Aboriginal and Torres Strait Islander Health

Australia is a rich country with quality infrastructure and a world-class health system. Australia's First Peoples, the Aboriginal and Torres Strait Islander peoples, are one of the fastest growing populations (nearing 3%), who provide a continuous link to upwards of 60,000 years of culture on this continent.

Yet Australia's Aboriginal and Torres Strait Islander First Peoples continue to suffer greater incidence of chronic disease and experience disadvantage and barriers to accessing appropriate and effective health care. Despite these long-standing inequities progress has been slow in reducing the health gap and concerted, sustained action is urgently needed.

Aboriginal and Torres Strait Islander people continue to experience poorer health outcomes than non-Indigenous Australians. The latest 'Closing the Gap' report found that Australia is not on track to close the life expectancy gap by 2031, with the gap remaining close to ten years for both men and women. The gap for deaths from cancer between Aboriginal and Torres Strait Islander and non-Indigenous Australians has in fact widened in recent years, with Aboriginal and Torres Strait Islander cancer death rates increasing by 23% between 1998 and 2016, while during the same period non-Indigenous Australians experienced a 14% decline in cancer mortality rates[11].

To address these inequities and improve access to care, continuing and strengthened focus and appropriate long-term legislated funding is required. It is imperative that there is secure funding for the *National Aboriginal and Torres Strait Islander Health Plan 2013-2023* (NATSIHP) Implementation Plan. Funding uncertainty and frequent changes create significant issues that impact the continuity of services to patients and organisations and hamper their ability to retain and expand their capacity.

Limited access to specialist care for many Aboriginal and Torres Strait Islander people is an issue of particular concern for the RACP. Data shows that Aboriginal and Torres Strait Islander people access Medicare-rebated specialist services 40% less than non-Indigenous people, notwithstanding their higher rates of chronic disease (this is the case both in urban areas as well as regional and remote settings).[12]

The RACP strongly supports existing programs that improve access to specialist care, including the Rural Health Outreach Fund (RHOF) and Medical Outreach Indigenous Chronic Disease Program (MOICDP). The RACP recommends that the Australian Government continue its investment in these programs, undertaking evaluation to ensure the programs are targeted at the most appropriate issues, achieving positive health outcomes for Aboriginal and Torres Strait Islander peoples, and that the funded services are culturally safe.

Aboriginal and Torres Strait Islander health leadership and authentic community engagement is crucial to achieving improved health outcomes. The Aboriginal Community Controlled Health sector is of vital importance in delivering effective, culturally safe care to Australia's First Peoples; as such, service development and provision should be led by Aboriginal and Torres Strait Islander health organisations wherever possible. The sector must have long-term, legislated, sufficient and secure funding to both retain and grow their capacity.

Given the recent focus by the Australian Government on improving mental health and reducing suicide rates in Aboriginal and Torres Strait Islander communities, the RACP supports the analysis, reporting and implementation of evidence-based solutions, with input from and led by these communities, to improve the quality and delivery of mental health promotion and suicide prevention services. The RACP recommends the establishment of clearinghouses which enable effective access to relevant, high-quality information and resources to support these efforts.

Sexual Health

[11] 2018 Closing the Gap Report - https://closingthegap.pmc.gov.au/
[12] Australian Health Ministers' Advisory Council, 2017, Aboriginal and Torres Strait Islander Health Performance Framework 2017 Report, AHMAC, Canberra at p. 1708.

There continue to be ongoing outbreaks of infectious syphilis across Australia affecting Aboriginal and Torres Strait Islander people, which are occurring in the context of increasing rates of other Sexually Transmitted Infections (STIs) and some Blood Borne Viruses (BBVs) in some Aboriginal and Torres Strait Islander communities.[13] STIs are endemic in some regions; an unprecedented syphilis epidemic in Queensland began in 2011 and extended to the Northern Territory, Western Australia and South Australia.

