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Prioritising Health

2018 Victorian election statement

About The Royal Australasian College of Physicians (RACP)

The RACP trains, educates and advocates on behalf of over 17,000 physicians and 8,000 trainee physicians, across Australia and New Zealand, including more than 3,900 physicians and over 2,000 trainee physicians in Victoria. The College represents a broad range of medical specialties including general medicine, paediatrics and child health, cardiology, respiratory medicine, neurology, oncology, addiction medicine, public health medicine, occupational and environmental medicine, palliative medicine, sexual health medicine, rehabilitation medicine.

Overview

Beyond the drive for medical excellence, the RACP is committed to developing policies, programs, and initiatives which will improve the health of communities. Patients should have access to an integrated and well-coordinated health system, and governments should take a whole-of-government approach to improve health, and address the social determinants of health.

The RACP and its Victorian Regional Committee are committed to working with all political parties to inform the development of health policies that are evidence-based, informed by specialist expertise and experience, and that focus on ensuring the provision of high quality healthcare accessible to Victorians—integrated across primary, secondary, and tertiary services, as well as across the public and private sectors.

We have identified a number of policy priorities that will help ensure the Victorian healthcare system continues to operate at a world-class level, delivering good health outcomes in a sustainable way. This will require innovation, increased efficiency and effectiveness, and a focus on integrated, high quality, high value specialist care.

This Election Statement outlines the RACP's position on a number of important areas of health policy and makes recommendations that we urge the incoming government to adopt.

The RACP calls on all political parties to engage and work with us. Accordingly, we seek a productive and effective working relationship with the incoming government, and would welcome a meeting with the incoming Health Minister to discuss the new government's plans to address our priorities.

Intergenerational health

Early childhood

There is strong evidence that investment in the early years of children's health development and well-being is the most cost-effective means of tackling long term health conditions and health inequity.[1]

A comprehensive, nationally coordinated and long-term strategic approach to identifying and addressing disadvantage and vulnerability in children and infants should be undertaken to ensure that every child receives the best possible start in life. Victorian children deserve the benefit of a government which pursues their interests by the best possible coordination of Victorian and Commonwealth health policy and resources.[2]

The incoming government should:

- Support and actively pursue the reinstatement of the Australian Health Ministers' Advisory Council subcommittee on child and youth health.
- Lead the way on developing a nationally coordinated strategic approach to addressing disadvantage and vulnerability in children and infants.
- Participate in development of nationally consistent equity-based key performance indicators for governments that promote the health, development and well-being of all children.
- Support the development, evaluation and scaling up of innovative models of care that coordinate and link vulnerable children and families to existing health and social services
- Make improved health outcomes for Aboriginal and Torres Strait Islander children a priority.

Mental health of children

Systemic changes are needed to develop more efficient, integrated, and responsive models of care for children and young people with developmental, behavioural or mental health problems. The role of paediatricians in delivering clinical care to children and young people with mental health problems must be recognised.[3] Paediatricians with appropriate training and experience can make a valuable contribution to

effective, integrated, multidisciplinary care in collaboration with child and adolescent psychiatrists and other clinicians, and must be supported to do so.

In Australia the relatively large number of children and young people with mental health problems contrasts with the limited number of specifically trained clinicians available to help.[4] This disparity makes it unlikely that either specialised programs based in secondary and tertiary treatment settings, or psychiatrists in private practice, will be able to provide direct care for all those with mental health problems. This shortage is exacerbated in country areas where access to child and adolescent psychiatrists and psychologists is more limited.

The incoming government should:

- Commit to, plan, fund and implement strategies for the prevention of mental health problems in children
- Commit to, plan, and fund improved and innovative models of mental health care focussing on preventive mental health and early intervention, including access to psychology services in the community
- Commit to and implement needs-based equitable funding for children's mental health across Victoria, including hospital and community-based care.

Obesity

Physicians and paediatricians see patients and families every day who are struggling with obesity and related health conditions. They understand that these conditions are influenced by unhealthy diets and low physical activity driven by the obesogenic environment we live in. People suffering from obesity are entitled to receive the same standard of care as sufferers of any other chronic condition, but unfortunately this is not always the case, and stigmatisation of these patients only exacerbates the issue.

Obesity is a health crisis, a systemic societal problem, and a chronic disease.[5]

In 2014–15, 70.4% of people in Victoria were overweight or obese (comparable to national obesity and overweight rates).[6]

Priority prevention strategies include the introduction of a tax on sugar-sweetened beverages, mandatory front-of-pack labelling and regulatory restrictions on marketing unhealthy foods and beverages to children, active transport, environmental planning, and encouragement of physical activity.

Treatment services should primarily focus on helping people with obesity to achieve optimal health at any weight. This will involve health professionals taking active steps to reduce weight bias and carefully balancing the benefits and risks of weight loss programs, acknowledging the health benefits of even modest weight loss on one hand with the evidence on the other hand that sustained weight loss is uncommon and failed weight loss attempts have negative psychological and physiological effects.

