

Australian Medical Association
Pre-Budget Submission
2020-21



AMA

Health – the best investment that governments can make

INTRODUCTION



Time for Australia to significantly increase recurrent spending on health

According to the most recent OECD data, Australia's current health expenditure as a proportion of gross domestic product (GDP) is 9.3 per cent spent. The USA is 16.9 per cent, and the UK is 9.8 per cent. We do not want to pursue either of those models of care.

As a nation, we love brand Medicare. We love the idea of universal free access to public hospitals.

Australia is often compared to Canada, which spends 10.7 per cent of its GDP on health care. Many look to Europe for inspiration in health reform. Denmark spends 10.5, Switzerland spends 12.2, while both France and Germany spend 11.2 per cent.

Whenever the AMA or others raise the need for more investment in health, the response of Health Ministers around the country is the same: "Record spending in health!" Yet the record spending claim is a result of a population that is growing larger and older, and getting sicker with rising rates of chronic disease.

Yet no Health Minister has ever said funding levels have been set to meet the actual cost of care delivery matched to growing population demand. The health system makes do with what it receives, rather than being funded to the level it needs.

With comparable countries spending more on health care than Australia, it's time the funders of our own healthcare system took stock. We need the right settings and appropriate funding to match our growing and ageing population with its complex needs.

So, with this submission, the AMA is calling on the Australian Government to do the right thing by the Australian people and dramatically lift spending on health – not just a one-off, but an increased share of GDP every year. Failure to lift funding appropriately will condemn Australians to less than the achievable health outcomes they deserve and expect.

The AMA formally calls on the Government to lift health spending from its current level of 9.3 per cent to a level in line with averages of comparable countries.

The Australian health system deserves no less. Health is the best investment that governments can make.



Dr Tony Bartone
President

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1

HEALTH CARE FOR OLDER AUSTRALIANS

Older Australians all too frequently do not have the same access to health care as other age groups - a longstanding result of inadequate funding and coordination in the aged care and health systems.

This inequity will likely only grow as the Australian population ages, with more complex and chronic medical conditions. Australia's population of people aged 65 and over will increase from 3.8 million in 2017 to 8.8 million by 2057¹.

Chronic condition rates and their risk factors continue to rise². This population group will require more medical attention than ever before, and we need to improve the system to cope with this demand.

The Royal Commission into Aged Care Quality and Safety has confirmed that Australia is experiencing an aged care crisis, with widespread abuse and neglect. However, to many this is not a surprise. The interim report has reaffirmed what was concluded via numerous reviews, consultations, and inquires over the past few years. The Government response to date, while welcome, remains far too little.

Older Australians contributed to our society for decades and, so far, we have abandoned them to an underfunded, unsafe, poor quality aged care system. Our parents, grandparents, family and friends deserve better.

There are several factors that contribute to poor quality care. However, many quality issues could be rectified by improving the capacity and capability of the aged care workforce. There is substantial evidence that links staffing numbers to the quality of care received^{3,4,5}.

We need to ensure that the critical role registered nurses play in caring for older Australians is recognised via minimum standards for registered nursing availability under staff ratios in residential aged care facilities (RACFs). The proportion of nurses is in decline in RACFs while the proportion of undertrained personal care attendants is increasing⁶. A 37.2 per cent increase in staffing is needed to reach minimally acceptable staffing standards⁷.

1 Australian Institute of Health and Welfare (2018) *Older Australia at a glance*.

2 Australian Institute of Health and Welfare (2018) *Australia's health 2018. Chapter 3.3: Chronic conditions*

3 Henderson et al (2016) *Missed care in residential aged care in Australia: An exploratory study* Collegian

4 Dellefield, M et al (2015) *The relationship between registered nurses and nursing home quality: an integrative review (2008-2014)* Nursing Economics. 33:2, Pages 95-108

5 Castle, N and Engberg, J (2005) *Staff turnover and quality of care in nursing homes* Medical Care. 43:6

6 Mavromaras et al (2017) *The aged care workforce, 2016*. Department of Health

7 Royal Commission into Aged Care Quality and Safety (2019) *How Australian residential aged care staffing levels compare with international benchmarks*.