Since 2011 there have been six fatalities in Northern Australia from congenital syphilis[14], and another baby required extensive care in the Northern Territory. In addition, there has been one reported case of congenital syphilis so far in 2017 in South Australia. Despite the existence of several Federal and state-level sexual health strategies, the situation remains dire.

Appropriate funding needs to be allocated to the implementation of the Fifth National Aboriginal and Torres Strait Islander Blood-Borne Viruses and Sexually Transmissible Infections Strategy and sexual health services, particularly to ensure sufficient capacity for the delivery of core STI/BBV services within models of care that provide comprehensive primary health care services (particularly Aboriginal and Torres Strait Islander community-controlled health services). People should have access to specialist sexual health care when needed, through integration with comprehensive primary health care services to ensure sustainable and culturally appropriate service provision.

We welcome the plans to activate a short-term response across the state and territories to the continuing syphilis outbreaks, to be coordinated by the Department of Health. However, while this Action Plan and short-term funding are urgently needed, the short-term activities must be aligned with and contribute to longer-term strategies and investments across states and territories.

The RACP recommends that the Australian Government:

- Legislate for guaranteed long-term funding to progress the strategies and actions identified in the National Aboriginal and Torres Strait Islander Health Plan (NATSIHP) Implementation Plan commensurate with the burden of disease.
- Commit to secure, long-term funding for the Rural Health Outreach Fund (RHOF) and Medical Outreach Indigenous Chronic Disease Program (MOICDP) commensurate with the burden of disease.
- Commit to sustained, secure funding for the evidence-based, locally-delivered Tackling Indigenous Smoking program to address the number one modifiable risk factor in the burden of disease in our Indigenous communities.
- Build and support the capacity of Aboriginal and Torres Strait Islander health leaders by committing secure long-term funding to the Indigenous National Health Leadership Forum.
- Reinstate funding for a clearinghouse modelled on the previous Closing the Gap clearinghouse, in line with the recommendations of the Fifth National Mental Health and Suicide Prevention Plan.
- Commit to secure, long-term funding for primary health care, community-led sexual health programs and specialised sexual health services to deliver STI/BBV services, and to ensure timely and culturally supported access to specialist care in all regions, to achieve low rates of STIs and good sexual health care for Indigenous Australians.
    - Within this framework explore with state and territory governments reciprocal funding arrangements whereby Commonwealth contributions are reciprocated with commitments by state and territory governments to fund specialist services

[13]Kirby Institute. Bloodborne viral and sexually transmissible infections in Aboriginal and Torres Strait Islander people: annual surveillance report 2018. Sydney: Kirby Institute, UNSW Sydney; 2018. Pg3.
[14] Nogrady, B. Sixth child dies from congenital syphilis in northern Australia. BMJ 2018; 360: k1272

to complement, augment and support primary health care in the provision of sexual health services.

- Invest in and support a long-term multi-disciplinary sexual health workforce and integrate with primary healthcare to build longstanding trust with communities.
- Fund the implementation plans of the National Blood Borne Virus and Sexually Transmissible Infection Strategies to ensure the implementation plan activities are delivered and targets achieved.

Silicosis and Occupational Lung Disease Prevention and Management

In 2016, the first index case of artificial stone silicosis in a patient with a history of working with artificial stone benchtops was identified in NSW and reported to regulators by concerned respiratory specialists. This patient was so severely affected that lung transplantation was soon required. Other cases were identified amongst similar workers; respiratory physicians from the Thoracic Society of Australia and New Zealand (TSANZ) collated such cases and published a 2018 case series[15] notable for the fact that the patients all had severe progressive disease.

This concern was confirmed in September 2018 when health surveillance of workers cutting and polishing artificial stone benchtops in Queensland found that 12 of 35 workers from just two businesses had a severe and rapidly progressive type of silicosis known as accelerated silicosis. By 5 December 2018, WorkCover Queensland had identified 66 cases from across the state. Worryingly, this number continues to rise and further cases have been reported in NSW and Victoria, where, due to the rapidly progressive nature of the condition leading to several cases of respiratory failure, lung transplantations have been required.