Health systems also need to improve equitable access to weightloss services, including bariatric surgery. Bariatric surgery is an effective, though expensive, intervention for the treatment of severe obesity. Patients who meet the criteria should be referred for assessment. More co-created and well-evaluated community-level interventions with priority populations are also needed to tailor actions for different communities, and better and more equitable access to bariatric surgery is needed within the publicly-funded health system.

The underlying commercial, economic and environmental conditions which are driving the obesity epidemic can be mitigated by collective efforts of governments, civil society and industry. Improved governance and policy-making processes, including attention to managing conflicts of interest and strengthening Health in All Policies approaches, will be essential to reducing obesity and its related inequalities.

Both prevention and treatment of obesity are urgent priorities.

The incoming government should:

- Set targets for reducing mean population intakes of nutrients associated with unhealthy diets based on World Health Organization recommendations.
- Introduce a health and wellbeing principle as part of local government decision-making when considering land use planning and zoning permissions.
- Implement consistent healthy food and drink service policies that promote and enable healthy diets.
- Implement a Health in all Policies approach across government, including transportation and urban planning design, prioritising active transport and active recreation solutions, and where appropriate embed this approach into legislation.
- Promote physical activity.
- Implement regionally appropriate actions to support and empower priority populations to address obesity at individual, family and community levels. These actions need to be designed, implemented and evaluated collaboratively with communities to ensure they are culturally appropriate and meet community needs.
- Provide greater and more equitable access to bariatric surgery for the treatment of severe obesity, including increased access to bariatric surgery in the public system.

Drug and Alcohol treatment services and harm prevention efforts

Substance use disorders are a health issue, and governments should move away from the dominant paradigm of criminality as the means to deal with individuals who use drugs. The incoming government should instead adopt an increased focus on health and wellbeing to improve outcomes for individuals and communities more broadly.[7]

Alcohol

Alcohol-related harms create enormous social and economic costs to Australian society, with estimates putting the figure at between $15 billion and $36 billion annually.[8] This is a cost of between $604 and $1450 per person per year.

The RACP's Alcohol Policy, developed jointly with the Royal Australian and New Zealand College of Psychiatry, provides an in-depth review of the evidence and provides recommendations on effective policies to reduce the harms of alcohol.[9]

As well as addressing harmful consumption, the RACP is calling for an increase in the availability and range of treatment services for those with alcohol addiction.

Evidence shows that a coordinated public health approach to reducing alcohol consumption is required to comprehensively tackle the harms associated with alcohol – this must involve all levels of government. The incoming government must demonstrate leadership in pro-actively working across jurisdictions to help instigate and support a national approach to addressing drug and alcohol issues.

Drug and alcohol services

Drug and alcohol services in Australia are chronically underfunded and consistently overstretched. This has been clearly shown by the work undertaken on the *Drug and Alcohol Service Planning Model* (DASP) and the *Drug and Alcohol Clinical Care and Prevention Project* (DACCP), developed by a project team with representation from Commonwealth and state governments, health care providers and consumers. These are valuable tools available to governments to determine the level of need for drug and alcohol treatment across Australia.

Every year approximately 200,000 Australians access drug and alcohol treatment. However, it is estimated that an *additional* 200,000 to 500,000 Australians annually are not able to access the treatment they need.

Even on an economic analysis, increased treatment is a good investment: one estimate is that for every dollar invested in substance abuse treatment is associated with a monetary benefit to society of $7, primarily because of reduced costs of crime and increased employment earnings.[10]

The RACP's Chapter of Addiction Medicine is represented on the SafeScript Expert Advisory Group, and the RACP supports the principles of SafeScript. However, we are concerned that due to the acute shortages of health professionals with the required expertise, appropriate treatment will not be available for the cohort of individuals who are likely to have problematic and often very challenging behaviours who will be identified through the introduction of SafeScript.

Medically supervised injecting centres

The RACP has been a clear and strong supporter of supervised injecting centres (MISCs).[11] The evidence is unequivocal: MISCs minimise the harms associated with injecting drug use and save lives. They also succeed in reaching out to vulnerable and marginalised individuals who may not otherwise access the health and welfare services they so desperately need. In so doing, they also benefit the wider communities in which they are located, including local residents and businesses.

There are approximately 110 MISCs around the world, and all allow a range of substances to be used on site including methamphetamine. Around 20 per cent of visits to the Sydney MSIC involve the injection of methamphetamines. The staff at these centres have the experience and expertise required to safely work with people injecting methamphetamines.

MSICs reduce public drug injecting by operating as low threshold services and taking drug use off the streets. They do this by ensuring those people already present and already injecting in public voluntarily attend a health service and use drugs under supervision instead. Excluding certain people on the basis of the drug they are injecting is not only impractical but would create a perverse situation where we are leaving people to inject methamphetamine in public. The crucial point is that a supervised injecting centre allows for early intervention, management of overdose and other adverse reactions, and referrals into treatment, rehabilitation and support.