HEALTH CARE FOR OLDER AUSTRALIANS

Australia's aged care system must support independence and healthy ageing. Older people must be supported to stay at home for as long as is appropriate to prevent early admission to RACFs or the hospital. The almost 120,000 older Australians waiting for home care packages is unacceptable. Older Australians have waited long enough. In a single year, 16,000 older Australians died waiting for a home care package⁸. This is an indicator of the Government's ageist and neglectful approach to older Australians.

The Department of Health has reported that for older people to never wait more than three months for a home care package, it will cost \$2-2.5 billion per year⁹. This is a worthwhile investment that produces savings by preventing more expensive RACF or hospital care.

Aged Care Funding Instrument data show that residents' care needs are increasing over time¹⁰ as people enter RACFs later in life with more complex medical conditions. While this implies a higher demand on doctor services, Medicare rebates for doctor visits to RACFs do not reflect the increasing medical complexity of the residents.

The 2017 AMA Aged Care Survey identified that one in three respondents (doctors) intend to visit current patients but not new patients, decrease the number of visits, or stop visiting RACFs entirely over the next two years¹¹. Respondents cited inadequate Medicare rebates as a reason to decrease their RACF visits.

An increase in funding for GP visits to RACFs can improve access to primary care and would result in savings from reduced ambulance transfers and hospital emergency department (ED) presentations. ED presentations, including ambulance costs, from permanent RACF residents, equates to approximately \$92 million in a year. Many of these presentations are preventable through high-quality primary and community care services. When comparing this expense to a \$94 Medicare rebate for one GP RACF attendance, to a potentially \$800 dollar ambulance call out, investing in primary care makes economic sense.

While the \$98 million additional GP funding via MYEFO 2018 funding was supported, it leaves GPs who treat a large number of patients in a single RACF financially worse-off than before the MYEFO change. Considering the benefits a usual GP brings to their patient, we need to encourage GPs to see more RACF patients, not less. MYEFO 2018 made a start, but much more is needed.

8 Royal Commission into Aged Care Quality and Safety (2019) *Transcript of Proceedings—22 March 2019* Page

9 COTA (2019) *COTA Australia federal election statement*.

10 Australian Institute of Health and Welfare (2018) *Explore people's care needs in aged care*.

11 Australian Medical Association (2017) *2017 AMA Aged Care Survey Report* Page 30

AMA POSITION

The AMA calls on the Government to:

- stop the abuse and neglect of older people through enhanced quality and safety by increasing overall investment in aged care;
- introduce mandatory minimum staff to resident ratios that reflect the level of care needs and ensures 24-hour, on-site, availability of registered nurses;
- prevent older people from prematurely entering RACFs and hospitals by increasing the number of home care packages to reduce waiting times;
- act on the results of the AMA aged care survey by significantly increasing Medicare rebates by at least 50 per cent - \$500 million over four years (on top of announcements in MYEFO 2018) for services in RACFs so that they adequately cover the time that doctors spend with the patient assessing and diagnosing their condition and providing medical care;
- take responsibility to ensure quality of, and timely access to, specialist support and allied health in all aged care settings. This includes palliative care, mental health care, physiotherapy, audiometry, dentistry, optometry, and occupational therapy;
- provide better funding support for services being delivered on site (such as mobile radiology services), which can save on costly hospital transfers; and
- introduce new telehealth Medicare items that compensate GPs, and other medical specialists, for the time spent organising and coordinating services for the patient, and the time that they spend with the patient's family and carers to plan and manage the patient's care and treatment.

2

GENERAL PRACTICE AND PRIMARY CARE

Primary health care (PHC) is the front line of the healthcare system and usually the first level of contact for individuals, the family, and the community with the health system.

General practice is the cornerstone of successful primary health care, which underpins population health outcomes and is key to ensuring we have a high-quality, equitable, and sustainable health system into the future.

GPs have a profound influence on both health outcomes and health expenditures. It is estimated that primary health care professionals control or influence approximately 80 per cent of health care costs, which means that they have an important role to play in ensuring that health expenditure remains sustainable.

To ensure that general practice is equipped to meet the challenges of providing care to an ageing population and the growing burden of complex and chronic disease, the Commonwealth needs to deliver real resources to frontline GP services.

Spending on general practice services currently represents around eight per cent of total Government spending on health, and this proportion has remained relatively stable despite a growing workload.