The cases have been identified in workers and stonemasons using artificial stone (also known as engineered, reconstituted or manufactured stone, and quartz conglomerate), which contain a high proportion of crystalline silica. Artificial stone is used to make kitchen, bathroom and laundry stone bench tops. Building and renovation of kitchens, bathrooms and laundries using artificial stone is widespread throughout Australia and New Zealand. Although the number of workers in the industry is currently unknown, the number of registered businesses undertaking kitchen benchtop manufacture in Queensland suggests there may be at least 1000 workers at risk of accelerated silicosis in that state alone. The number of workers across Australia and New Zealand who are at risk is significant.

Affected workers were using no precautions at all against dust inhalation and were dry-cutting the engineered stone both in the preparation factory and at the site of installation despite existing preventative regulatory provisions. A uniform feature in these patients was their rapid decline. Another concern was the fact that cases of silicosis were first detected in secondary care, suggesting that there were likely to be many more workers affected remaining undiagnosed throughout Australia.

This is not the only reported outbreak of occupational lung diseases (OLDs) in Australia. There are thousands of workers' lives at risk across Australia from accelerated silicosis and other OLDs. Cases of coal workers pneumoconiosis have been identified in Queensland since 2016. There have been many cases of asbestosis diagnosed in Australia and there are still about 650 cases of mesothelioma diagnosed nationally every year. There are many other types of OLDs, including dust diseases and occupational asthma. There are potential major costs to public hospitals from management of OLDs. When present in young people, these diseases may be difficult to diagnose and often require specialised respiratory diagnostic services such as lung biopsy. The cost of lung transplantation is borne by state and territory governments, albeit partially federally funded through the COAG Agreements.

[15] Hoy, Ryan F., et al. "Artificial stone-associated silicosis: a rapidly emerging occupational lung disease." *Occup Environ Med* 75.1 (2018): 3-5.

Consequently, prevention and identification of OLDs in its early stages is likely to reduce demands on the public hospital system. This situation requires a national response centred around the urgent establishment of a national OLDs registry to map cases across Australia.

The RACP recommends that the Australian Government:

- Provide sustained support and funding to establish a national occupational lung disease registry which is currently considered by COAG.

- Establish a national occupationally acquired respiratory disease surveillance and registry program.

End of Life

It is widely acknowledged that too often, end-of-life care is not meeting the needs of patients and their loved ones. If patients nearing the end of life are not identified and their needs and wishes are not respected, inappropriate and even harmful investigations and treatments may be provided in the last weeks, days or even hours of life.[16] This can increase or prolong suffering for the patient and cause distress for the families, carers and health professionals. There are several barriers to good end-of-life care, including systemic and cultural issues.[17]

Good end-of-life care is patient-centred, culturally appropriate, coordinated and focused on rational investigation, symptom management and de-prescribing. It involves early identification, assessment and treatment of pain and other symptoms, and enables patients nearing the end of their lives to live as well as possible, and without unnecessarily prolonging the dying process.[18] Well-designed and integrated end-of life care has also been demonstrated to be more cost-effective than other therapeutic strategies.[19]

The RACP recognises the important contribution of national palliative care[20] projects and welcomes the recent funding allocated to palliative care, namely through the *National Specialist Palliative Care and Advance Care Planning Advisory Services* project, the *Greater Choice for At Home Palliative Care Measure*, the new funding allocated to the National Palliative Care Projects grants initiative and, most recently, the Comprehensive Palliative Care in Aged Care package announced in the 2018-2019 budget. These measures will help to greatly improve quality, coordination and access to palliative care. However, we call on the Australian Government to commit to secure, long-term funding to facilitate progress in end-of-life workforce development and quality of care and ensure that national palliative care initiatives continue to be funded as part of mainstream health care.

To ensure that these investments lead to sustained improvement in end-of-life care, it is imperative that all state and territory governments endorse palliative care and end-of-life care as a key priority for the COAG Health Council agenda. As palliative care spans multiple sectors, including health, aged care, community care, disability care and mental health, endorsement from COAG will be important to improve access to palliative care across a range of settings in accordance with consumer-directed care.