These services are responding to an existing large-scale drug problem, not creating another one.

The incoming government should:

- Implement a minimum price per standard alcoholic drink, following the lead of the Northern Territory.
- Ban all outdoor advertising of alcohol, including outdoor advertising using Victorian government property. This would support the principle of preventing the exposure of young people to direct and indirect alcohol advertising due to its recognised harmful impact. We note that this is one of the few media channels for alcohol advertising which is directly within the control of state governments.
- Identify and progress items within the consultation Draft National Alcohol Strategy 2018-2026 that are within the Victorian government's responsibilities.
- Increase funding for drug and alcohol treatment services, including supporting appropriate workforce development, to address the unmet need.
- Increase investment in prevention services to reduce the incidence of illicit drug use and alcohol use disorders.
- Invest in and support initiatives to reduce the inappropriate and harmful use of prescription drugs.
- Prioritise specialist addiction workforce development so that the availability of specialist treatment is commensurate with the identified need.
- Commit to exploring a pain-focussed telehealth facility dedicated to supporting general practitioners in their management of rural pain patients, particularly those at risk from problematic use of opioid analgesics.

- Support the ongoing pilot of the Medically Supervised Injecting Centre in Richmond as currently rolled out without excluding certain people from accessing this evidence-based health service on the basis of the drug they are injecting.

End of life care

People are approaching the end of life when they are likely to die within the next 12 months, including the last months, weeks or days of life. All physicians, working as part of a multi-disciplinary team, have a key role in providing clinical leadership to help patients to live well in their last year of life, and to proactively manage the dying process. Specialist palliative care services are required to address complex needs, as well as provide consultancy, mentoring and education to other healthcare practitioners. It is essential that patients in need of specialist palliative care services can access them.

However, many Victorians, including aged care residents, rural communities, culturally and linguistically diverse communities, and those with special needs are not gaining equitable access to quality end-of-life care and palliative care services. Palliative care has been recognised internationally to improve quality of life, prolonging life in some cases, whilst better utilising health care resources.[12] It is not limited to older people with cancer, but beneficial to all people with a life-limiting illness, regardless of age, diagnosis, or prognosis, and is provided on a needs basis from diagnosis to bereavement. Only 46% of Victorians have a good understanding of palliative care and even fewer among diverse communities. This lack of awareness limits palliative care involvement, and the known benefits when provided early in the disease trajectory.

In 2016, deaths in Victoria totalled 40,015. However, at least 25% of these deaths received no generalist or specialist palliative care.[13] Population growth, ageing and chronic disease will drive the demand for palliative and end-of-life care services. Ensuring that patients have access to the right care, at the right time, and by the right provider can be challenging but is fundamental to providing optimal care and maintaining patient dignity. In order to achieve such care, policy frameworks internationally, nationally and in Victoria have advocated for palliative care to be integrated into healthcare services across all settings.[14]

The importance of improving access to palliative care has been highlighted by Victoria's End of Life and Palliative Care Framework, the Victorian End of Life Choices Inquiry (2016), the Victorian Auditor General's recommendations (2015), and the Productivity Commission's recent recommendations for community and aged care settings. Palliative Care Victoria conservatively estimates that 10,000 Victorians who die each year miss out on needed palliative care.[15]

Victoria's End of Life and Palliative Care Framework highlights the need to build workforce and service system capacity across the Victorian healthcare system. Patients who are in the last year of their lives may receive input from a great number of medical and non-medical health professionals in a range of care settings (acute, community, public, private), and may present repeatedly. The provision of end-of-life care to these people should be seamless in transitioning between services. Co-ordinated and integrated information technology systems need to be coupled with the ability of clinicians to have clinical conversations to plan care. Physicians play a key role in promoting Advance Care Planning (to inform clinicians, families and carers of patient wishes), and participating in goals-of-care discussions that ensure clinically appropriate treatments are continued. This includes discussions with the patient, families and carers, relating to limitations of treatment and their preferred place of care as disease progression occurs.

The incoming government should:

- Promote community awareness to ensure consumers are knowledgeable about palliative and end-of-life care options, respecting the cultural values of the diverse population of Victoria.
- Increase community palliative care services to meet current and future need for care at home, including improved support for carers who provide most of the care, and a focus on rural and regional communities.

- Increase access to consultancy palliative care. Many of these services cannot meet current demand. They facilitate the right care at the right place and at the right time in inpatient and community settings across Victoria.
- Increase inpatient palliative care services with a particular focus on non-cancer services. The rate of palliative care related hospitalisations in Victoria increased by 10% between 2010–2015, and 78.3% of these admissions were public patients. Increasing inpatient services will improve capacity to meet this growing need.
- Increase access for residents in aged care services. Specialist palliative care and end of life consultancy teams are needed to provide proactive and responsive specialist clinical support for aged care staff and GPs caring for residents with complex needs.
- Improve after-hours access to GPs and pharmacists with palliative care and end-of-life care expertise by providing education and by establishing effective links and protocols to facilitate access to urgent after-hours support.
- Enhance workforce availability, education and models of care. Education and workforce development programs are required to ensure staff with the requisite skills and expertise are available to meet the current and growing need for high quality palliative care and end-of-life care across Victoria's health and care system. Further innovation and collaboration are necessary so that service models and practices deliver the best outcomes for people with a life-limiting illness, their carers, and the overall health system.

