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PKS



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

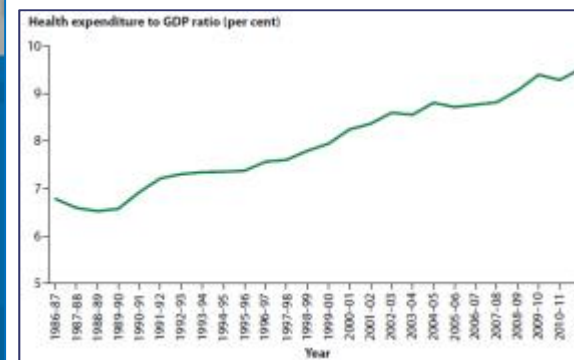
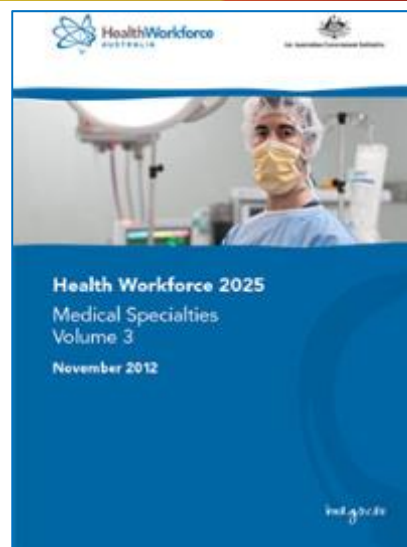




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## My 4 areas of focus

- “**Sustainability**” reforms
- Training & distribution of the **medical workforce**
- Global threat of the **obesity** challenge
- Delivering change on top of the plans in **Antimicrobial Resistance**