The AMA believes this figure should be lifted, over time, to around 10 per cent as part of an effort to re-orientate the health system to focus more on general practice, with long-term savings to the health system anticipated in return.

AMA POSITION

The AMA calls on the Government to:

- **progressively extend its over 70s voluntary enrolment program to cover the entire population, with the next step being the voluntary enrolment of children who are 5 years old and under;**
- **increase support for longer GP consultations through the introduction of an 'extended' Level B MBS consultation item that recognises the extra work involved for those GPs who spend more time with their patients;**
- **improve access to after-hours GP services for patients by bringing forward the Medicare definition of after-hours in-rooms consultation items so that they commence at 6.00pm on weeknights and 12 noon on a Saturday;**

GENERAL PRACTICE AND PRIMARY CARE

- **introduce specific MBS rebates for GP telehealth consultations provided by a patient's usual GP for:**
 - + **after-hours services,**
 - + **patients with a GP Management Plan,**
 - + **patients with mobility problems, and**
 - + **patients in residential aged care facilities;**
- **support patients with hard-to-heal wounds by funding the costs of dressings for patients who:**
 - + **have a diabetic foot ulcer or diabetic leg ulcer; or**
 - + **have a venous or arterial leg ulcer; or**
 - + **are 65 years of age and over; and**
- **support enhanced access to GP-led team-based care for patients by lifting the caps on subsidies available through the incoming Workforce Incentive Program, better supporting the employment of nurses, pharmacists, and allied health professionals in general practice.**

LONG-TERM CHANGE

While the previous measures will provide much-needed support for general practice in the short term, a long-term funding plan is required to transform general practices into high performing patient-centred medical homes.

This transformation is necessary to ensure general practice can rise to the challenge of delivering quality care - which is patient-centred and cost effective, and which will reduce patients' need for more complex, high-cost health care - to patients, particularly to those with chronic disease or at risk of chronic disease.

The AMA calls on the Government to ensure that the ten year Primary Care Strategy that is currently under development includes co-designed initiatives that deliver more robust long-term funding model for general practice, building on existing fee-for-service arrangements and enabling patients to access improved care in the community.

Prevention is an integral part of a doctor's approach to 'whole-of-patient' health care.

General Practitioners are multi-skilled and highly trained professionals with expertise in caring for their patients. Increasingly, doctors are helping their patients manage chronic health conditions, many of which are preventable, with the right interventions, treatments, referrals, and management.

3

MENTAL HEALTH

Reforming the Australian mental health sector and addressing the Commonwealth-State/Territory divides over management and accountability is a long-term goal.

The AMA welcomes the draft report of the Productivity Commission Inquiry into Mental Health and sees this as an opportunity to address mental health services, workforce, and issues that impact on the mental health and well-being of Australians such as inequity and inequality, lack of access to services, family breakdown, pressures at school and workplace, housing, employment and cultural issues.

Innovation and a willingness to invest in new approaches has not always been properly supported by governments. The so-called 'missing middle' has been attributed to historic divisions of responsibilities: primary care in funded and overseen by the Commonwealth and acute care managed by states and territories. The latter have not always invested sufficiently in community-based mental health services and supports.

Those in need of mental health care often require a mixture of psychosocial and clinical care, but the gaps in services places additional pressure on GPs and the primary sector.

AMA POSITION

The AMA calls for specific investment in developing the capacity of primary care through funding mental health support services in GP clinics. This model has already been implemented the successful Mental Health Nurse Incentive Program (MHNIP).

Having an accredited mental health nurse, social worker or other suitably qualified mental health supports benefits patients through greater continuity of care, enhanced follow-up, timely access to support, and increased compliance with mental health treatment plans.

Investing in evidence-based nursing programs would deliver better outcomes for patients and build on existing service capacity by providing enhanced integration in the mental health system.

We need appropriate rebates to facilitate longer consultations and management of complex mental health issues.

Facilitating GP clinic access to mental health supports for their patients increases the ability of GPs to put mental and physical health and wellbeing at the heart of general practice.

4

PREVENTIVE HEALTH

Funding a mental health nurse (or other qualified person) within primary care ensures earlier intervention, allowing patients to access help before problems escalate to the point where they may require more intensive specialist mental health intervention.