Sexually Transmitted Infection (STI) rates and access to care

The rates of gonorrhoea and syphilis in Victoria have been rising for some years but are now reaching record levels[16]: There were 1,337 notifications of infectious syphilis in 2017.[17] Cases are now beginning to increase significantly in heterosexual men and women. The significance of cases in women is that it heralds the significant risk of congenital syphilis and gonorrhoea neonatorum (i.e. in newborn babies). Congenital syphilis cases occurred in Victoria in 2017 for the first time since 2004; one case resulted in fetal death. Syphilis occurring in pregnant women results not only in increased numbers of stillbirths but also results in substantial lifelong consequences.

Access to comprehensive primary health care is the most effective method for controlling syphilis at a population level: timely and best practice treatment of cases and sexual partners, and screening of at-risk groups (including antenatal screening).

Countries or regions with better access to health care (e.g. the United Kingdom) are seeing syphilis rates in their heterosexual populations remain stable yet regions with less accessible health care (e.g. California) are seeing rapidly rising cases and large increases in congenital syphilis.

Victoria has one specialist sexual health centre, the Melbourne Sexual Health Centre, which provides about 50,000 consultations a year. However, over the last few years it has reached near capacity. While a significant proportion of Victorians do see their general practitioners, some will not and need a sexual health service with high levels of confidentiality. If people who will only attend a sexual health service cannot access one, their sexually transmitted infections will go untreated and be passed on to others.

In contrast New South Wales has over 20 specialist sexual health services that provide over 108,000 consultations a year with a greater capacity to provide new patients with specialist sexual health needs. NSW also has a substantially lower rate of syphilis than is seen in Victoria; limited access to specialist STI services in Victoria may be a reason that STI rates in Victoria are rising more rapidly than NSW.

The limited access to services in Victoria may also explain why non-Medicare clients (such as overseas students) have rising rates of HIV in Victoria but clients with access to Medicare have rapidly falling rates of HIV, due to greater access to HIV preventative treatment.

The incoming government should:

- Commit to and deliver more accessible specialist sexual health services, including improved geographic access to specialist health services.

Addressing increased sexually transmissible infections (and blood borne viruses) in Indigenous populations

The RACP is advocating effective, coordinated, and timely action in response to increasing sexually transmissible infections (and blood borne viruses) in Indigenous populations.

Commonwealth and State governments are currently implementing the Action Plan: Enhanced response to addressing sexually transmissible infections (and blood borne viruses) in Indigenous populations.

RACP representatives are participating in the Clinical Education Advisory Group, the Workforce Advisory Group, and the Antenatal Care Advisory Group to assist with the implementation of the Action Plan.

The RACP is developing a consensus statement on the interpretation of syphilis point of care test results, at the request of the Commonwealth Department of Health, to assist with the roll out of syphilis point of care tests as part of the Action Plan.

The incoming government should:

- Enhance or implement disease control interventions including:
  - opportunistic and community screening/testing, particularly among young sexually active people aged less than 29 years
  - immediate treatment of people who are symptomatic (e.g. genital ulceration), have tested positive for syphilis, or are sexual contacts of cases
  - reinforcement and focus on antenatal screening for syphilis, with particular attention paid to recommended guidelines for the 'at risk' population
  - public health alerts, health protection education and campaigns
  - active follow up of cases.[18]

- Fund and deliver sexual health programs and services proportionate to community needs and led by Aboriginal and Torres Strait Islander leaders and communities, to achieve low rates of STIs and BBVs, and support good sexual health for all people in Victoria.

Additional Priorities

Climate change and health

The RACP is calling for strong action to mitigate the health risks of climate change and extreme weather events, including more sustainable healthcare and evidence-based strategies for management of extreme weather related risks to healthcare infrastructure, operations and personnel.[19]

In Australia there is already a noticeable impact from increased frequency and intensity of bushfires, floods, dust storms, drought and extreme heat, biodiversity decline, and reduced quality and increased salinity of fresh water. Australians are already seeing higher rates of respiratory illness, diarrhoea and morbidity requiring hospital admission during hot days, and higher rates of suicide in rural areas during drought years.

The governments of Australia, New Zealand and other Pacific nations have signed the 2015 Paris Climate Agreement, which commits signatory states to reducing greenhouse gas emissions "as soon as possible". It aims to hold global average temperatures to well below 2ºC above pre-industrial levels (and ideally below 1.5ºC).[20] [21] The latter level of warming is the highest level compatible with the geographic survival of many Pacific nations. In October 2018 the IPCC warned that "global warming is *likely* [emphasis in original] to reach 1.5°C between 2030 and 2052 if it continues to increase at the current rate."