HIGH-LEVEL MEETING ON  
**ANTIMICROBIAL RESISTANCE**

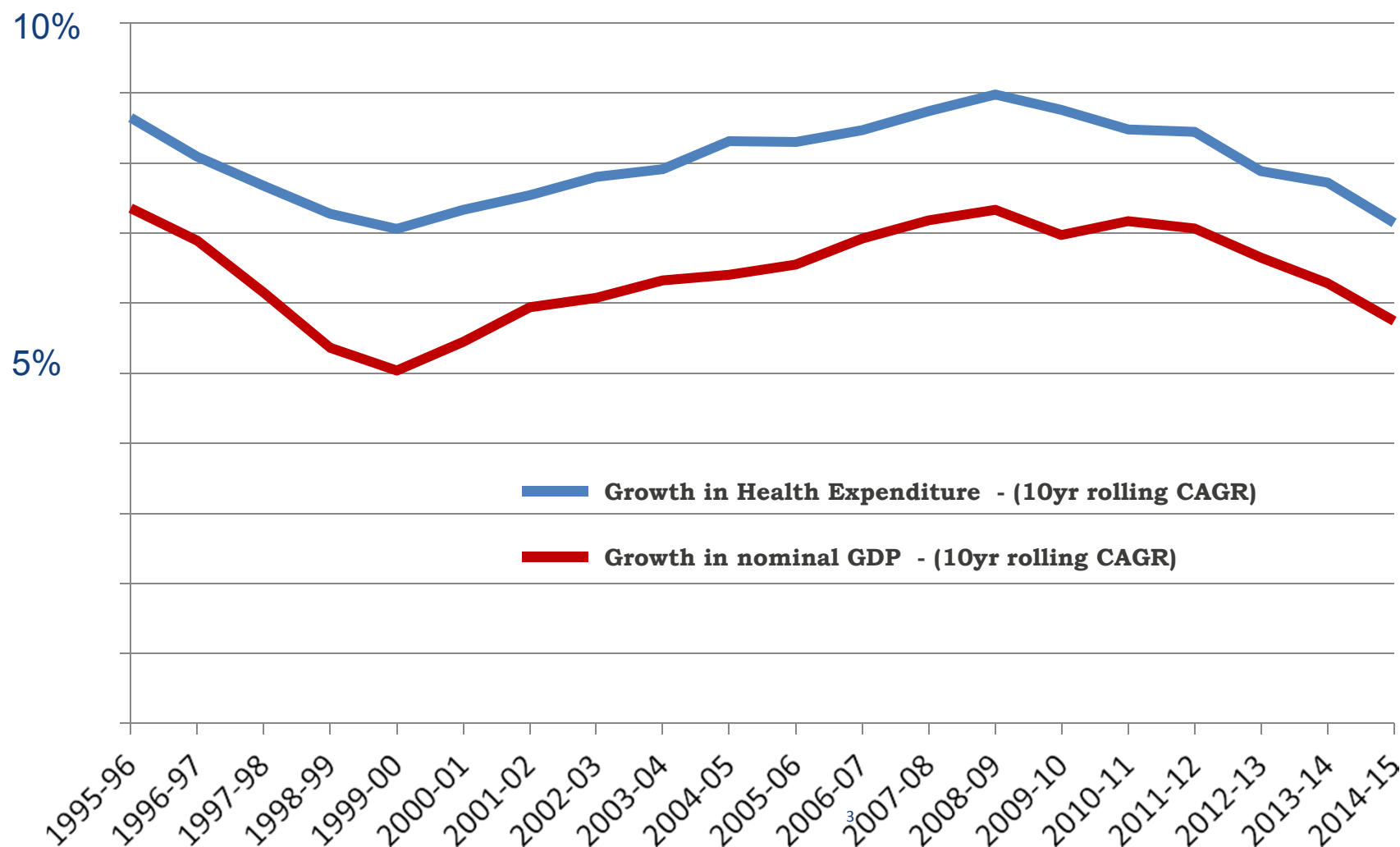


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