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AMA submission – Inquiry into health policy, administration and expenditure

The scope of the Select Committee on Health's inquiry is extremely broad. Rather than attempt to raise all issues that could be addressed under the terms of reference, in this submission the AMA focuses on key concerns that also serve to illustrate lost opportunities for improving health services in Australia.

Unfortunately the health sector is confronted with dramatic changes to funding and funding arrangements which have been justified on the basis of runaway unsustainability of health expenditure at Commonwealth or State levels.

The share of health spending as a proportion of the Commonwealth Budget has reduced by 2% since 2006-07. The share of state and territory spending allocated to health has been broadly constant over the period from 2006-07, and certainly does not indicate that health expenditure is unsustainable.

Health spending as a proportion of overall spending – annual Budget projections 2006-07 to 2014-15

Budget year	Cwth %	NSW %	Vic %	Qld %	SA %	WA %	Tas %	ACT % #	NT %
2014-15	16	28	32	29	31	28	28	31	25
2013-14	16	28	32	29	31	26	28	28	26
2012-13	16	27	32	26	31	27	27	28	25
2011-12	16	27	31	25	31	25	28	28	24
2010-11	16	27	31	25	30	24	27	28	22
2009-10	15	26	30	24	29	24	27	27	24*
2008-09	16	27	31	23	29	24	28	27	27*
2007-08	18	28	29	22	30	25	25	27	27*
2006-07	18	28	31	22	29	24	27	26	26*
Average (rounded to whole numbers)	16	27	31	25	30	25	27	29	25

Notes: From projected spending in annual Budget papers for each jurisdiction.

ACT expenses include community care

* Northern Territory Expenses for 2009-10 and earlier years include welfare spending

The impact of reduced Commonwealth funding for hospital and other health services provided by state and territory governments, in particular, the impact on elective surgery and emergency department waiting times, hospital bed numbers, other hospital related care and cost shifting.

The 2014-15 Budget has significantly reduced Commonwealth funding for public hospitals and other health services provided by states and territories. This involves a reduction in funding of \$1.8 billion over the four years to 2017-18 and an expected reduction of \$50 billion in the period to 2014-25.

The 2014-15 Budget abandoned the funding guarantees agreed by all governments in the National Health Reform Agreement. Clause 15 of the agreement provided an explicit commitment that no state would be worse off in the short or long term under the new funding arrangements established by the NHRA. It also guaranteed the Commonwealth would provide at least \$16.4 billion in additional funding over the 2014-15 to 2019-20 period, including meeting 50 per cent of efficient growth from 2017-18 onwards (clause 12).

The states and territories have been quick to highlight the basic choice they face is to reduce services to accommodate reduced funding, or to increase funding from other areas of state health or other funding to meet the shortfall, or a combination of the two. The responses of individual states (to reduced funding over the four years to 2017-18) are not yet known.

Questions of overall sustainability aside, the significant funding reductions in the 2014-15 Budget come in a context where public hospitals already have insufficient funding to meet patient demand and COAG performance targets.

The AMA's *Public Hospital Report Card 2014* (at <https://ama.com.au/ama-public-hospital-report-card-2014>) provides an analysis of public hospital performance against key performance measures. The Report uses the most recent publicly available data. It also reflects the experiences of the AMA doctors who work in our public hospitals every day.

It shows that while public hospitals do not have the capacity to meet demand, they will struggle to meet performance targets. Insufficient capacity to meet demand means patient safety and quality care are at risk.

The AMA's *Public Hospital Report Card 2014* shows only marginal improvement in public hospital performance against the performance benchmarks set by all Governments. Details are provided in the report but key failures for the period 2012-13 include:

- Bed numbers per 1000 of the 65 and over population (those most likely to need acute care) remained unchanged.
- Only 68 per cent of emergency department patients classified as urgent were seen within the recommended 30 minutes, compared with the nationally agreed target of 80 per cent.
- Only 67 per cent of all emergency department visits were completed in four hours or less, well short of the 90 per cent target to be achieved by the end of 2015.
- Median waiting times for all elective surgery have increased over the last ten years.

- An estimated 79 per cent of elective surgery category 2 patients were admitted within the clinically recommended time, well short of the target of 100 per cent to be achieved by 2016.