It is crucial that adequate resources are allocated towards supporting patients wishing to die at home, in a hospice or in a residential aged care facility. The RACP calls on the Australian Government to support the development of population-based, integrated models of care that improve the provision of palliative care services in non-hospital settings.

The RACP recommends that the Australian Government:

[16] Cardona-Morel, M, Kim, JHC, et al, 'Non-beneficial treatment in hospital at the end of life', International Journal for Quality in Health Care, 2016
[17] Hawley, P, 'Barriers to Access to Palliative Care', Palliat Care 2017
[18] Australian and New Zealand Society of Palliative Medicine, Position Statement on quality end-of-life care, 2017
[19] Smith, S, Brick, A, Evidence on the Cost and Cost-Effectiveness of Palliative Care: A Literature Review, Palliat Med, 2014
[20] Palliative care is a subset of end-of-life care; however, not all palliative care deals with end-of-life cases.

- Provide secure, long-term funding to improve the volume, co-ordination of and delivery of community specialist palliative care services across the life span (including paediatric palliative care services), in ways which support integration with hospital services and are delivered in conjunction with equitable access to flexible and rapidly responsive social and community services.

- Commit to secure, long-term funding to develop and implement models of care which improve the availability of palliative and supportive care services, with a particular focus on non-cancer services in hospitals and in non-hospital settings such as residential aged care facilities, in people's homes and in rural and remote communities and among other underserviced populations.
- Substantially expand the Comprehensive Palliative Care in Aged Care package to fund additional specialist doctors and nurses across Australia to meet the unmet needs of patients who would benefit clinically from the delivery of high-quality palliative and end-of-life services in residential aged care settings.
- Endorse population-based palliative and supportive care, including end-of-life care, as a COAG priority.

Obesity

The growing rate of obesity in Australia is an issue of serious concern. Obesity is associated with a range of health problems and consequences, including many non-communicable diseases such as cardiovascular disease, type II diabetes, and high blood pressure.

Physicians and paediatricians see patients and families every day who are struggling with obesity and related health conditions. They understand that these conditions are influenced by unhealthy diets and low physical activity driven by our obesogenic environment[21]. People suffering from obesity are entitled to receive the same standard of care, but unfortunately this is often not the case, and stigmatisation of these patients only exacerbates the issue.

Both prevention and treatment of obesity are urgent priorities. Since 1980, obesity rates have nearly doubled in Australia. In 1980, 15% of Australian adults over 20 years were obese; by 2013, obesity rates for adults over 20 years of age had increased to 28%. Trends are replicated for children and young people under 20 years: in Australia in 1980, 3.5% of children had obesity, increasing to 7% in 2013.[22] An Access Economics report quoted by the Australian Bureau of Statistics estimated that in 2008, the total annual cost of obesity to Australia, including health system costs, loss of productivity costs and carer costs, was around $58 billion.[23]

The National Health and Medical Research Council's clinical practice guidelines published in 2013 states that for adults, "bariatric surgery is currently the most effective intervention for severe obesity". In 2012, a prospective cohort study of over 49,000 Australians suffering from obesity stated that their "findings suggest that bariatric surgery, an MBS-listed procedure, is currently largely available only to those who can afford private health insurance and the associated out-of-pocket costs, with poor access to these cost-effective procedures in the section of the population that is most in need" and that "continuing inequity in access is likely to exacerbate existing inequalities in obesity and related health problems".[24]

[21] The obesogenic environment can be defined as "the sum of influences that the surroundings, opportunities or conditions of life have on promoting obesity in individuals or populations." Lake A, Townshend T. Obesogenic environments: exploring the built and food environments. J R Soc Promot Health. 2006;126(6):262-7.