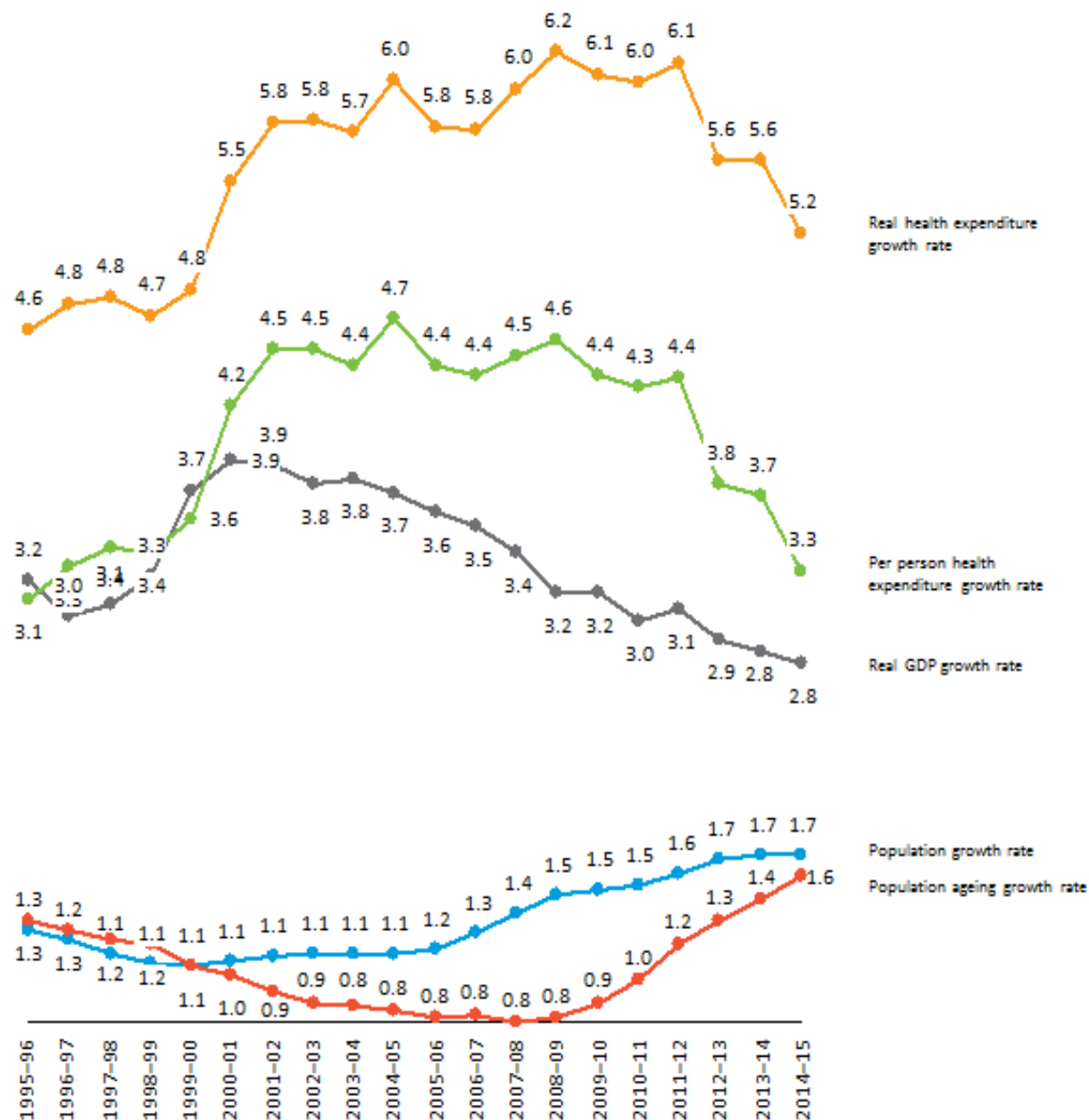
## Growth in Health Expenditure consistently greater than GDP growth