It is important to note that in relation to elective surgery, the real length of time that patients are waiting for elective surgery is much longer than the publicly reported data. It is only after patients have seen the specialist that they are added to the official waiting list. The time patients wait from when they are referred by their general practitioner to a specialist for assessment is not counted, but should be to provide an accurate picture of unmet demand.

The capacity of public hospitals to meet emergency services and elective surgery demand will only get worse with the announced funding cuts.

Public hospitals provide quality, accessible care for millions of Australians. They are the safety net for people who cannot afford private health care. Public hospitals need greater support; not funding cuts.

A further aspect of the 2014-15 Budget is the Commonwealth's decision to move away from activity based funding (ABF) as the basis for determining Commonwealth funding, to block funding adjusted for population growth and CPI. This is a significant change with important implications.

Activity based funding provides transparency in terms of the activities that are funded. It provides a mechanism to deal with inefficiencies in the public hospital system by enabling comparison of costs and the activities and services produced. ABF classification of activities, together with the transparent application of standard costs, enables better assessment of performance and informed consideration of issues like unwarranted clinical variation.

The impact of additional costs on access to affordable healthcare and the sustainability of Medicare.

The AMA assumes that the Senate is referring to the Government's proposals to introduce a general practice, pathology and diagnostic imaging co-payment, and to increase the PBS co-payment and safety net threshold.

The measures target the sickest and most vulnerable individuals in our community rather than attempting to refine and shape the Australian health care system to enable it to deal with future challenges. Changes of this magnitude, without any long term forecasting and analysis of their impact, subject the health of Australians and the Australian health care system to enormous and unnecessary risk.

The AMA has already made a number of submissions in response to Senate Committee inquiries related to the proposed health-related Budget measures. These submissions provide detailed information about the impacts, referenced by a large body of peer-reviewed Australian and international research, and are published on our website at <https://ama.com.au/submission-inquiry-legislation-increase-patient-co-payments-pbs-medicines> and <https://ama.com.au/submissions-out-pocket-costs-australian-healthcare>.

We have also put forward to the Government an alternative GP co-payment model that we believe will mitigate the most risky aspects of this Budget measure (see <https://ama.com.au/media/ama-model-protects-vulnerable-patients-co-payment-pain>).

However, we have summarised below for the Select Committee our key points on the impact of the health-care related Budget measures as they currently stand.

Impact on Medicare sustainability

The Government is justifying the health budget measures on the basis that Australia's health spending is unsustainable. It is not.

- Health is 16.13% of the total 2014-15 Commonwealth Budget, down from 18.09% in 2006-07.
- Health was 8.9% of Australia's GDP in 2010, stable when compared with 8.2% in 2001, and lower than the OECD average of 9.3%.

The Government fails to acknowledge that Australia's nominal GDP continues to grow at rates that are above OECD averages¹. Australia can afford the health system it currently has.

Utilisation of general practitioner services is not out of control. Since 2007-08:

- The population has grown on average by 1.51%.
- Medicare funded GP services has grown on average by 2.47%.
- GP services per capita have grown on average by 0.94%.²

This is despite an increase in the practising GP workforce, to the tune of 3.5%, which has occurred as a direct result of Government initiatives.

The cost of subsidising medicines is not out of control.

- The Productivity Commission's *Report on Government Services 2014* found that the Pharmaceutical Benefits Scheme (PBS) had the slowest growth in cost across all areas of health expenditure in the last 10 years to 2011-12. The PBS grew an average of only 0.2% each year.³
- In 2012-13, PBS expenditure actually decreased 2.1% from the previous year⁴.

¹ OECD Economic Outlook, Volume 2014, Issue 1, Annex Table 2, *Nominal GDP: Percentage change from previous year*, page 262 (last updated: 28-April-2014)

² Department of Health. *Annual Medicare Statistics – Financial Year 2007-08 to 2012-13*. Group Statistics Report. Table 1.1. Non-referred attendances – GP/VR GP; Department of Health. *GP Workforce Statistics - 1984/85 to 2012/13*; Australian Bureau of Statistics. *Estimated Resident Population ABS catalogue 3101.0 Australian Demographic statistics*, December 2009 released 26/4/2010.

³ Productivity Commission *Report on Government Services 2014* Table EA.7

⁴ PBS *Expenditure and prescriptions twelve months to 30 June 2013*

<http://www.pbs.gov.au/info/browse/statistics#Expenditure>

The AMA is concerned that the Government's Budget measures therefore appear to ignore systemic opportunities to address health care spending. They appear to be driven by ideology rather than based on evidence and have not been developed within a vision and framework of systemic reform.