The RACP recognises the multiple roles of physicians in promoting action on climate change.[22] These include educating the health sector, delivering more sustainable healthcare, raising community awareness, and influencing public policy. At a local level, many RACP Fellows and Trainees have already begun to address climate change in the public and private hospital sector and in their private practices by promoting initiatives aimed at "greening the healthcare sector" (such as the introduction of more energy efficient lighting and reduction of wastage).

We also recognise the steps Victoria has already taken towards environmental sustainability in healthcare and sustainable environments for a healthy lifestyle.

To maximise the potential health benefits of mitigating climate change[23], the incoming government should:

- continue to facilitate the transition from fossil fuels to renewable energy and improved energy efficiency across all economic sectors
- work towards the legislated target of net zero greenhouse gas emissions by 2050 that is required by the Climate Change Act 2017
- work towards the target to reduce Victoria's emissions by 15-20 per cent below 2005 levels by 2020
- work towards increased availability of public transport, particularly to inadequately serviced areas
- increase active transport use and safety, for example by funding the construction of bicycle and pedestrian paths
- ensure that opportunities for improved community health, such as availability and accessibility of public and active transport and green spaces, sustainable and resilient housing, are incorporated into the planning phase of new developments, by using environmentally and health-sensitive urban planning
- ensure strong adaptation, emergency and response planning for extreme weather events, including heatwaves and fires.

Support for rural patients—Dual training

The Victorian Dual Training Program is the result of collaboration between the Victorian Department of Health and Human Services and the RACP. Trainees in the program receive training in general and acute care medicine and another specialty. The purpose of the program is to address regional areas of need and encourage trainees to build careers in rural Victoria.

This program provides efficient way to address specialist workforce shortages in regional Victoria. A major benefit of the program is that it allows the regional health service to determine the second specialty in which training is undertaken on the basis of the region's own identified needs.

Applications consistently exceed the number of available positions. To expand the program, we recommend that funding be made available for a further two positions per year for the next three years, and that funding for positions in this program be increased to a level equivalent to that of the positions funded through the Commonwealth's STP Program.

At current levels there is a shortfall for these positions of up to $65,000 per year per position, which is currently left to the hospital to make up. This is because the trainees who fill these positions are in the advanced phase of their training and thus at postgraduate years (PGY) 5 to 8, in contrast to the Victorian Government's program for funding junior doctors in regional settings which is targeted at PGYs 1 and 2. The gap limits the ability of potential partner hospitals to participate in the program.

The incoming government should:

- fund positions in this program at a level equivalent to that of the positions funded through the Commonwealth's STP Program
- make funding available for a further two positions per year for the next three years
- map specialist workforce requirements to identified needs, such as sexual health and palliative care services, thereby providing an equitable benchmark against which future applications can be measured.

Support for rural patients—Telehealth

Investment in telehealth has increased patient access to medical care in rural and regional areas nationwide. Telehealth improves specialist access for rural and remote patients, and minimises disruption to the home, school, work, and care responsibilities. The use of telehealth could be further supported within the palliative care and pain management specialties as part of an integrated model of care.

These benefits to those living in rural and regional areas, are not currently available to many people who experience difficulty in travelling to see doctors; for example, those with mobility issues, frail and older people, and parents with young children. Given the clearly demonstrated value in enhancing access to tertiary hospital-based specialist care,[24] the RACP is advocating (at the Commonwealth level) the removal of the Medicare limitation to patients beyond 15km from the specialist service. There would be significant benefits – for patients, health services and healthcare providers, and for government expenditures – in removing this limitation and extending access to telehealth MBS items to a wider population. Should this restriction be removed, the potential benefits for Victorian patients and to the Victorian health budget may be considerable, but this will depend on sufficient investment in increased telehealth facility infrastructure and associated planning and operational arrangements.

The incoming Government should:

- Commit to continued digital transformation within Victorian hospitals consistent with the "Digitising Health" strategy for Victoria's public health sector, with genuine clinical leadership and the goal of improved clinical outcomes for all Victorians across the state and efficiency gains for the system as a whole.
- Support the RACP's position in favour of Medicare rebatable specialist telehealth consultations for patients living within 15 km of the specialist service.
- Fund the promotion of extended access to telehealth to the community, healthcare professionals, and health services organisations.
- Plan and resource telehealth facilities accordingly to support the technology being as widely and effectively used as possible within the specialist sector.

Indigenous health

Aboriginal and Torres Strait Islander people continue to experience poorer health outcomes than non-Indigenous Australians.

Australia is not on track to close the life expectancy gap by 2031: with the gap remaining close to ten years for both men and women. The gap for deaths from cancer between Aboriginal and Torres Strait Islander and non-Indigenous Australians has in fact widened in recent years, with Aboriginal and Torres Strait Islander cancer death rates increasing by 23 percent between 1998 and 2016, while there was a 14 per cent decline for non-Indigenous Australians in the same period.[25] Indigenous Australians have a three-fold higher rate of preventable hospital admissions than the rest of the population.