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# Growth in Health Expenditure not only explained by chronic disease & ageing



nousgroup.com



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# 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’

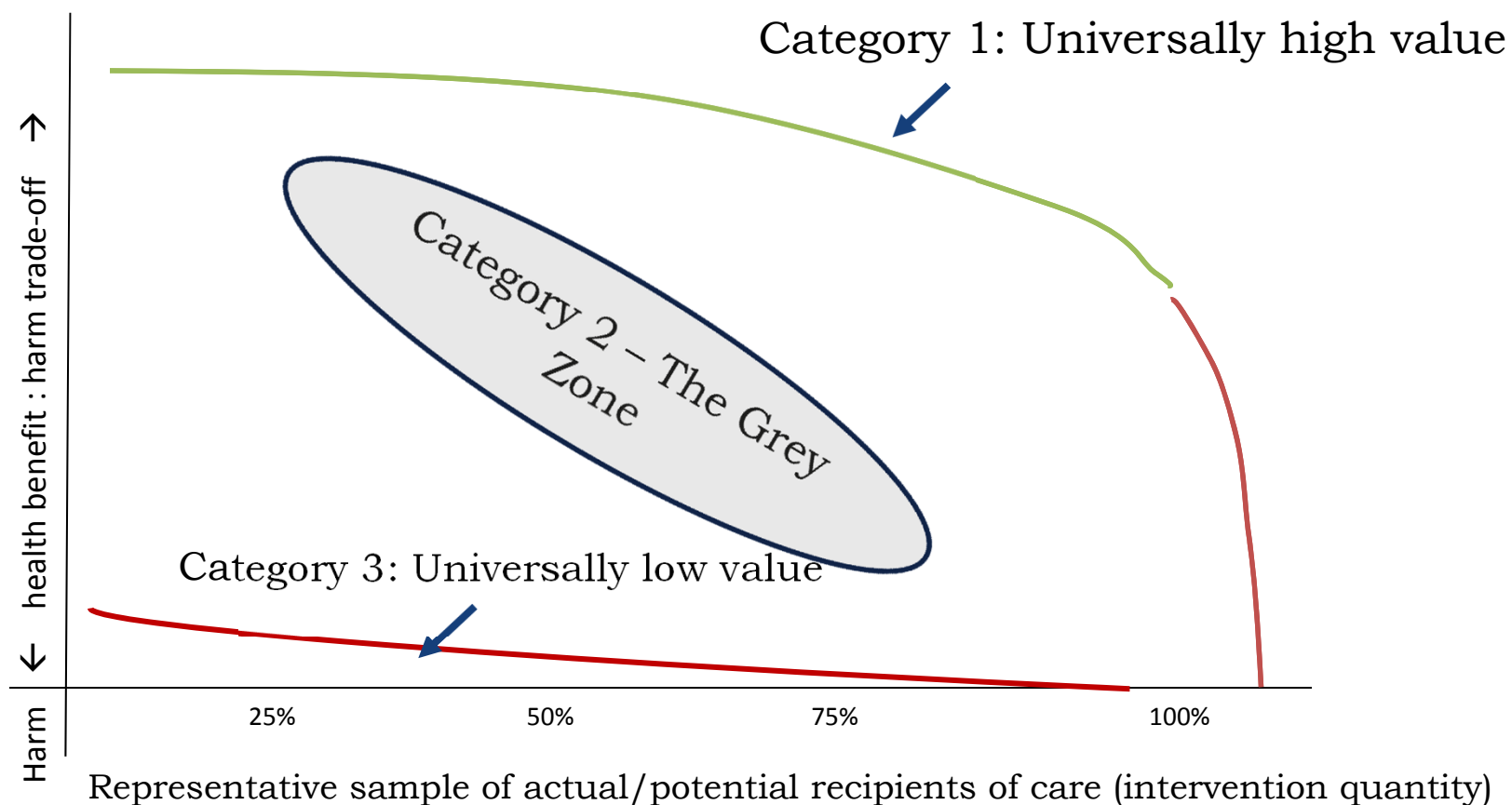






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# Focus on reducing low value care

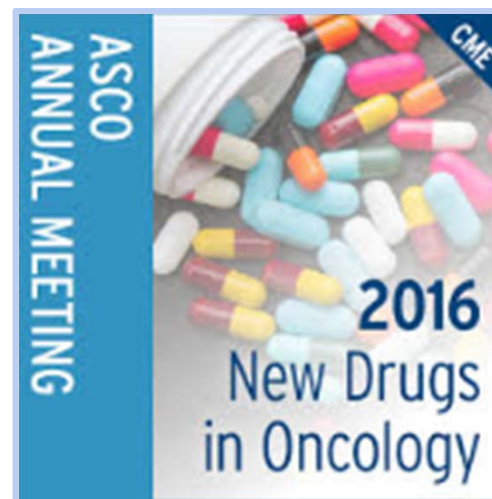




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## PBAC and the Future of the PBS

- 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





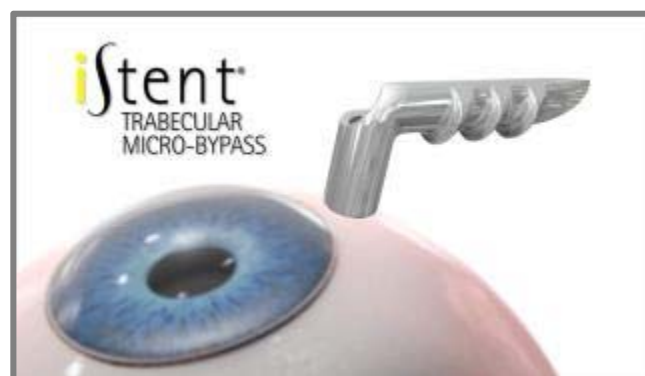
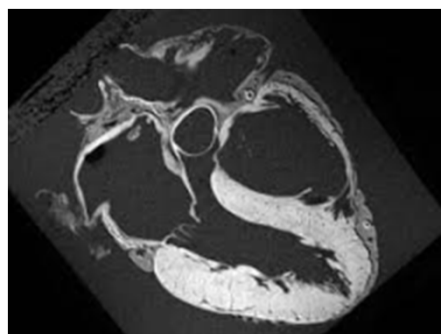


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# MSAC



- New services and tests
- Safety, clinical and cost effectiveness
- Another huge pipeline \$\$\$\$
- Devices – TAVI
- Genetic testing
- Diagnostics