Costs to patients

The Government is reducing its financial assistance to patients for their health care costs in several ways, each with a cumulative effect on the other.

- \$5 cut to Medicare rebates for general practitioner (GP) attendances and all pathology and diagnostic imaging services, and removal of bulk billing incentives for pathology and diagnostic imaging services for all patients. The cost to patients is \$3.5 billion in the first three years of implementation.
- No indexation of Medicare rebates for all medical services. The cost to patients is \$1.8 billion over the next four years – including the \$160 million already saved by Government in 2013-14 by not indexing Medicare fees on 1 November 2013.
- Simplifying the Medicare safety net. The cost to patients is \$268 million over the first four years of implementation.
- Increasing PBS co-payments and the safety net thresholds. The cost to patients is \$1.3 billion in the first four years of implementation.

Through these structural changes to Medicare and the PBS, the Government is shifting \$8.4 billion of health care costs onto patients over the next four years.

Assuming that the \$5 rebate cut is offset by the \$7 co-payment, the \$2 difference imposes a further cost on patients of around \$1.4 billion⁵.

Impact on patient care

The Government's measures will have an immediate, cumulative impact on patients because most medical services do not occur in isolation of each other.

An episode of care can involve multiple GP visits in a short period, including a range of diagnostic tests and prescription medicines, with increased costs impacting on both general patients and concession card holders.

Families will experience even more pressure as higher health care costs impact household budgets because co-payments apply to individuals and are not counted on a family basis.

International research has repeatedly demonstrated that the impact of increasing co-payments is greatest on those most vulnerable in our population (the elderly, the chronically ill, the unemployed, the 'working poor', Indigenous peoples).

⁵ As the AMA does not have any information about the Government's modelling, this is a simple calculation.

When people defer or avoid care due to costs there are downstream consequences. An episode of acute care in a public hospital is vastly more expensive to taxpayers than preventive or first line treatments, with a greater impact on workforce participation and flow-on economic impacts.

The AMA believes the current and proposed safety nets will be insufficient to ensure that the most vulnerable patient groups are not deterred from seeking medical assistance because of higher costs. Getting this safety net right is critical to avoiding the additional downstream costs to the health system of delayed diagnosis and treatment.

The impact of reduced Commonwealth funding for health promotion, prevention and early intervention.

Commonwealth Government investment in health promotion, prevention and early intervention is essential to supporting population health and economic productivity, reducing downstream healthcare costs and improving the sustainability of healthcare spending. Given the burgeoning costs of chronic disease to the Australian health care system, the case for national leadership on disease prevention and health promotion can be made on both effectiveness and efficiency grounds.

The continuing growth in lifestyle related chronic diseases such as Type 2 diabetes and the contribution of modifiable risk factors such as smoking, diet and alcohol consumption underlie the need for national action on disease prevention, health promotion and early intervention.

The AMA has consistently advocated for strategic, long-term and properly resourced population based approaches to preventive health to reduce these risks and minimise the health and economic costs associated with chronic disease.

Despite the health and economic imperatives of preventive health, the Commonwealth has moved to downgrade preventive health efforts and reduce funding for health promotion, prevention and early intervention. The loss of the National Partnership Agreement on Preventive Health (NPAPH) has resulted in cuts to important programs around the country that address obesity, cancer prevention, diabetes and other conditions that result in substantial costs to the health system.

The Commonwealth has also dismantled the Australian National Preventive Health Agency and most of the programs it administered, as well as cutting funding to national smoking cessation programs and education campaigns.

At the same time it has abolished the key governance structures that were involved in monitoring and evaluating the performance of disease prevention and health promotion programs. Under the NPAPH, a series of cross-jurisdictional performance measures, indicators and benchmarks had been developed to track progress in smoking, alcohol and obesity. The absence of robust monitoring, benchmarks and reporting mechanisms undermines efforts to strengthen accountability and ensure effective deployment and targeting of preventive health spending.

These cuts in Commonwealth funding coincides with the retraction of funding in public health and prevention by state and territory governments, as indicated by cuts to community health, sexual health services, smoking cessation programs, and other health promotion programs in jurisdictions such as Queensland and South Australia.

