Health System Challenges
Physicians Leading
8 May 2017
“Reform Challenge”

1. Government led reform hard, stakeholders, media, compromises, federation
2. Partial measures
3. Reviews, strategies, agreements, think tanks, articles.....
4. Perception
My 4 areas of focus

• “Sustainability” reforms
• Training & distribution of the medical workforce
• Global threat of the obesity challenge
• Delivering change on top of the plans in Antimicrobial Resistance
Growth in Health Expenditure consistently greater than GDP growth
Growth in Health Expenditure not only explained by chronic disease & ageing.
Cost Containment for the Future

- Work of models of care – HCHs, others – important but slow
- Where else can physicians lead?
- Reinvestment driver rather than ‘budget repair’
Focus on reducing low value care

Representative sample of actual/potential recipients of care (intervention quantity)

Category 1: Universally high value

Category 2 - The Grey Zone

Category 3: Universally low value

Adapted from Skinner and Chandra typology of medical technologies with heterogeneous benefits.
PBAC and the Future of the PBS

• PBS/PBAC process
• Big recent saves
• Government implements
• Hep C drugs
• Further containment crucial
• Huge & exciting pipeline
• Biosimilars – huge potential
• Fair & balanced market
• Savings - pipeline
MSAC

- New services and tests
- Safety, clinical and cost effectiveness
- Another huge pipeline $$$$$
- Devices – TAVI
- Genetic testing
- Diagnostics
Medicare Benefits Schedule Review Taskforce

- Most items never reviewed
- MBS funding → clinical evidence
- Variation, non-evidence based
- Arthroscopy, imaging for OA
- Align with clinical guidelines - colonoscopy
- IVF – 44 and over – 1.5% success rate
- Office procedures in day hospitals
Urgent after-hours services by practitioners - sociable hours

Number of Services (millions)

- GP Trainee
- non-VRGP
- VRGP
Are we in Medical Workforce Oversupply?

![Graph showing medical workforce data from 2005 to 2016. The graph compares advanced trainees, basic trainees, temporary and permanent migration, and medical graduates (Domestic) against medical stock employed in medicine.](image-url)
## Historical GP Full-time Service Equivalent to estimated population

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<th>Financial Year</th>
<th>1 GP FSE to population</th>
<th>Growth in FSE (%)</th>
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The transitional generation

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Source: NHWDS 2013-2015
*Based on General practitioners who lack specialist registration in NHWDS 2013-2015
Collaborative Action to Match Supply with Demand

- Redesign **hospital service** workforce - service needs of health services can NO LONGER determine trainee numbers
- Review doctor **migration** pathways
- Distribution **levers**
- **Perverse incentives** need to go
- Post Graduate training in regions and underserved specialties
- All jurisdictions and Colleges
- NMTAN
- Medical Leadership
New Hospital Service Workforce

- ACEM accepts status quo can’t continue
- Service needs ≠ training needs
- Limited private overflow
- Generation of underemployed VMOs

Different workforce structure
- More consultants
- Non ACEM training senior HMOs & CMOs
- Advance Practice nursing & physio roles
- More trainees to Rheumatology???
Fixing the Bush

• Maxed out student and intern relocation – partial effect
• Vocational trainees come back to the City
• Need vocational training to be BASED in non metro areas
• Colleges need to be much more flexible with accreditation
OBESITY - A Global Health Threat

• No country has yet made significant inroads

• Two main challenges
  - Management of currently obese population
  - The prevention strategy

• No issue in greater need of clinical leadership
Some thoughts

• Unhelpful dichotomy between personal & public responsibility
• Complex, systematized, whole of life strategies – food at the heart
• Governments are very aware, want to act
• But need broad public support and org. capacity
• Without broad citizen support – safer options
• Complexity of the Federation
• Food is not the same as tobacco
Managing the currently obese

- Most people can lose significant weight, very few can keep it off
- Huge and long lasting endocrine response

Intense multi year commitment mainly around food intake, reinforced at every level
- Likely effective pharmacological interventions?
- Bariatric surgery currently has a role – access is limited, cultural issues
- Other clinical interventions??
Clinical Leadership in Reversing the Epidemic

• Broad civic coalition – key role of health professionals, partner with community groups,
• Can’t just be health professionals pushing for action
• Gather the evidence, particularly for regulatory measures
• Particular focus on antenatal and early childhood
• Avoid the narrative of short term return on investment
Antimicrobial Resistance

- Understand the problem – change is slow in many areas
- Only one Pharma left
- AUSTRALIA
  - 1 of highest rates - vancomycin resistance in Enterococcus faecium in the world.
  - E. Coli – ↑ extended spectrum B lactamase producing – community
  - Low incidence of Carbapenamase producing & highly resistant gram negatives
  - Low incidence fluoroquinolone resistance
  - Poor surveillance in animal sector
  - Antibiotic usage rates in human health are high compared with other OECD countries.
  - Hospitals – interstate variation – overall 23% inappropriate (esp. surgical prophylaxis & respiratory infection).
  - Community prescribing unacceptably high – nearly 50% 1/year, 50% of URTIs given Abs
  - Aged care – 11% on ABs with < half having infection
AMR Action

- Big international political engagement
- Action plans, UN, WHO, G7, G20, GHSA
- Developing nations hard to engage
- What have we achieved at home?:
  - Stewardship in most hospitals & national centre
  - Other national centres including work on novel solutions
  - Action from NPS Medicine wise
  - Work of the Commission

We need:

- Clinical leadership (particularly in and to help primary care)
- Some regulatory measures - animal bans, prescription repeats, potentially aged care accreditation
- Community education that works – personalise the message, broad civic response
How can College Fellows & trainees provide leadership in AMR

- Self reflection
- Join the cause – adopt the language and approach of ID colleagues
- Believe it! – Victorian CRE outbreak was a warning
- Advocate for appropriate surgical prophylaxis (especially in private)
- Support general practice – by setting examples and gently intervening with advice and support
- Walk the talk – don’t prescribe inappropriately or for too long, reinforce the narrative to patients and consumers
- Help spread the community message – waiting rooms, community involvement, media
- Universal, consistent leadership in Hand Hygiene