[22] Global Burden of Disease 2013 Obesity Collaboration; Ng M, Fleming T, Robinson M, Thomson B, Graetz N, Margono C. Global, regional and national prevalence of overweight and obesity in children and adults 1980-2013: A systemic analysis. Lancet [Internet] 2014; 384(9945):766-78 http://condor.depaul.edu/bsykes1/Publications_files/Obesity_Lancet_2014.pdf

[23] Access Economics, 2008, The Growing Cost of Obesity in 2008: Three Years On, Diabetes Australia, Canberra, https://static.diabetesaustralia.com.au/s/fileassets/diabetes-australia/7b855650-e129-4499-a371-c7932f8cc38d.pdf

[24] Korda, R. J., Joshy, G., Jorm, L. R., Butler, J. R., & Banks, E. (2012). Inequalities in bariatric surgery in Australia: findings from 49 364 obese participants in a prospective cohort study. *The Medical journal of Australia*, *197*(11), 631-636.

The RACP's *Position Statement Action to prevent obesity and reduce its impact across the life course*[25] and accompanying Evidence Review[26] call on the Australian Government to lead a concerted effort address the many causes and complications of obesity with the development of a comprehensive, evidence-based national strategy to address obesity being an urgent priority. Such a strategy must contain measures to address factors including, but not limited to, challenging and changing societal and cultural norms; food and physical activity environments; the availability, affordability and marketing of energy-dense, nutrient-poor foods and beverages; individual behaviours and biological factors.

An obesity strategy must address the contribution of sugary drinks to obesity. Sugary drinks have been directly linked to weight gain and obesity. Many countries and regions including Mexico, France, and Belgium, have already implemented a tax on sugary drinks whilst other countries including the UK, Ireland and Portugal rolled out a tax in 2018. The evidence to date has shown that taxes on sugary drinks are an effective mechanism to reduce consumption of these drinks and encourage manufacturers to reformulate their products. Revenue generated by the implementation of a sugar-sweetened beverage tax should facilitate access to healthy diets, culturally relevant, community initiatives and improve health equity.

Considering the above, the RACP commends the important commitment made by the COAG Health Ministers in October 2018 to develop a national strategy on obesity with a 'strong focus on the primary and secondary prevention measures, social determinants of health, especially in relation to early childhood and rural and regional issues'.[27]

The RACP recommends that the Australian Government:

- Prioritise obesity prevention by:
    - Implementing an effective tax on sugar-sweetened beverages to reduce consumption and using generated revenue to facilitate access to healthy diets and culturally relevant initiatives to improve health equity.
    - Committing appropriate funding to develop and implement the national strategy on obesity recently announced by COAG which would focus on primary and secondary prevention and social determinants of health, especially in relation to early childhood and rural and regional issues and would do so over an extended period.
    - Establishing a national taskforce including sustained funding, regular and ongoing monitoring and evaluation of key measures and regular reporting on targets. This recommendation is aligned with a recommendation of the December 2018 final report of the Select Senate Committee on the obesity epidemic in Australia.
    - Committing to secure, long-term funding for evidence-based prevention measures for overweight and obesity and ensuring primary prevention interventions focus on those most affected by overweight and obesity.
    - Allocating funding to the development, implementation, update and monitoring of comprehensive and consistent national guidelines on diet, physical activity and weight management, with a focus on critical periods in the life course.

- Provide hospital funding to state and territory governments specifically geared towards delivering equitable access to bariatric surgery for public hospital patients.

Preventative Health Agency

The need for nationally coordinated preventative health measures has never been greater. The increasing pressures on the Australian health system caused by burden of chronic disease are

[25] The Royal Australasian College of Physicians (RACP) (2018), *Position Statement Action to prevent obesity and reduce its impact across the life course*. https://www.racp.edu.au/docs/default-source/advocacy-library/racp-obesity-position-statement.pdf
[26] Ibid.
[27] COAG Health Council Communiqué 12 October 2018.

widely recognised as Australia faces significant and growing problems with potentially preventable disorders such as obesity, diabetes and cardiovascular conditions due to factors such as smoking, sedentary lives, unhealthy diet and alcohol misuse. Approximately 31% of Australia's total burden of disease can be attributed to modifiable risk factors.[28]