Qualified and accredited mental health nurses are ideally positioned to assist GPs in managing the different needs of patients and will relieve pressure on other components of the health system. General Practitioners are at the forefront of health prevention. In 2014–15, 85 per cent of

Australians reported seeing a GP in the last 12 months, and there were more than two million GP visits every week, and there is an increase in the number of Australians using primary health services.

Australia currently spends about \$2 billion on prevention each year, equivalent to about \$89 per person. The spending on health prevention is estimated to be 1.34 per cent of the total Australian health spend.

This is significantly less than other countries expend. Although Australian governments allocate around the OECD average on health care (9.3 per cent of GDP, with the OECD average being around 9.0 per cent), they allocate for less on prevention than New Zealand, Canada, Netherlands, UK, and even the USA.

AMA POSITION

The AMA calls on the Government to set a target of 5 per cent of total health expenditure to be dedicated to health prevention. This would represent a sustained and substantial investment from the currently expenditure of about 1.3 per cent.

The AMA wants this increase to be accompanied by mechanisms to ensure funding is allocated appropriately and this increase will ensure multi-generational benefits and increased investment in health prevention must be consistently resourced, implemented, and independently evaluated and reported on.

5

PUBLIC HOSPITALS

Timely access to high quality public hospital diagnostics and treatments, irrespective of capacity to pay, is fundamental to a healthy productive Australian workforce and broader society.

Demand for public hospital services is driven by population growth, ageing, the prevalence of chronic disease and new technologies. The recent decline in the number of Australians who can afford private health insurance is also contributing to added pressure on public hospitals.

Our ageing population has a substantial impact on public hospital budgets. Australians aged 65 years or more account for roughly 16 per cent of the population¹² but this cohort utilises around 40 per cent of all public hospital admitted separations¹³. Not only are older people more likely to be admitted, the duration of their admission is 29 per cent longer compared to all other age cohorts¹⁴. Older people also present to emergency more frequently and are more likely than any other cohort to require urgent emergency care.

Chronic disease also drives demand. Approximately half of all Australians now have a chronic disease – many people have multiple chronic conditions¹⁵. Collectively, chronic conditions are estimated to account for 87 per cent of all deaths, 61 per cent of the total disease burden and 37 per cent of hospitalisations¹⁶.

The combined demand drivers will only continue to increase year on year and public hospital funding must rise beyond current levels to match.

AIHW waiting list data suggests public hospitals are already close to breaking point. In 2017-18, **more than one million patients** who presented to a public hospital emergency department in need of urgent treatment waited longer than clinically recommended¹⁷.

Emergency departments are struggling to manage over-crowding and bed block is delaying the transfer of very sick patients to appropriately staffed in-patient ward beds for ongoing care.

The result is ambulance ramping and delayed patient treatment which threatens the safety and quality of patient care and diverts valuable emergency staff and resources away from patients still waiting for emergency treatment.

¹² ABS Australian Demographic Statistics June 2018, Publication 3101, Table 7

¹³ AIHW Australian Hospital Statistics: Admitted Patient Care 2016-17 and ABS Australian Demographic Statistics June 2018, Publication 3101.0, Table 59

¹⁴ AIHW Admitted Patient Care 2016-17, Data tables, Table 3.1: Separations and patient days, by age group and sex, all hospitals, 2016-17

¹⁵ AIHW Australia's Health in Brief 2018, p8

¹⁶ AIHW Australia's Health in Brief 2018 p13

¹⁷ AIHW Australian Hospital Statistics: Emergency Department Care 2017-18, Table S5.1: Emergency presentation(a) statistics by public hospital peer group and triage category, public hospital emergency departments, states and territories, 2017-18

PUBLIC HOSPITALS

Public patients are also waiting too long for elective surgery. In 2017-18, the median waiting time for elective surgery (all categories) increased again – the worst performance against this measure since 2001-02¹⁸. The same AIHW data showed slow to negative growth in public hospital elective surgeries per 1,000 population¹⁹, suggesting patients are not only waiting too long to get onto public hospital waiting lists, access to public hospital elective surgery is becoming more difficult. This is not the sign of an equitable health system.