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# MEDICARE BENEFITS SCHEDULE REVIEW TASKFORCE



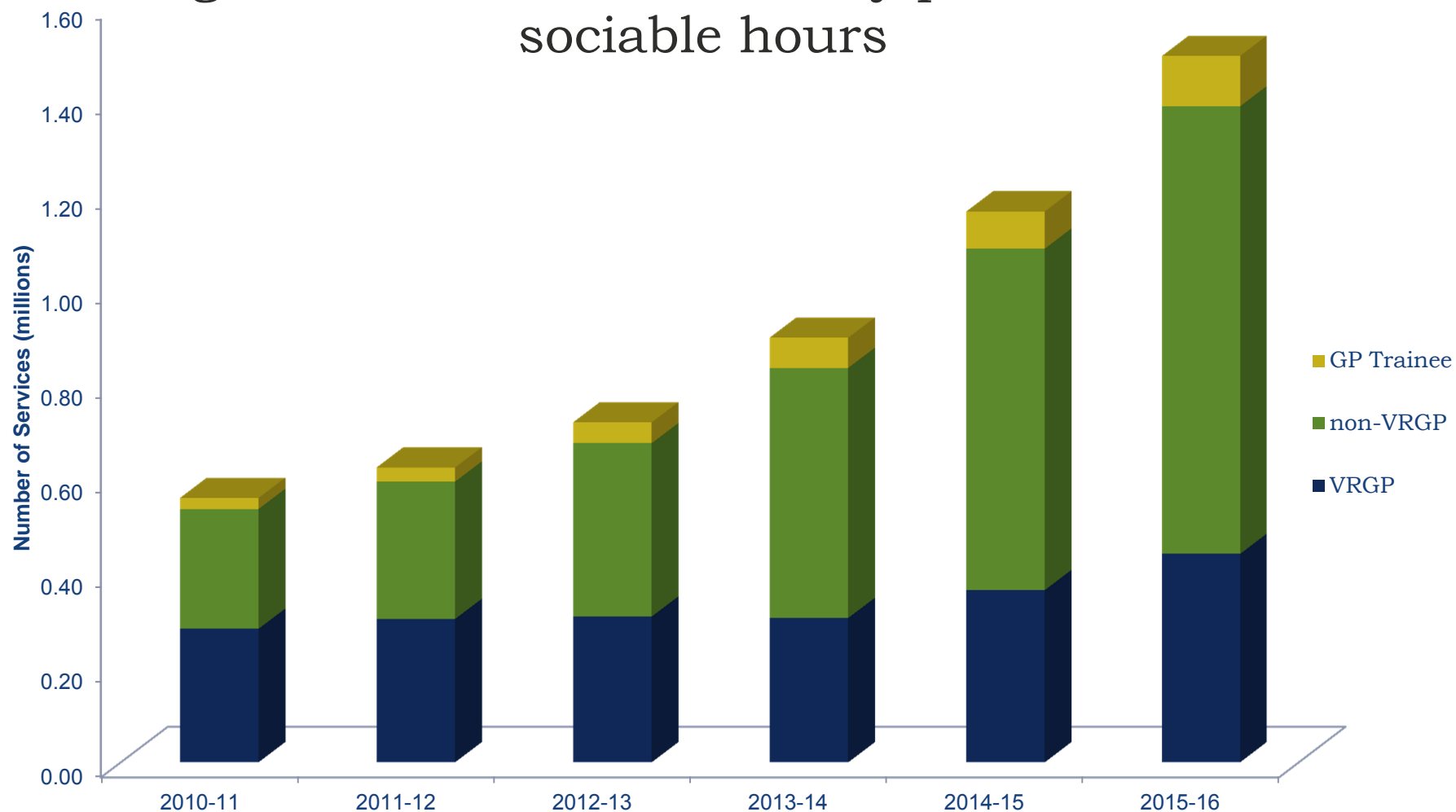
- Most items never reviewed
- MBS funding ➡ clinical evidence
- Variation, non-evidence based
- Arthroscopy, imaging for OA
- Align with clinical guidelines - colonoscopy
- IVF – 44 and over – 1.5% success rate
- Office procedures in day hospitals