There is inconvertible evidence that long-term, sustained and targeted preventative health measures are highly effective. Some approaches promote health and cut overall costs because of the reduced need to treat expensive diseases; others allow Australians to live longer and better-quality lives at a reasonable cost to the system.[29]

In 2016-17, Australia spent nearly $181 billion on health, 69% of it funded by Australian governments.[30] However, in recent years it was estimated that Australia spent only an overall $2 billion or $89 a year per person on prevention. This amounts to a mere 1.34% of all health spending, considerably less than the UK, NZ and Canada.[31] Many people are missing out on access to prevention, early detection and quality care, with the expanding needs of Indigenous Australians, people in rural and remote areas, people with mental health issues and the growing cohort of older Australians – to name a few – presenting urgent and cumulative challenges to health and welfare systems.

The current piecemeal, reactive response to preventable public health crises is leaving many Australians behind. To successfully deal with the escalating public health challenges, Australia needs a national health body dedicated to planning, strategic investment and leading the implementation of a coordinated, evidence-based public health agenda for the whole of Australia. This Australian Government-led independent body would have a clear nationwide remit to define long-term strategic goals and coordinate and scale up all relevant preventative health action across jurisdictions and partnered research institutes, universities and non-government organisations.

In addition to setting national preventative health priorities, the agency would advise on the most effective and cost-effective ways to implement and fund them, as well as evaluating progress based on need and evidence. A key role of the agency would be to identify the most appropriate government jurisdiction and who should take responsibility for and be held accountable for the delivery of outcomes.

To ensure its effectiveness, the agency and its work of health prevention must be appropriately resourced over a sustained period. While the exact design and funding model for the agency remain to be decided, it is clear that to deal with the increased burden of preventable health disease in our country, Australia must significantly increase our spending on prevention.

The RACP recommends that the Australian Government:

- Prioritise prevention by re-establishing a national preventative health body to set nationwide goals, directs strategic investment, coordinate implementation of initiatives and evaluate the evidence for the cost-effectiveness of population-wide preventative health interventions.

Alcohol and Other Drugs

Alcohol Taxation

[28] AIHW Australian Burden of Disease Study: impact and causes of illness and death in Australia 2011, https://www.aihw.gov.au/getmedia/d4df9251-c4b6-452f-a877-8370b6124219/19663.pdf.aspx?inline=true

[29] Jackson H, Shiell A. (2017) *Preventive health: How much does Australia spend and is it enough?* Canberra: Foundation for Alcohol Research and Education., p.8 http://fare.org.au/wp-content/uploads/Preventive-health-How-much-does-Australia-spend-and-is-it-enough_FINAL.pdf

[30] Australian Institute of Health and Welfare (2018), Health expenditure Australia 2016-17

[31] Jackson, Shiell, Preventive health, p.7. https://www.aihw.gov.au/getmedia/e8d37b7d-2b52-4662-a85f-01eb176f6844/aihw-hwe-74.pdf.aspx?inline=true

Alcohol-related harms create enormous social and economic costs to Australian society, with estimates putting the figure at between $15 billion and $36 billion annually.[32] This is a cost of between $625 and $1500 per person per year. These costs vastly outweigh the amount of taxation revenue generated from alcohol sales, which is approximately $6 billion a year.[33] In effect, Australian taxpayers are subsidising the harms that result from risky alcohol consumption.

These harms take many different forms, with alcohol being a causal factor in more than 200 disease and injury conditions. Adolescents are at particular risk due to alcohol's proven impact on the development of the brain during adolescence and the tendency of young people to combine drinking with high risk activities, increasing their risk of alcohol-related injury, illness, and death.[34] Cheap alcohol contributes disproportionately to alcohol-related harms, given its affordability and availability to vulnerable groups such as adolescents and people with or at risk of alcohol dependence.