The reductions in funding represent a false economy given that much of the growth in health expenditure (and anticipated future growth) is in treating preventable non-communicable or lifestyle diseases – cancer, heart disease, type II diabetes and other chronic diseases.

They come at a time when evidence has emerged showing the potential benefits of the large-scale preventive programs implemented under the national partnership agreements. A slowing in the rate of increase of childhood obesity and reductions in smoking rates among Indigenous populations have been hard-won achievements. Such outcomes reinforce an earlier comprehensive review of the value of Australia's investment in five major prevention programs: tobacco control, coronary heart disease, HIV/AIDS, vaccination and road trauma. This review found that investment in prevention had resulted in net savings to government and yielded substantial dividends.⁶

All national governments in the OECD actively engage in health promotion, disease prevention, public health and health protection. Most countries frame the benefits of preventive health both in terms of improving the health of their populations including their ability to contribute to economic productivity, as well as the positive long-term financial impact on publicly-funded health care systems.

Despite international recognition that investment in prevention and public health is vital to contain healthcare costs, Australia lags behind most other comparable countries in terms of the level of investment in prevention. Currently, Australia invests a lower proportion of its health expenditure in prevention than most other OECD countries. In 2011-12, only 1.7 per cent of health spending in Australia went towards prevention efforts, or less than 0.2 per cent of GDP.

The AMA urges the Commonwealth Government to strengthen Australia's efforts in promoting health and preventing disease by prioritising prevention within the health portfolio and taking a key leadership role nationally to reinforce and coordinate activity being undertaken at the local, regional and state level.

The interaction between elements of the health system, including between aged care and health care.

The health system fails to provide an effective and efficient framework for different elements of the health care sector and community support sector to interact. This is well illustrated by the lost opportunities to achieve better services for older Australians needing aged care.

⁶ Applied Economics (2003). *Returns on investment in public health*. Canberra: Department of Health and Ageing.

Australians are living longer and delaying the move into residential aged care. As a result, residents are now older, frailer and have more complex healthcare needs than in the past.

We need to adapt to these changes and get better at caring for our ageing population. The aged care sector needs the capacity to support medical care for residents, so that they can be managed within the facility and rather than shipped off to hospital unnecessarily.

According to the latest Australian Institute of Health and Welfare data published in 2013, of all the hospital admissions of people aged 65 and over, 8.7% were people who were permanent residents of aged care facilities⁷. This represents 93,400 transfers from residential aged care to hospital each year. Hospital admissions are extremely distressing for patients and their families, and put increasing pressure on our already strained hospitals. Many of these people could be appropriately cared for in residential aged care.

The aged care sector should be recognised as a component of the health system. In the same way that medical practitioners are an integral part of the hospital workforce, medical practitioners are an integral part of the aged care workforce. The aged care sector needs to be supported by governments to better integrate medical care into the sector so that older Australians can get the care they need in aged care settings.

Medicare data shows that on average each resident has around 15 GP visits a year. For a very old, very frail person with complex conditions and comorbidities, this is not frequent enough to properly manage them.

There is no recognition of the need, let alone requirement, for aged care providers to have sound administrative and clinical systems to work with medical practitioners to ensure residents have access to appropriate medical care.

There are three key issues that affect the provision of care for older Australians in the aged care sector.

- The aged care sector needs to work more closely with the medical profession to support access to medical care for residents of residential aged care facilities. According to a 2012 AMA survey, only around 21% of the general practitioner workforce make regular visits to aged care facilities.
- Providing medical care in the aged care sector is challenging. Basic practicalities such as travelling to the facility, finding parking, obtaining security access (particularly after hours), and then finding the patient, their file and someone who can describe their symptoms can take a long time. In addition, treatment usually has to be provided in a shared room where there is lack of privacy for the patient, and no equipment for the treating doctor.
- We know through our membership that the cohort of doctors currently attending residential aged care facilities are generally older male doctors, who have developed a tolerance for the conditions and have a strong sense of professional responsibility to continue to care for their patients. We also know that younger doctors are aware of the barriers to providing good quality care in residential aged care facilities and are understandably reluctant to factor visits

⁷ AIHW 2013. *Movement between hospital and residential aged care 2008-09*. Canberra: AIHW

to residential aged care into their practices. As the current cohort of doctors retire, there is a risk Australia will face a dramatic drop in the medical workforce available to aged care residents. Whilst Medicare rebates are payable to all GPs who provide medical care in RACFs, the current rebates are inadequate to cover the real costs of providing services, including non face-to-face time with the patient.