The number of people in Victoria identifying as Aboriginal or Torres Strait Islander has risen to 47,788 (as of the 2016 Census), up from 37,992 in 2011.[26] This increase of 25% over five years likely reflects an increased willingness to identify as Aboriginal or Torres Strait Islander as well as normal population growth, but also

places the onus on the Government and on health services to properly quantify and plan for the availability of appropriate services.

Aboriginal and Torres Strait Islander health leadership and genuine community engagement is crucial to achieving improved health outcomes. The Aboriginal Community Controlled Health sector is of vital importance in delivering effective, culturally safe care to Australia's First Peoples; and service development and provision should be led by Aboriginal and Torres Strait Islander health organisations wherever possible.

The RACP's Aboriginal and Torres Strait Islander Health Committee has developed the Medical Specialist Access Framework, a strengths-based guide for health sector stakeholders to promote and support equitable access to specialist care for Australia's Indigenous peoples. The Framework is the RACP's principal contribution to Strategy 1B of the Implementation Plan for the National Aboriginal and Torres Strait Islander Health Plan 2013–2023.

The Framework includes case studies of innovative and successful models of Aboriginal and Torres Strait Islander people accessing specialist care. The Framework aims to connect stakeholders involved in delivering specialist medical care including patients, carers, communities, funders, facilitators, service providers and individual medical specialists and other health practitioners.

The incoming government should:

- Prioritise and support the leadership and engagement of Aboriginal and Torres Strait Islander leaders and communities.
- Support community led early childhood services
- Prioritise community engagement and leadership for public health programs
- Prioritise equitable access to specialist care for Aboriginal and Torres Strait Islander people in Victoria. This requires systems and mechanisms to drive regional collaboration in identifying and planning specialist healthcare service provision for Aboriginal and Torres Strait Islander people.
- Properly quantify the need for specialist services and plan to ensure this is appropriately met.
- Encourage the use of the RACP's Medical Specialist Access Framework in Victoria.

Indigenous children in out-of-home care

Aboriginal and Torres Strait Islander children are being removed and placed into statutory out-of-home care at far greater rate than non-Indigenous children:

- The removal rate of removal of non-Indigenous children (nationally) is 5.8 per 1,000.
- The removal rate of children in Victoria is 7.5 per 1,000.
- The removal rate of Indigenous children in Victoria is 95.9 per 1,000. [27]

We are concerned that there are no publicly funded dedicated paediatric services for Indigenous children in out-of-home care in Victoria.

This is despite a recommendation of the Taskforce 1000 report: [28]

> 8.1 DHHS, in partnership with VACCHO, to develop and implement a strategy and practice standard to ensure all Aboriginal children in out-of-home care have a specific Aboriginal children's health check upon entry to care, and then annually, at an ACCHO.
>
> The strategy should ensure that funding for ACCHOs aligns with the initial and future demand for new services and in accordance with the numbers of Aboriginal children in out-of-home care.

We understand the Victorian Aboriginal Health Service, together with the Wadja Unit at the Royal Children's Hospital, Melbourne, is developing a model for providing the health assessments and health care for Aboriginal children in out-of-home care, and we recommend its considered and coordinated implementation.

We praise Victoria's leadership on Aboriginal self-determination, including its progress towards a treaty, and its commitment to early intervention for vulnerable children, as outlined in the Roadmap for Reform and the Koorin Koorin Balit Djak strategic plans.

The incoming Government has the responsibility to improve health access, including to paediatricians, for Indigenous children in out-of-home care in accordance with the National Clinical Assessment Framework for Children and Young People in Out-of-Home Care.

This is consistent with *Victoria's Mothers, Babies and Children 2016* (the 55th survey of perinatal deaths in Victoria), which recommended that, as part of a new model of care for the health and welfare of vulnerable children (Indigenous and non-Indigenous):

> Staff in non-government community service organisations and community health centres have improved access to consultation with health professionals, especially paediatricians and general practitioners. This requires **more paediatricians who are based within community health centres** [emphasis in original] and closer links between community service organisations and the health sector.[29]

The incoming government should:

- Commit to long-term planning and investment in social determinants of health to reduce the rate of removal of Aboriginal and Torres Strait Islander children.
- Implement recommendation 8 of the Taskforce 1000 report, ensuring all Aboriginal children in out-of-home care have a comprehensive and specific Aboriginal children's health check at an Aboriginal Health Service, which complies with the recommendations of the National Clinical Assessment Framework for Children and Young People in Out-of-Home Care.
- Implement recommendation 6 of *Victoria's Mothers, Babies and Children 2016*, improving access to paediatricians, working within community health services, who can provide coordinated and integrated care.[30]

Integrated care

Victoria faces similar challenges to other Australian states and territories: multi-morbidity, a greater proportion of older people, varied geographical availability of different clinicians and finite funding including for public hospitals. Australian health services have historically been organised around responses to episodic, acute care needs. Patients must often navigate services among healthcare sectors that often involve disconnected services that deal with single conditions.