Pricing measures have been shown to be the most effective, evidence-based measures for reducing risky alcohol consumption. Taxation reform provides an opportunity for the Australian Government to reduce alcohol-related harms by simultaneously limiting the availability of cheap alcohol to vulnerable groups and by raising revenue to support investment in prevention and treatment of alcohol-use disorders.

A nationally consistent, volumetric tax on alcohol products is required to replace the current system. This should include abolishing the Wine Equalisation Tax which, by taxing wine based on its wholesale value rather than alcohol content, encourages the production and consumption of cheap high-alcohol wines. This change has been recommended by numerous government reviews, including most recently, the Productivity Commission in its Five-Year Productivity Review.[35]

Recent research also demonstrates that a uniform volumetric tax on alcohol is the most cost-effective policy for preventing obesity.[36]This suggests that there are strong synergistic public health benefits from reducing alcohol consumption through volumetric taxation.

Alcohol and other Drug Treatment

There is a severe shortage of treatment services for individuals suffering with addiction to alcohol and other drugs. While approximately 200,000 Australians access treatment for substance dependency every year, it is estimated that a further 200,000 to 500,000 Australians requiring treatment are unable to access it.[37] Additional funding provided through the National Ice Action Strategy, while welcome, has not addressed the shortage of treatment services and did not adequately incorporate specialist expertise and input into the design and delivery of evidence-based treatment services.

Increased investment in evidence-based alcohol and other drug treatment services is crucial. Research indicates that for every dollar invested in alcohol and other drug treatment, society saves seven dollars[38]. Investing in alcohol and other drug treatment services clearly yields high returns. Treatment has been shown to reduce substance use and crime, while improving health, psychological wellbeing and social participation.

A proportion of the additional revenue raised through volumetric taxation should be hypothecated to the health budget to fund improved access to alcohol and other drug treatment services and harm prevention and minimisation programs.

[32] The Royal Australasian College of Physicians. Alcohol Policy, p11. Available at: https://www.racp.edu.au/docs/default-source/advocacy-library/pa-racp-ranzcp-alcohol-policy.pdf?sfvrsn=6.
[33] Alcohol Policy, p.17.
[34] Alcohol Policy, p. 28.
[35] Australian Productivity Commission, Shifting the Dial: 5-year productivity review, 2017
[36] Assessing Cost-effectiveness of Obesity Prevention Policies in Australia, ACE-obesity policy 2018.
[37] New Horizons: The review of alcohol and other drug treatment services in Australia, p. 13.
Available at: https://ndarc.med.unsw.edu.au/resource/new-horizons-review-alcohol-and-other-drug-treatment-services-australia.
[38] Ibid.

The RACP recommends that the Australian Government:

- Introduce a volumetric taxation system for all alcohol products and abolish the Wine Equalisation Tax (WET) and rebate.
- Allocate a proportion of the increased revenue raised from volumetric taxation to funding alcohol and other drug treatment and prevention services as part of a coordinated national response to alcohol and other drug use disorders.
- Substantially increase funding for alcohol and other drug treatment system reform, including for appropriate and multidisciplinary workforce development, capital works to improve the physical infrastructure and the development of appropriate needs-based planning models and suitable models of care to address unmet demand for treatment
- Increase funding for prevention services to reduce the incidence of alcohol and other drug use disorders.

Climate Change and Health

The RACP is part of a large and growing global network of health and medical organisations calling for urgent action on climate change, including other medical colleges, the World Health Organization, the World Medical Association, and the Lancet, to name but a few.

Australians are already suffering health impacts including higher rates of respiratory illness, diarrhoea and morbidity requiring hospital admission during hot days, and higher rates of suicide in rural areas during drought years. Unchecked, climate change will not only have serious impacts on human health, but will put pressure on healthcare personnel and delivery of healthcare services as a result of increasing frequency and intensity of extreme weather events.