This means that aged care facilities need to be supported to better integrate medical care into the residential aged care sector. This includes being required to provide administrative support so medical care can be provided efficiently and effectively. Dedicated, adequately equipped clinical treatment areas that afford patient privacy need to be incorporated into facility planning. Sufficient numbers of registered nurses should be on site to manage patient care between doctor visits. Inadequate nurse to patient ratios in residential aged care is symptomatic of increased transfers to hospitals.

With more and more people choosing to delay the move to residential aged care, we also need community aged care services to take account of the medical needs of older Australians as they support them in staying in their homes for longer.

It is important aged care assessments that trigger access to government funded services seek the input of the person's treating medical practitioner to ensure funding is directed to the most critical needs of older Australians in the community.

Finally, carers of older Australians need access to emergency residential respite services. Almost half of all primary carers have a disability themselves⁸. Every medical practitioner that cares for older Australians has had to deal with situations where the condition of the carer deteriorates quite rapidly. In these situations the doctor needs to arrange residential respite care quickly. When this is not possible, the only alternative is admission to hospital and that can make the situation much worse.

Older people living in the community need to be confident that there will be support when they need it – a safety net that responds rapidly to their changing needs. Medical practitioners authorising urgent access to respite care is but one way of providing that safety net. This would ensure that people are cared for in the most appropriate place.

The AMA urges careful planning so that the aged care sector is better integrated with the broader health care system and ready for the challenge posed by Australia's ageing population.

Improvements in the provision of health services, including Indigenous health and rural health.

Effective health services for Indigenous Australians is a priority. The statistics demonstrating the much poorer health outcomes and life expectancy of Indigenous Australians compared to the rest of the population do not need to be repeated here.

⁸ AIHW 2013. *Australia's welfare 2013. Australia's welfare no. 11*. Canberra: AIHW

As a long standing member of the Close the Gap Steering Committee, the AMA has called for renewal of the COAG Close the Gap partnership agreements as soon as possible (with the same level of funding as the previous agreements). The renewed agreement should include an implementation strategy for the *Aboriginal and Torres Strait Islander Health Plan* (at <http://www.health.gov.au/natsihp>) which includes:

- development of a comprehensive set of measurable targets that need to be achieved over the next ten years;
- development and implementation of a service model that will effectively and efficiently achieve those targets;
- development and implementation of a national workforce strategy for existing and emerging areas of need in service provision;
- the formulation of a funding and resource model commensurate with the health care needs and priorities in Aboriginal and Torres Strait Islander populations over the next ten years, and
- clear, measurable requirements for governments to work together in genuine partnership and with the guidance of Indigenous health leaders and Indigenous communities.

It is also worth noting that poor mental health and low social and economic well-being are persistent problems for many Aboriginal and Torres Strait Islander people. These problems can begin early in life and can continue to have significant impacts during adolescence and adulthood.

The AMA's *Report Card on Early Childhood Development 2012-13* (at <https://ama.com.au/2012-13-ama-indigenous-health-report-card-healthy-early-years-getting-right-start-life>) makes recommendations to ensure the best start in life for Aboriginal and Torres Strait Islander infants and children including:

- the development of a comprehensive plan for maternal and child services;
- support for families at risk;
- measures to keep children at school;
- strengthening community capacity;
- improving the living environment; and
- ensuring better data, research and evaluation of current and new programs.

In terms of health service delivery, the AMA acknowledges the important contribution of the Aboriginal Community Controlled Health sector, and has called for funding reform in the sector. Consistent with a report released earlier this year⁹, the AMA has publicly highlighted that the Aboriginal Community Controlled Health sector contributes to improved health outcomes (and reductions in health and life expectancy gaps) as well as being a major employer of Aboriginal and Torres Strait Islander people.

A funding review should ensure that Aboriginal Community Controlled Health Services should be established and appropriately funded in areas of need according to the demand for services.

⁹ National Aboriginal Controlled Community Health Organisation *Investing in Aboriginal community health makes economic sense* NACCHO Press Club 2014

The better integration and coordination of Medicare services, including access to general practice, specialist medical practitioners, pharmaceuticals, optometry, diagnostic, dental and allied health services.

There are many unrealised opportunities for better integrated health care services that more effectively meet the needs of patients, particularly those with complex and/or chronic conditions.