Cancer Guidelines



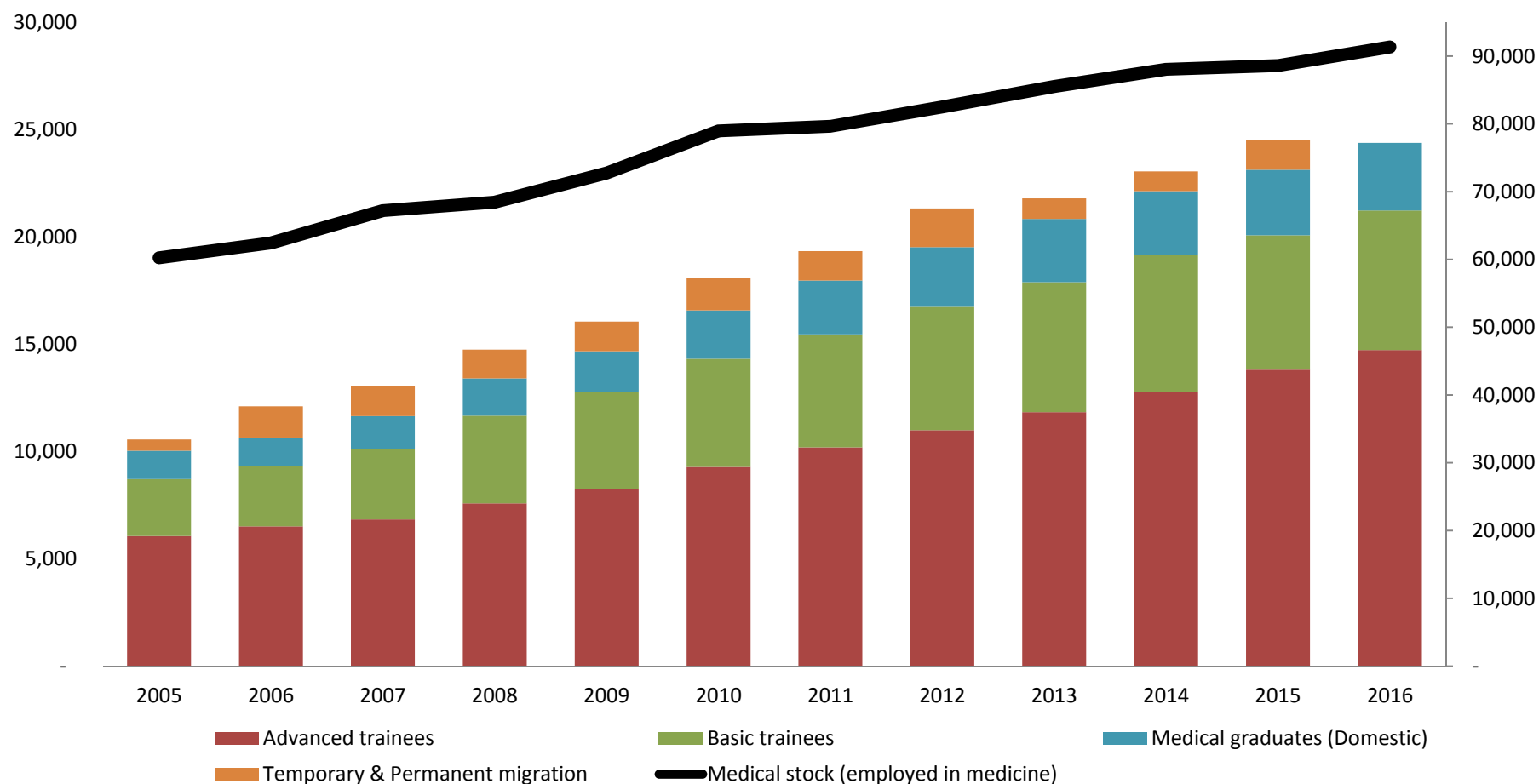
## Urgent after-hours services by practitioners - sociable hours





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# Are we in Medical Workforce Oversupply?





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## Historical GP Full-time Service Equivalent to estimated population

Financial Year	1 GP FSE to population	Growth in FSE (%)	Growth in population (%)
2006-07	1,254		
2007-08	1,209	6	2
2008-08	1,203	3	2
2009-10	1,182	4	2
2010-11	1,169	3	2
2011-12	1,156	3	1
2012-13	1,130	4	2
2013-14	1,080	6	2
2014-15	1,029	7	1
2015-16	994	5	1



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# The transitional generation

	2013	2014	2015
HNS	9,669	9,595	9,731
Non-VRGP*	4,578	5,127	5,689
Non specialist workforce intending to train	5,013	5,599	5,964
Intending to train in adult medicine	1,167	1,339	1,426

Source: NHWDS 2013-2015

*\*Based on General practitioners who lack specialist registration in NHWDS 2013-2015*





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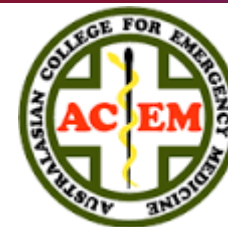
# Collaborative Action to Match Supply with Demand

- 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





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## New Hospital Service Workforce

- ACEM accepts status quo can't continue
- Service needs  $\neq$  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???