In this respect, climate change can be regarded as a health emergency warranting urgent and decisive government action to address what will be a growing contribution to mortality and morbidity.[39]

Acting on climate change represents an opportunity to simultaneously reduce the harms and risks of climate change and improve health outcomes for Australians, our region and the world. The RACP calls on the Government to commit to developing and implementing a national climate and health strategy to reduce the risks to health and realise the health benefits of adaptation and mitigation. The strategy should be closely aligned with obesity-prevention and chronic disease-reduction efforts, such as incentivising fresh vegetable intake, reducing consumption of meat and processed food and cutting food waste will result in improved population-wide health and environmental outcomes.

We also call on the Australian Government continue to enable Pacific Island countries and territories to develop their medical workforce and support development of prevention/mitigation and response measures to climate change. The impact of severe weather events in the Pacific Islands including health impacts due to rising sea levels and biosecurity concerns will be of growing importance in the years to come.

Given that the core business of healthcare is to promote and protect human health, there is also an imperative for the health sector to reduce its own carbon emissions. The carbon footprint of the Australian health sector has been estimated at 7% of Australia's total, evidencing the need for effective measures to lower the impact of health-care services on the environment, including reducing its own carbon emissions.[40]

An environmentally sustainable healthcare system is one that has no cumulative harmful impacts on the natural environment or society, while providing high-quality healthcare. 'Green' initiatives such as improving energy efficiency and promoting recycling are important, but healthcare

[39] Solomon CG and RC LaRocque 2019. Climate Change — A Health Emergency. N Engl J Med 2019; 380:209-211
[40] Malik, A, Lenzen, M, et al, The carbon footprint of Australian health care, Lancet, 2018. https://www.thelancet.com/journals/lanplh/article/PIIS2542-5196(17)30180-8/fulltext

organisations need to act more broadly to reduce carbon and resource use by developing integrated models of care, strengthening primary care, and optimising use of new technologies.

We note that there are other recommendations in this submission that will also have positive environmental benefits as well as health benefits. This reinforces the case for a whole-of-government approach which can take account of health and environmental interdependencies.

The RACP recommends that the Australian Government:

- Establish a national healthcare environmental sustainability unit. The unit would draw on local best practice as well as leading international models, such as the Sustainable Development Unit in the UK. The first tasks of the unit would be to:
    - consult with stakeholders
    - establish appropriate metrics and measure the total carbon footprint of the health sector in Australia
    - work with health stakeholders to develop an environmental sustainability strategy and
    - support health services to implement the strategy.

- Develop a national climate change and health strategy for Australia, including meaningful mitigation and adaptation targets, effective governance arrangements, professional and community education, effective intergovernmental collaboration, and a strong research capacity.

Refugee and Asylum Seeker Health

People who are seeking asylum in Australia (those who arrive by boat and plane) have previously received support from the Status Resolution Support Service (SRSS). The program provides a basic living allowance (typically 89% of Newstart allowance, or approximately $250 per week), casework support and access to torture and trauma counselling. In 2018, the Australian Department of Home Affairs changed the eligibility criteria for the program to make it far more restrictive. The plan was to reduce the number of people receiving assistance through the program from 13,299 (as of February 2018) to fewer than 5,000.

From August 2018, the first group of asylum seekers who were now deemed to be ineligible from the SRSS funding had their payments cease. The plan to continue reducing the number of people eligible means that there will be a 60% reduction in the program. Of the 13,299 people who were previously in the program, 4,059, or one third, are children. The removal of this support will impact harshly on those who are most vulnerable. A Refugee Council of Australia (RCOA) survey of asylum seeker support organisations found almost four in five (79%) people on the payment were likely to face homelessness if they were no longer eligible for SRSS. A cost-analysis detailed in the report found these cuts would cost state governments between $80 and $120 million a year, with significant extra costs in health, corrections and homelessness services.

This policy is entirely within the discretion of the Minister and does not require Cabinet approval or legislative change to reverse. In the context of the overall budget, the savings appear to be relatively minor.

The RACP recommends that the Australian Government:

- Immediately reinstate the Status Resolution Support Service payments to those asylum seekers who have been removed from the program due to changes in eligibility criteria in 2018.

- Reverse the changes to the eligibility criteria and discontinue the removal of people already accessing the program.