The National Primary Health Care Strategic Framework highlighted that general practice is the foundation of good primary health care in Australia. Many years of intensive study, specific training and experience underpin the breadth of skills and knowledge that give patients the holistic care that specialist general practitioners provide.

A strong general practitioner-led primary health care system keeps people well and saves lives. GPs and their patients have long held the view that having a good relationship with a GP and a link to a particular general practice is highly valued and one of the features of the Australian primary health system which should be supported and encouraged.

GPs provide all the care needed for 90% of the problems they encounter. According to the Productivity Commission's *Report on Government Services*, the age-standardised Commonwealth Government expenditure on general practice per person was \$286 in 2012-13. Services provided by GPs provide very good value for money and are an efficient means of utilising scarce health dollars.

Primary care has seen the increasing involvement of multidisciplinary teams in the care of patients, particularly those with chronic and complex disease. Well-functioning GP-led multidisciplinary teams are helping to improve access to care for patients as well as the overall quality of care. At the same time, there is no substantive evidence that shows that nurses and allied health professionals working independently of GPs can deliver the same quality health care outcomes as the team-based model of primary health care delivery that is supported by the AMA and is currently established in Australia.

The *Bettering the Evaluation and Care of Health Report, General Practice Activity Australia in 2011-12*, confirms that GPs are increasingly treating older patients with more complex care needs. The management of chronic and complex disease is a key part of general practice, with chronic conditions making up more than one third of all problems managed.

The increasing burden of chronic disease has a significant cost impact on Australia's health system and, on some estimates, 10% of hospital stays for patients with chronic conditions are potentially preventable. Investing in general practice and primary health care can lead to much better patient outcomes and significant downstream savings in other parts of the health system.

Australia has moved to implement more structured arrangements through Medicare to tackle chronic and complex disease. Unfortunately, these arrangements adopt a one size fits all approach and fail to target more resources towards patients with higher levels of clinical need. They are also administratively complex.

The AMA believes that they could be significantly improved through the removal of red tape, streamlined access to GP-referred allied health services, as well as the option of additional allied health services in circumstances where a patient's clinical needs are high. We also support a more proactive approach to the coordinated management of patients in the latter category.

The Department of Veterans Affairs (DVA) has initiated the Coordinated Veterans Care (CVC) program that provides additional funding support for GPs to provide comprehensive planned and coordinated care to eligible veterans, with the support of a practice nurse or community nurse. This program is designed to reduce avoidable hospital admissions and deliver overall savings to the health system. The DVA CVC program was developed with strong clinical input and has broad stakeholder support.

The AMA supports the development of a broad coordinated care program to tackle chronic and complex diseases based on the model of care and funding arrangements developed for the CVC program.

Health workforce planning

The AMA highlights two key issues in health workforce planning.

Medical workforce planning and coordination

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

In response, the Commonwealth Government has moved to significantly increase the number of medical students. The number of medical graduates has grown sharply in the last decade and is set to expand even further, from 1287 in 2004 to a projected 3824 in 2017 – an increase of almost 200 per cent.

Increasing the number of medical school places is only one step towards training sufficient doctors to meet the nation's health needs. It must be accompanied by a focus on maintaining the quality of medical training for which Australia is renowned, and a matching expansion in the number of medical training places beyond medical school. In this regard, graduates go on to complete one to two years of generalist (prevocational) training and then three to eight years of specialty training in one of a range of specialties, including general practice.

This means that increasing the number of medical school places will be ineffective in addressing medical workforce shortages unless there is an increase in:

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

This must be done in a planned and coordinated way to ensure that the training pipeline operates efficiently and the future medical workforce matches community need.

Unfortunately, Australia has a poor record in this area and over the last ten years we have seen a number of workforce planning agencies come and go.

The former Health Workforce Australia (HWA) was first established in January 2010 and, after a slow start, had started to achieve some momentum in the area of workforce planning and coordination. In 2012 it published *Health Workforce 2025* (HW2025), with volumes one and three providing clear evidence that Australia faces significant bottlenecks in medical training due to projected shortages of intern, prevocational and specialist training places.

This was the first set of credible workforce planning projections since 2005, with HW2025 predicting future medical workforce shortages in the following areas:

- obstetrics and gynaecology;
- ophthalmology;
- anatomical pathology;
- psychiatry;
- diagnostic radiology; and
- radiation oncology.