The consequences of delayed emergency and elective surgery includes increased deaths, increased complications, delayed care, overdue pain relief, and longer length of stay.

Public hospital operating budgets dominated by staffing costs, new technology costs and the high cost of treating an older and sicker patient cohort, will only continue. In 2017-18, Commonwealth public hospital funding increased by just 2.1 per cent - a growth rate that covers input cost growth and increased service volume to meet demand. This rate of funding growth is well below the decade average of 3.9 per cent²⁰ and well below the funding levels public hospitals need to cover real operating cost increases *and* service volume increases necessary to meet public hospital demand.

Public hospital doctors, nurses, and other staff are working hard to optimise admitted patient throughput. Australia already has one of the lowest admitted patient length-of-stay in the OECD.

With admitted patient length-of-stay already very low, the next round of new efficiencies will be extremely difficult for public hospitals to achieve unless they receive new and substantial funding injections to clear waiting lists, address over-crowding, and start the digital transformation required to deliver data-driven innovation and optimum health outcomes at an efficient cost. This transition will take time and will cost much more than public hospitals can carve out of already under-funded, over-stretched public hospital operating budgets.

18 AIHW elective surgery data cubes (2001-02 to 2006-07); AIHW Australian Hospital Statistics: Elective Surgery Waiting Times (2007-08 to 2017-18)

19 AIHW Australian Hospital Statistics: Elective Surgery Waiting times 2017-18, Table 2.4

20 AIHW Health Expenditure 2018-19, table A10

PUBLIC HOSPITALS

AMA POSITION

The AMA calls on the Government to:

- **boost the Commonwealth's share of public hospital funding to 50 per cent to:**
 - + **support public hospitals meet demand and reduce waiting lists;**
 - + **lift public hospitals out of their current funding crisis, which is putting doctors and patients at risk.**
- **index Commonwealth contributions to public hospitals so public hospitals can afford to pay staffing costs, new technology and still treat older, sicker patients without constraining the supply of public hospital services relative to demand;**
- **commit an explicit ongoing Commonwealth contribution to public hospital innovation, beyond the activity-based formula, to finance the work required by public hospitals to make the digital transformation needed to achieve the next level of optimum health outcomes at an efficient cost;**
- **stop financially penalising public hospitals for adverse patient safety events – it cuts public hospital budgets and makes it even more difficult for hospitals to fund the changes to hospital systems necessary to improve the quality of patient care; and**
- **commit an explicit ongoing Commonwealth contribution above and beyond the activity-based formula, to fund the obligations on jurisdictions to deliver integrated care post discharge to prevent avoidable re-admissions.**

6

PRIVATE HEALTH INSURANCE (PHI)

The AMA believes in an affordable private health insurance system that delivers value to its customers. The AMA has long contended that, without the private system, the public system would be inundated.

The Government's recent reforms have delivered a greater level of certainty and transparency, but they did not address affordability or value. As a result, an increasing number of younger and healthy Australians are opting out of private health insurance. With the pressures of high mortgages and low wage growth, PHI is fast losing its relevance as a necessity, and becoming a luxury they can't afford.

At the same time, older people (especially those aged over 75) see good value in PHI and they are taking up policies in increasing numbers. The result is a higher proportion of older patients who are increasingly more likely to be suffering from illness or chronic disease and, as a result, are more expensive to insure, further driving up premiums.

Without any other change in rates of membership, government policy, or underlying costs, premiums will rise by 0.6 percent per annum due to the increased share of older members as the population ages.

The situation can, and is, being made worse still by the younger members dropping cover and older members taking up cover. This change in membership drove up premiums by an estimated 3.1 percent from 2015 to 2018. Combined, these two factors increased premiums by approximately 5 percent over this period. This trend is not sustainable.

The Government must work closely with the medical profession, health insurers, and private health providers to ensure that private health insurance provides better cover, increased transparency, and greater value. This includes better regulation of private health insurance, consideration of new models of care, better value for money, as well as the below specific initiatives.

Lifetime health cover penalty age

Raising the Lifetime Health Cover penalty loading age from 30 to 35 would line up the decision age of whether to join PHI to a time when people have the income to afford premiums.