We must increase the degree of integration between health services to address service demand pressures and maintain quality and safety as an increasing proportion of our population develops chronic, complex and multiple health care needs. More than 80 per cent of Australians are estimated to have at least one chronic condition or risk factor[31]. Physicians are specifically trained to care for and advise on the diagnosis and management of patients with complex illnesses (including multiple morbidities).

Fundamental to the RACP vision for more integrated care is the need to support specialists to care for patients with chronic, complex and multiple health care needs and for this to include working in community based ambulatory settings, physically and virtually, in ways that are better connected with GPs (primary care).[32] This is integral to reducing hospital readmissions, unnecessary admissions, and potentially preventable hospitalisations. Importantly, this will improve the experience of patients. The RACP is keen to consider opportunities to partner with health services in Victoria on alternative models of specialist care in community settings, with potential benefits to patients and health services alike.

The Productivity Commission report "Integrated Care, Shifting the Dial: 5-year Productivity Review" specifically highlighted the need for stronger links between primary care and hospitals[33]. Further, a 2013 ABS survey found that 14.3 per cent of people who saw three or more health professionals for the same condition reported issues caused by a lack of communication between health professionals. Lack of integration results in delays in care and adds to the costs of health care.[34]

Essential to efficient and integrated delivery of healthcare are secure and accessible patient information systems that enable interprofessional communication, shared care planning, Remote Patient Monitoring, Patient Reported Measures and telehealth.

The RACP recommends the incoming government:

- Work with clinical leaders and other key stakeholders to develop and implement policies and practices to better connect and integrate hospital specialist services with primary care and allied health, and facilitate increased provision of specialist care in community settings.
- Provide funding to support and evaluate integrated care projects that focus on connecting primary, secondary, and allied health care.
- Facilitate specialists to contribute securely to shared care plans at an early stage of care with primary health professionals and patients.
- Enable specialists to be better integrated with the primary care sector and within secondary care organisations by supporting robust communication and information systems.

High-value care

While Australia is recognised as providing high-value, high-quality patient care, it is important that all states and territories continually improve their clinical processes to ensure the delivery of contemporary best practice and patient care.

Part of a global movement, Evolve is an initiative led by physicians and the RACP to drive high-value, high-quality care in Australia and New Zealand, making sure patients receive care that is proven to be necessary, safe and effective. Evolve identifies each specialty's 'top five' clinical practices that, in particular circumstances, may be overused, provide little or no benefit, or cause unnecessary harm to patients, enabling physicians to make the best use of health resources.

RACP is a founding member of Choosing Wisely in Australia and New Zealand, and all Evolve recommendations are available via these campaigns. By bringing together recommendations from multiple medical colleges and healthcare organisations, together with expertise in consumer and patient care, Choosing Wisely helps healthcare providers and consumers start important conversations about improving the quality of healthcare.

Evolve, and the broader Choosing Wisely campaign, provides the Victorian Government with an invaluable opportunity to appropriately invest, via grants or other support initiatives, in the implementation of recommendations that aim to reduce low-value care and improve both the quality and safety of healthcare and also support the best use of valuable healthcare resources. Aspects that would be particularly valuable for the Victorian Government to invest in include the development of patient resources, quality improvement initiatives, change management strategies, and translational research across the health sector. This will maximise ongoing and effective use of health resources, promote clinical quality improvement, shared-decision making, and improve clinical culture and patient outcomes.

The incoming government should:

- Continue to drive high-value, high-quality care in clinical practice by supporting the implementation of the Evolve recommendations in clinical services it funds and more broadly in Victoria e.g. reducing unnecessary imaging and blood pathology tests.
- Invest in providing accessible resources relating to appropriate patient care for consumers and promoting shared decision-making.
- Invest in quality improvement measures and change management strategies across the health system, via grants or supported initiatives.
- Support translational research, bridging the divide between academic identification of low-value clinical practices and the reduction of these practices in clinical environments.

The Way Forward

High quality and appropriate training of junior doctors, including physician trainees, is crucial to ensuring the availability of a competent specialist workforce to meet current and future healthcare needs.

Over and above the specific commitment to dual training, the incoming government must be cognisant of, support, and value the contribution made by physicians within the Victorian health system to training junior doctors.

An incoming government should acknowledge that the contribution constitutes an essential investment in Victoria's future specialist workforce, and:

- Recognise that the training of physicians is an integral part of the delivery of healthcare services, and commit to services having adequate physical resources and sufficient protected time for teaching, supervision, and research.
- Support the health and wellbeing of physicians and physician trainees, and collaborate with sector partners in improving training environments and medical professional culture.
- Continue to work with the Commonwealth and other State and Territories in undertaking workforce planning.
- Ensure that any post-election new directions in clinical workforce policies (regardless of the election's outcome) are only developed and implemented with appropriate consultation and appropriate clinical leadership from physicians.