Psychiatry and radiation oncology services were considered by HW2025 to be particularly at risk because of their existing workforce position of perceived shortage, with the projections indicating this will worsen further by 2025.

In contrast, the report highlighted that the following specialties are perceived to currently be in adequate supply, and are projected to move towards oversupply by 2025 if recent trends in supply and demand continue:

- cardiology;
- gastroenterology and hepatology
- neurology, and
- surgical specialties.

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

Based on this work, Health Ministers agreed to the establishment of the National Medical Training Advisory Network (NMTAN), with this body enjoying broad stakeholder support in recognition of its potential to improve available medical workforce data as well as the coordination and planning of the medical training pipeline.

NMTAN commenced operation at the beginning of this year and was undertaking a substantial amount of work to define better the number and distribution of prevocational posts and the capacity for vocational training within our health system.

NMTAN was also tasked to provide advice on the preparation of *Australia's Future Health Workforce – Doctors* report. This report will update the figures from the original HW2025 report as well as provide new projections. NMTAN was also to develop a National Medical Training Plan, which will give recommendations on future medical school intakes, including for 2015.

The future of medical workforce planning and coordination, since the 2014/15 Budget, is now much less clear. The Commonwealth has closed HWA and moved its core functions within the Department of Health (DoH). The Department has no proven record in the area of medical workforce planning and the AMA understands that very few former HWA staff agreed to take up offers of positions with the DoH in Canberra.

This presents a real challenge. Australia's medical workforce planning capacity has been significantly diminished as a direct result of the 2014/15 Budget and we appear to have lost vital momentum at a critical time. Unless the DoH gives priority to this work, backed by effective resourcing, there is the real danger of a growing mismatch between the medical workforce and future community need.

Therefore the performance of the DoH in medical workforce planning and coordination should be examined taking into consideration such matters as:

- DoH support for the work of the NMTAN;
- The output of the NMTAN, including workforce planning and coordination and specific policy advice; and
- The delivery of a comprehensive National Medical Training Plan detailing the number of medical school, intern, and prevocational, specialist medical training places required each year, with the latter broken down according to specialty area.

Rural and regional medical workforce

The AMA has identified medical workforce shortages in regional and rural Australia as a major health issue. While the Government had made additional investments to encourage more locally trained doctors to work in these areas, rural and regional communities are still overly reliant on international medical graduates (IMGs) to fill workforce gaps.

There is no single solution to regional and rural workforce shortages. The following areas need to be addressed as part of a strategy to deliver a sustainable workforce:

- provide a dedicated and quality training pathway with the right skill mix to ensure GPs are adequately trained to work in rural areas;
- provide a realistic and sustainable work environment with flexibility, including locum relief;
- provide family support that includes spousal opportunities/employment, educational opportunities for children's education, subsidy for housing/relocation and/or tax relief;
- provide financial incentives including rural loadings to ensure competitive remuneration; and
- provide a working environment that would allow quality training and supervision.

These are outlined in more detail in the AMA Position Statement on Regional/Rural Workforce Initiatives 2012 at <http://ama.com.au/node/7681>.

One of the most pressing areas of policy that remains unaddressed is the way in which the Australian Standard Geographical Classification – Remoteness Areas (ASGC-RA) is being applied to determine the distribution of rural medical workforce incentives.

The continued utilisation of the ASGC-RA system is leading to incongruous outcomes. It places many smaller rural towns in the same classification category as larger regional centres. For example Hobart (Tasmania), Tumut (NSW), Wagga Wagga (NSW), Bendigo (Victoria), Cootamundra (NSW), Dalby (Queensland), Balaklava (South Australia), and Busselton (Western Australia) are now all classified as having the same level of rurality. In other cases, smaller towns are now just separated from larger centres by one classification level whereas previously there was a separation of two or three levels.

Despite the Mason Review of Australian Government Health Workforce Programs recommending that the ASGC-RA classification system be abandoned, and there being broad agreement for it to be replaced with the modified Monash Model of rural classification, the current Government has stalled processes put in place by the previous Government to give effect to this recommendation.

The AMA recommends that the modified Monash Model of rural classification be adopted as the basis for determining eligibility for rural medical workforce incentive payments.

The AMA has also recently called for Governments to collaborate on the creation of Regional Training Networks (RTNs) for medical specialist training to maximise resources and expertise to produce a high level medical workforce in sufficient numbers to meet the future health needs of rural and regional Australian communities.