The AMA estimates that there are currently 312,798 policy holders paying an average loading of 5.5 percent across the age cohort. The cumulative amount of this loading is 17,288 policy premiums. This is paid by current loadings on people that entered PHI between the age of 31 and 35. There would need to be an increase of approximately 33,000 PHI members aged 30-34 years (a 1.7 percent increase in the share of the 1.94 million Australians aged 30-34 in 2019) to immediately offset this revenue loss. But any additional members that join over this period will continue to be a net contributor to PHI over the coming decades.

The AMA estimates that the additional rebate would equate to approximately \$17 million for a 1.7 percent membership increase.

PRIVATE HEALTH INSURANCE (PHI)

Medicare Levy Surcharge

The Medicare Levy Surcharge (MLS) was introduced in 2000 at 1 percent of income for people earning \$50,000 (the top marginal income tax bracket). Currently, the threshold is \$90,000 which is close to average weekly earnings and now represents the middle of the tax brackets. The future tax structure has fewer brackets, so an MLS that lines up in both thresholds and tax proportions makes sense.

In 2000, an entry level policy could be purchased for approximately 1 percent of the \$50,000 threshold. Currently, even at the Tier 2 rate of 1.25 percent for someone on \$105,001, this incentive does not generate much difference between how much you currently pay for a health insurance policy versus paying the surcharge. Any change in this policy would also require further analysis from Treasury.

Youth Discount

The government 'Youth Discount' allows insurers to offer premium discounts on hospital cover to a maximum of 10 per cent for 18 to 25-year-olds. If we were to increase the age of LHC loading from 30 to something like 35, it would make sense to extend the age at which the 'youth discount' applies to line up for consistency.

The cost of the program would be driven by the current number of members who are in the 25-34 years-old bracket, multiplied by 1 percent for 26-year-olds, increasing to 5 percent for 30 year-olds, and again reducing to 1 percent through to 34 year-old (across the 10-year discount period). Additional members in these ages would increase net premium revenue by substantially more than the discount offered to them.

Private Health Insurance Rebate (for hospital products)

Most Australians with private health insurance are eligible for some level of rebate to help cover the cost of their premiums. Introduced at 30 percent, the rebate is now means tested so that the average rebate has fallen to 25.3 percent of premiums in 2017-18 across all age cohorts and income tiers, and by 2019-20 for people under 65 it will be down to 24.7 percent. Restoring the rebate for younger and lower income workers will increase the affordability of health insurance.

If the membership rate was to increase by 5 per cent for Australians in under 65 cohorts, this would add a further \$415 million to the cost of the rebate. It would add an additional 675,000 paying members and add approximately \$1.5 billion in additional premium revenue.

PRIVATE HEALTH INSURANCE (PHI)

Minimum Payout levels

For-profit health insurers receive significant taxpayer contributions, and the AMA's reforms indicate that more may be needed to deal with an increasingly complex, ageing population who require health treatments.

There is clearly a need to ensure that these funds, along with people's hard-earned premiums, go to the provision of quality health care. Therefore, private health insurers should be made to return a **minimum** proportion of benefits to members, and not increase their profit taking.

If the current payout ratio, which varies from high 70 per cent to in excess of 90 per cent were to be lifted to a stable, minimum 90 per cent across the industry, in the first instance, this would lower premiums across the board by 2 per cent. It would also encourage all funds to be more efficient in the way they run their businesses.

AMA POSITION

The AMA calls on the Government to:

- **fully examine the current impact of the complex policy arrangements supporting private health insurance and determine whether the Lifetime Health Cover and Medicare Levy Surcharge levels should be adjusted to match the changes in demographics and wage growth;**
- **to increase the number of younger people maintaining or taking up health insurance, extend the current 'Youth Discount' Program;**
- **maintain the affordability of private health insurance through targeted changes to the Private Health Insurance rebate for hospital cover;**
- **put in place a minimum benefit payout from insurance funds to ensure that premiums go to health services, not to costly administration charges or profit taking;**
- **investigate further reforms to ensure better value for money, while also considering models of care in lower cost environments with the aim of reducing the cost of providing health care while maintaining clinical independence; and**
- **create an independent body with adequate resources to regulate the private health insurance sector.**

7

INDIGENOUS HEALTH

Over recent years, there have been some modest health gains for Aboriginal and Torres Strait Islander people, notably, the reductions in rates of child mortality and smoking. Despite this progress, the life expectancy gap between Aboriginal and Torres Strait Islander people and other Australians is still significant.