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## Fixing the Bush

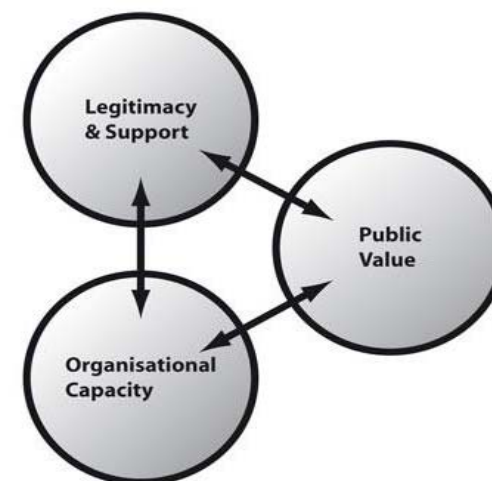
- Maxed out student and intern relocation – partial effect
- Vocational trainees come back to the City
- Need vocational training to be BASED in non metro areas
- Colleges need to be much more flexible with accreditation





## OBESITY - A Global Health Threat

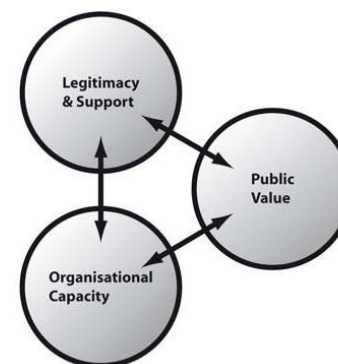
- No country has yet made significant inroads
- Two main challenges
  - Management of currently obese population
  - The prevention strategy
- No issue in greater need of clinical leadership





# 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

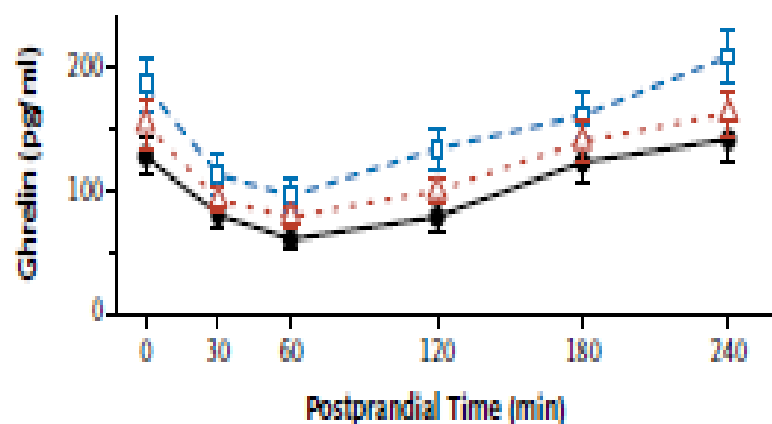






# Managing the currently obese

- 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??







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## Clinical Leadership in Reversing the Epidemic

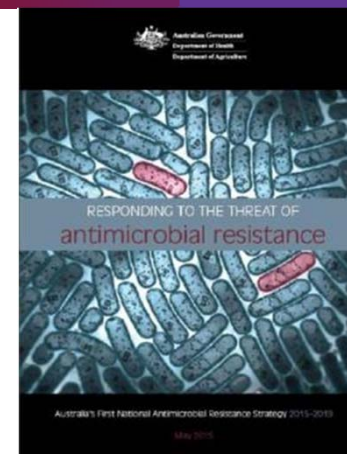
- Broad civic coalition – key role of health professionals, partner with community groups,
- Can't just be health professionals pushing for action
- Gather the evidence, particularly for regulatory measures
- Particular focus on antenatal and early childhood
- Avoid the narrative of short term return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





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# 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



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## AMR Action

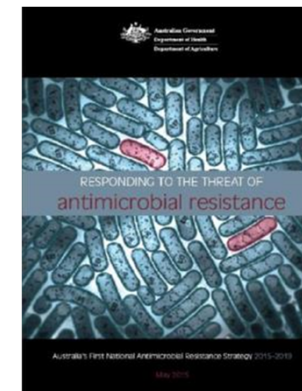


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- Big international political engagement
- Action plans, UN, WHO, G7, G20, GHSA
- Developing nations hard to engage
- What have we achieved at home?:
  - Stewardship in most hospitals & national centre
  - Other national centres including work on novel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