Many medical students have positive training experiences in rural areas. Almost a quarter of medical students have a rural background and almost a quarter of Australian medical students go through Rural Clinical Schools. However, prevocational and specialist medical training often requires a return to metropolitan centres. At this point in their lives, trainees develop personal and professional networks that are important to their future life and career path, and many are less likely to return to practise in rural areas.

RTNs would see the development of models for regionally-based specialist medical training and would enable junior doctors to spend a significant amount of their training in rural and regional areas, only returning to the city to gain specific skills. This would bolster rural training opportunities, and to provide a valuable and meaningful career pathway for junior doctors who want to work in regional and rural Australia.

This evidenced based approach recognises that one of the most effective policy measures to address rural workforce shortages is the delivery of training in rural areas.

The AMA does not see the establishment of RTNs as involving significant new investment. They would effectively build on the investment that has already been made in training medical students in regional centres, and expand that to trainee prevocational and specialist doctors. More information on RTNs is on the AMA Website at <https://ama.com.au/position-statement/regional-training-networks-2014>

We consider that the Commonwealth should work with the states and territories, as well as the medical profession, to establish regional training networks for medical specialist training based on the principles outlined in the AMA Position Statement Regional Training Networks – 2014.

Non-medical workforce

Australia is not currently taking a uniform and consistent approach to expanding scopes of practice of the non-medical workforce.

Most proposals for expanded scopes are dressed up as filling gaps in service provision. However, of the proposals seen by the AMA, not one has been supported by hard evidence of gaps in service.

Further, proponents of expands scopes of practice are citing a problem which is already being addressed by the medical workforce measures described above. Proposals for expanded scopes of practice for non-medical health practitioners should never be offered as solutions to medical workforce shortages.

The workforce reform agenda needs to be underpinned by a robust forum for scrutinising the need and evidence for, and public debate of, changes to the roles and responsibilities of health professionals.

There is an urgent need for an independent process that allows a proper and robust cross-profession assessment of proposals for expanded scopes of practice where it can be determined that:

- the required competencies are predetermined, and accredited training and education programs are available to deliver those competencies;
- there are documented protocols for collaboration with other health practitioners;
- there are no new safety risks for patients;
- the change in scope of practice is rationally related to the practice of the profession and to core qualifications and competencies of their profession;
- the change in scope of practice is consistent with the evolution of the healthcare system and the dynamics between health professionals who work in collaborative care models;
- the training opportunities for other health practitioner groups is not diminished;
- the cost to the health care system will be lower than the current service offering, taking account of supervision costs.

Related matters.

Outsourcing of Medicare-PBS services

The Government has sought expressions of interest from the private sector for the task of providing claims and payment services for Medicare and the PBS. The Government's component of this function is currently undertaken by the Department of Human Services (DHS).

Every day, medical practices ascribe MBS item numbers to, and lodge claims on behalf of their patients for, tens of thousands of medical services. This not only allows patients to access the Medicare rebates with little effort, it also allowed DHS to process in excess of 320 million patient rebates in 2013-14 and with very little administrative cost to the taxpayer.

The call for expressions of interest appears to have been made without any analysis of the cost savings and efficiencies already provided by medical practices. There needs to be a full understanding of the current costs to government and medical practices before any tendering proceeds.

Any consideration of outsourcing needs to be firmly based on good evidence that the cost and efficiency of service provision will be at least matched, or preferably improved, by private enterprise. Ideology favouring private enterprise over public sector delivery should not be the driver for determining how MBS and PBS claims and payment services should be provided.

A transfer of current DHS responsibilities can therefore not occur without comprehensive engagement with medical practitioners on the potential impact on medical practices. Tendering must not result in costs being transferred to or imposed on medical practices, either directly or inadvertently.

There are also broader implications for transferring this role to the private sector.

Medicare and PBS data contain very sensitive information about a person's medical treatment. On principle this demands extreme caution and a highly risk averse approach as to where this very sensitive information is processed.

Further, de-identified Medicare and PBS data is an essential resource for research, analyses and planning to ensure appropriate services into the future. It must remain accessible to both government and non-government researchers. Any change in claims processing arrangements must guarantee continuity in data capture and availability for research and analysis. The sale of MBS and PBS data by a commercial enterprise should be prohibited.

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