Chronic diseases are a primary contributor to the life expectancy gap between Indigenous and non-Indigenous Australians, many of which, stem from the social determinants of health - poverty; unhygienic, overcrowded living conditions; poor food security and access to safe drinking water; lack of transport; as well as an absence of health services.

To make any significant progress in improving health and life outcomes for Aboriginal and Torres Strait Islander people, these social determinants must be addressed. This should be done through culturally appropriate programs that are responsive to the needs of Aboriginal and Torres Strait Islander communities.

The 2020-21 Budget presents an opportunity for the Government to translate available knowledge into action, including identifying and filling service gaps, and directing Indigenous health funding according to need. This is particularly important given that the burden of disease for the Aboriginal and Torres Strait Islander population is 2.3 times higher than for other Australians.

AMA POSITION

The AMA calls on the Government to:

- **allocate Indigenous health funding in the 2019-20 budget based on the much higher health needs of Indigenous communities, recognising that chronic disease is inextricably connected to the social determinants of health; and**
- **implement the recommendations of the AMA's recent Report Cards on Indigenous Health, in particular:**
 - + **commit to achieving a minimum standard of 90 per cent population access to fluoridated water;**
 - + **systematically identify, cost and fund unimplemented parts of the national Aboriginal and Torres Strait Islander Health Plan 2013-2023;**
 - + **implement a coordinated national response to address chronic otitis media in Indigenous communities;**
 - + **fund and implement a strategy to eradicate rheumatic heart disease from Australia; and**
 - + **appropriately fund services that divert Aboriginal and Torres Strait Islander people from prison.**

8**RURAL HEALTH**

For too many years, regional, rural, and remote Australians have been treated like second class citizens when it comes to the provision of essential services. They often struggle to access health services that urban Australians would see as a basic right. These inequalities mean that they have lower life expectancy, worse outcomes on leading indicators of health, and poorer access to care compared to people in major cities. Death rates in regional, rural, and remote areas are higher than in major cities, and the rates increase in line with degrees of remoteness .

People living in regional, rural, and remote areas are more likely to defer access to general practitioners due to cost. They have higher rates of potentially preventable hospitalisations, and are less likely to gain timely access to aged care.

Rural communities often find it very difficult to attract and retain doctors, making local access to even basic medical services challenging. Rural patients often have to travel significant distances for care, or endure a long wait to see a GP close to where they live.

Rural Australians deserve a fair go when it comes to health care. Despite Government policy efforts at both Federal and State/Territory level, this goal is a long way from being achieved.

The AMA believes that health care in regional, rural, and remote Australia deserves significant real funding increases. It is essential that government policy and resources are tailored and targeted to cater to the unique nature of rural health care and the diverse needs of rural and remote communities to ensure they receive timely, comprehensive, and quality health care.

General practice is the backbone of rural health care, providing high quality primary care services for patients, procedural and emergency services at local hospitals, as well as training the next generation of GPs. Rural GPs would like to do more, but face significant infrastructure limitations in areas such as IT, equipment, and physical space.

RURAL HEALTH

AMA POSITION

The AMA calls on the Government to:

- provide funding and resources to support improved staffing levels and workable rosters for rural doctors, including better access to locum relief and investment in hospital facilities, equipment and practice infrastructure;
- replace the Junior Doctor Training and Innovation Fund with the AMA's Community Residency Program, while significantly bolstering the available places to 1700 per annum by 2022;
- expand the successful Specialist Training Program to 1,700 places by 2022, with higher priority being given to training places in regional and rural areas, generalist training, and specialties that are under-supplied;
- fund a further 425 rural GP infrastructure grants of up to \$500,000 each;
- reform medical school entry requirements so that the targeted intake of medical students from a rural background is lifted from 25 per cent of all new enrolments to one-third of all new enrolments, and the proportion of medical students required to undertake at least one year of clinical training in a rural area is lifted from 25 per cent to one-third;
- ensure that the creation of 'end to end' rural medical school programs are supported through the redistribution of existing CSPs with no offsetting increase in full fee-paying student numbers;
- expand Telehealth MBS Items available in MMM 6-7 to MMM 4-5. The requirement for the patient to have visited the same GP three times in the past 12 months must be changed to visiting the same practice; and
- fund a dedicated rural medical research stream through the NHMRC or MRFF.