The RACP calls on all political parties and candidates to make a commitment to the health of all people in Victoria that extends beyond the election cycle, and to engage and work with key health stakeholders to deliver effective evidence-based and expert-informed health policies. The RACP looks forward to working collaboratively with the incoming government, as well as all successful candidates, to improve the health of Victorians.

For more information on the RACP or content in this election statement, please contact Aaron Thompson, Senior Executive Officer, by emailing racpvic@racp.edu.au.

[1] See our Health in All Policies Position Statement (RACP, 2016), especially "Early Childhood Development and Equity," p. 21.
[2] See our Inequities in child health Position Statement (RACP 2018).
[3] RACP Position Statement: The role of paediatricians in the provision of mental health services to children and young people (2016).
[4] Patrick D McGorry, Rosemary Purcell, Ian B Hickie and Anthony F Jorm, Investing in youth mental health is a best buy, Med J Aust 2007; 187 (7 Suppl): S5.
[5] See RACP Position Statement on Obesity: Action to reduce obesity and reduce its impact across the life course (2018) along with a companion Evidence review (2018).
[6] Table 2.1 on p. 6, Weight loss surgery in Australia 2014–15: Australian hospital statistics, AIHW, https://www.aihw.gov.au/reports/hospitals/ahs-2014-15-weight-loss-surgery/contents/table-of-contents
[7] See RACP submission to the Victorian Parliament Law Reform, Road and Community Safety Committee Inquiry into Drug Law Reform, March 2017.
[8] The Royal Australasian College of Physicians. Alcohol Policy, p 1.
[9] The Royal Australasian College of Physicians. Alcohol Policy.
[10] Ettner, S., Huang, D., Evans, E., et al. (2006). Benefit-cost in the California treatment outcome project: does substance abuse treatment "pay for itself"? Health Services Research, 41(1), 192-213.
[11] RACP submission to the Victorian Parliament Inquiry into the Drugs, Poisons and Controlled Substances Amendment Bill 2017 (Pilot Medically Supervised Injecting Centre), reflecting the RACP's Medically Supervised Injecting Centre Position Statement.
[12] National Centre for Social and Economic Modelling, University of Canberra, and Palliative Care Australia, 2017 The Economic Value of Palliative Care and End-of-life Care Fact Sheets.
[13] Palliative Care Victoria, Estimated Need and Unmet Need for Palliative Care in Victoria.
[14] World Health Organisation; Palliative Care Australia, 2018, Palliative Care Service Development Guidelines; Victorian End of life and palliative care framework, 2016.
[15] Palliative Care Victoria, Estimated Need and Unmet Need for Palliative Care in Victoria, p. 1.
[16] https://www2.health.vic.gov.au/about/news-and-events/healthalerts/rising-syphilis-cases-august-2018
[17] Health Advisory 180009, August 2018
[18] Commonwealth Department of Health, Infectious syphilis outbreak information
[19] RACP Position Statement: Climate Change and Health (2016)
[20] United Nations 2015. Framework Convention on Climate Change: Paris Agreement.
[21] United Nations. List of Parties that signed the Paris Agreement on 22 April 2016.
[22] RACP Position Statement: Environmentally sustainable healthcare (2016).
[23] RACP Position Statement: Health benefits of mitigating climate change (2016).
[24] Schulz TR, Richards M, Gasko H, Lohrey J, Hibbert ME, Biggs BA. Telehealth: experience of the first 120 consultations delivered from a new refugee telehealth clinic. Internal medicine journal. 2014 Oct 1;44(10):981-5
[25] 2018 Closing the Gap Report.
[26] Census: Aboriginal and Torres Strait Islander population, and associated media release.
[27] Data as of 30 June 2017. See Children in care Resource Sheet, September 2018 (AIHW, 2018)
[28] Recommendation 8.1, Commission for Children and Young People, *'Always was, always will be Koori children': Systemic inquiry into services provided to Aboriginal children and young people in out-of- home care in Victoria* (Melbourne: Commission for Children and Young People, 2016), p. 19
[29] Recommendation 6, *Victoria's Mothers, Babies and Children 2016* (the 55th survey of perinatal deaths in Victoria), (The Consultative Council on Obstetric and Paediatric Mortality and Morbidity, 2016), p. 29.
[30] See RACP Integrated Care discussion paper, Physicians supporting better patient outcomes.
[31] Business Council of Australia, Overview of megatrends in health and their implications for Australia: Background paper (2015).
[32] RACP Integrated Care discussion paper, Physicians supporting better patient outcomes
[33] Productivity Commission 2017, Integrated Care, Shifting the Dial: 5 year Productivity Review, Supporting Paper No. 5, Canberra.
[34] Greenberg, J.O., et al., The "medical neighborhood": integrating primary and specialty care for ambulatory patients. JAMA internal medicine, 2014. 174(3): p. 454-457.