9

GENERAL PRACTICE TRAINING

Doctors looking at a career in general practice face an unenviable choice when considering applying for the Australian General Practice Training Program. While conditions vary across the country, a first-year registrar position in a hospital based specialist training program can expect to be paid a minimum salary that is around \$500 per week more than what a GP registrar can expect when they first commence work in a general practice.

This is before penalty rates, shift loadings, educational allowances and other public sector entitlements are added in, which make the disparity even more pronounced.

The current employment model for GP registrars also means that their leave entitlements are much less generous, and unlike the public sector, this leave is not portable as they move around to satisfy their training requirements. If they get sick or must look after an unwell member of their family, their personal/carers leave entitlement will usually be exhausted in a matter of days.

GP trainees who have children are also particularly vulnerable, with no access to paid parental leave other than the Government's own scheme. In contrast, public sector trainees can generally access between 6 and 16 weeks paid parental leave from their employer. The impact on female GP trainees is particularly obvious.

None of these problems are the fault of supervising practices who commit significant resources to training the next generation of GPs and often suffer a reduction in practice income as a result.

The potential loss of conditions is having a real impact on the recruitment of the next generation of GPs. Since 2015 we have seen a 20 per cent fall in the number of applications for GP training and a 6 per cent drop in the number of first year GP training posts filled.

For 2019, 63 first year GP training places went unfilled even though multiple recruitment rounds were initiated, and this position is expected to worsen in 2020. This is despite Australia now graduating around 3700 medical students each year.

AMA POSITION

The AMA calls on the Government to:

- **commit to the development of a 'single' employer model for GP registrars, designed in consultation with the profession, to deliver equitable remuneration and employment conditions for GP registrars while also ensuring adequate support and funding for supervising practices.**

10**MEDICAL WORKFORCE AND TRAINING**

The health of a population relies upon care from a highly skilled, well-trained medical workforce and a strong comprehensive primary health care sector.

Over the past decade, the number of doctors in Australia has increased significantly, driven by a significant rise in the number of medical schools and medical graduates. The number of doctors in Australia (2017) sits just above the Organisation for Economic Co-operation and Development (OECD) average at 3.7 per 1000 population (compared to UK 2.8 per 1000 and USA 2.6 per 1000 population).

Current medical workforce projections show a potential medical workforce oversupply in the years ahead. However, while the Commonwealth is able to regulate Commonwealth Supported Places (CSPs) according to community need, it is currently unable to control or directly influence the number of domestic and overseas full fee-paying medical school places offered by universities.

The Commonwealth Government has also demonstrated a tendency, despite its own medical workforce projections to the contrary, to support universities in increasing full fee-paying medical school places to offset the loss of any CSPs as part of efforts to shift CSPs to rural areas.

Notwithstanding medical workforce modelling showing a situation of oversupply, the distribution of the medical workforce remains an issue both geographically and by specialty. In this regard,

Australia continues to rely heavily on overseas trained doctors to fill workforce gaps, particularly in rural and remote areas.

Some medical specialties are in undersupply, with others in over-supply, especially in metropolitan areas. This is exacerbated by a shortage of vocational training places, increased competition for entry into vocational training, the suitability of the unaccredited registrar employment model, and how to better manage workforce planning in the prevocational space and exit block for employment of new fellows.

MEDICAL WORKFORCE AND TRAINING

AMA POSITION

The AMA calls on the Government to:

- **implement the Commonwealth's 2018/19 Budget commitment to regulate full fee paying domestic and international medical student numbers and, beyond this, commit to no further increase in the total number of medical school places to address issues of oversupply;**
- **show national leadership through the Council of Australian Governments (COAG) to commit to fund and resource the appropriate agencies to undertake the accreditation of all prevocational training positions to improve the quality of training and support for prevocational doctors not in a College training program;**
- **work with medical colleges and jurisdictions to increase specialty training positions and create employment opportunities to improve the distribution of the medical workforce in areas of unmet community need, based on the advice of the Medical Workforce Reform Advisory Committee (MWRAC).**