



RACP
Specialists. Together
EDUCATE ADVOCATE INNOVATE

Prioritising Health
2021 Tasmanian election statement

About The Royal Australasian College of Physicians (RACP)

The RACP trains, educates and advocates on behalf of over 18,000 physicians and 8,500 trainee physicians across Australia and New Zealand, including 341 physicians and 128 trainee physicians in Tasmania.¹ The College represents a broad range of medical specialties including general medicine, paediatrics and child health, geriatric medicine, infectious diseases, cardiology, respiratory medicine, neurology, oncology, addiction medicine, public health medicine, occupational and environmental medicine, palliative medicine, sexual health medicine, and rehabilitation medicine.

The RACP acknowledges the traditional owners and custodians of the land on which our members practise, live, and teach. We extend our respect to all Aboriginal, Torres Strait Islander, and Māori people and value the importance of their ongoing connection to land, sea, sky, and community. We pay our deepest respect to Elders past, present, and emerging. And together we re-state our shared commitment to advancing Aboriginal, Torres Strait Islander, and Māori health and education as core business of the College.

Introduction

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

The RACP is committed to advancing Aboriginal and Torres Strait Islander health and education as core business of the College, implemented by a comprehensive [Indigenous Strategic Framework](#). We are a founding member of the Close the Gap Campaign for equality in health status and life expectancy between Indigenous and non-Indigenous Australians, and we promote health equity and equitable access to specialists for Aboriginal and Torres Strait Islander people.

We also acknowledge the critical contribution of public health physicians to the Tasmanian health system, including the response to COVID-19. The RACP has produced [Public Health Physicians: Protecting, Promoting and Improving Health for the Whole Community](#), which articulates for government decision-makers the value of Public Health Physicians credentialled as Fellows of the Australasian Faculty of Public Health Medicine (FAFPHMs) to the contemporary public health workforce and their capacity to contribute to the broader health system.

Our priorities

The RACP and its [Tasmanian Regional Committee](#) are committed to working with all political parties on the development of health policies that are based on evidence, informed by specialist expertise and experience, and focused on ensuring the provision of high quality healthcare accessible to all, and integrated across primary, secondary, and tertiary services, as well as across the public and private sectors.

Our priorities reflect the clinical expertise and professional experience of our members, as well as the opportunities for improvement that physicians and trainee physicians encounter in the course of our work across the state:

1. Sustainable long term workforce development
2. Fostering a culture of wellbeing for physicians and trainee physicians
3. Addressing health inequities, especially in the north-west
4. Reducing the harms of alcohol, including by minimum unit pricing.

Priority 1 – Sustainable long term workforce development

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

Workforce limitations stretch existing services and cause inequities across the state in areas of longstanding importance to the Fellowship in Tasmania such as child health, occupational health, and chronic illness.

The incoming government must be cognisant of, support, and value the contribution made by physicians to training junior doctors within the Tasmanian health system. Direct clinical care is the ultimate role of most specialist medical practitioners, but their duties to that end include indispensable non-clinical activities such as supervision, research, mentoring, and management.

The incoming government should acknowledge that these activities constitute an essential investment in Tasmania's future specialist workforce, including in specialties with relatively few practitioners in the state.

Tasmanian doctors report colleagues leaving the state due to a lack of funded positions, poor job security, and poor pay compared with other states. Most junior doctors have to apply yearly for positions, so offering longer contracts could assist in staff retention.

The incoming government should:

- Commit to funding training places commensurate to population size and distribution
- Recognise that the training of physicians is an integral part of the delivery of healthcare services, and commit to services having suitable physical resources and sufficient protected time for teaching, supervision, and research.
- Continue to work with the Commonwealth and other states and territories in undertaking workforce planning.
- Ensure that any post-election new directions in clinical workforce are only developed and implemented with appropriate consultation and leadership from physicians and the RACP.
- Develop and implement specific attraction/retention strategies for specialties with unique characteristics, such as Occupational and Environmental medicine and Public Health medicine.

As we have said to the Commonwealth in relation to the National Medical Workforce Strategy 2021-2031, attraction and retention strategies should be developed in conjunction with physicians, should be evidence based, and should focus on the professional and social dimensions of retention, not just on remuneration. The following points which we made to the Commonwealth should also drive Tasmanian efforts to recruit specialists in a long-term sustainable way:

- Actively creating local interprofessional teams or hubs of health professionals is important to provide the elements of employment that incentivise doctors (and their families) to commit to a rural life. For instance, providing a reasonable employment roster and work/life balance, together with consistent colleagues (and potentially friends).
- While there are numerous policy initiatives which may be used to drive changes in the medical workforce composition a key factor will remain the provision of impartial current and projected data regarding employment opportunities to trainees at all phases of their career.
- Focusing on remuneration as a major driver of career choice and practice location fails to appreciate that the marginal return on increased remuneration in a relatively highly paid workforce is small and unlikely to achieve a dramatic change in behaviour. A greater understanding of (1) who decides to work in a regional or remote location and why they may do so, (2) who decides not to work in these locations and why, and finally (3) who leaves regional or remote practice and why is required.
- A detailed understanding of these three healthcare worker groups will be key in informing initiatives in this sector. Focused research funding would facilitate this understanding. Unfortunately, existing workforce surveys often suffer from low participation rates and relatively simplistic analysis and projection modelling and may be viewed as biased by the dissatisfied few.
- Only by understanding and identifying personal and environmental factors which drive location of practice will it be possible to develop evidence-based policies. A detailed review of past programs at a national and jurisdictional level also is required to avoid recycling past unsuccessful policies.
- Finally, a significant issue for the medical workforce, irrespective of location, is accountability and competence at a senior management and executive level. The advent of managerial structures in health services means senior health service leadership is typically devoid of practising clinicians. This often leaves medical staff involved in providing health care 'at the coal face' detached from workforce planning and strategy whilst being held responsible for issues relating to quality and preventable adverse outcomes. Any medical workforce strategy should explore pathways for developing medical leadership and management skills and facilitating their deployment throughout health service structures. The impact of limited clinical rather than managerial leadership in healthcare is important in all health services but can be particularly relevant in ensuring rural and remote training and practice is valued by medical practitioners and in recruiting and retaining the medical workforce in these settings.

Priority 2 – Fostering a culture of wellbeing for physicians and trainee physicians

One part of the workforce challenge is improving the culture and experience of practicing specialist medicine in Tasmania. We agree with the draft Healthy Workforce 2040 strategy that “the culture in healthcare organisations needs improving to support the work of health professionals.”

Doctors’ health and wellbeing is a growing concern within the RACP, and within the medical profession and the community more generally, prompted by several tragic early deaths of doctors in training. A steadily increasing literature and a profession-wide consensus supports wellbeing being taken seriously.

We have long known that junior doctors report high rates of burnout, emotional exhaustion, and cynicism,² and our members see this first-hand. All RACP’s Tasmanian trainees are simultaneously engaged in postgraduate specialist medical training and work in accredited training locations throughout the state’s health system.

The RACP recognises that high quality specialist training is demanding and that there are intrinsic pressures and stressors within medical workplaces. We believe that improving the health and wellbeing of trainees requires the cooperation of government, hospitals, health services, specialist colleges, training supervisors, doctors’ own doctors, and doctors themselves.

The RACP has previously joined the New South Wales Government, other colleges, educators, and regulators in endorsing the NSW Health [Statement of Agreed Principles on a Respectful Culture in Medicine](#), which recognises that “past practices and behaviours have not always met the accreditation standards required to provide a safe, inclusive and respectful environment.” The development of a comparable Statement of Agreed Principles in Tasmania would be a powerful signal about workplace culture and expectations.

The RACP is determined to take an active role in shaping a healthier training culture for doctors. While recent improvements to working hours and culture in medicine are a good start, more needs to be done to address the untenable working hours and unacceptable behaviour in some hospitals and training sites.

Our new accreditation standards reflect our expectation that all training sites provide a safe, respectful working and learning environment and address any behaviour that undermines self-confidence or professional confidence as soon as it is evident.

The RACP seeks a continuing commitment from all political parties to work in partnership with the College in finding ways to combat discrimination, bullying, harassment, and racism. This includes taking proactive steps to enable, normalize, and accommodate safe work arrangements and practices, and to support all aspects of a physician’s work including leadership, training, and career development opportunities in a way that is appropriately mindful of family and other care responsibilities.

Bullying or harassment of any kind is totally unacceptable—to or from Fellows, trainees (of the RACP or other colleges), non-trainee junior doctors, other health practitioners, or anybody. The RACP has zero tolerance for such behaviour.³

While working conditions are improving for junior doctors, albeit gradually, there are also areas of improvement for senior doctors. At present, many physicians and paediatricians have only enough time for clinical duties. The RACP would like the government in office after the election to explore measures that support senior doctors’ ongoing professional development, and flexibility to conduct research.

Rural and remote specialists already face professional challenges that can impede good patient care as well as practitioner wellbeing. We urge an appropriate focus on rural and remote workplaces as part of the government’s responsibility to maximise wellbeing.

Our recommendations reflect the RACP’s strong support for building a safe and respectful culture of training for junior doctors, and high-quality specialist care for patients.

We recommend that the incoming government:

- Commits to the wellbeing of the specialist and trainee specialist workforce.
- Commits to providing a positive workplace culture and working conditions for trainees and physicians and providing workforce models that support high quality specialty training, including support for research.
- Works collaboratively with the RACP and other stakeholders to eliminate bullying and harassment in the specialist workforce.
- Adopts or develops a set of agreed [principles for a respectful culture in medicine](#), similar to those developed by the NSW Government.
- Becomes a signatory to our [Health Benefits of Good Work](#) principles, an initiative from the RACP's Australasian Faculty of Occupational and Environmental Medicine to further champion health, wellbeing, and supportive workplace culture in the health sector.

Priority 3 - Addressing health inequities, especially in the north-west

While we acknowledge previous work to address health inequity⁴, we are concerned that improvements in Tasmanian health outcomes are inequitably distributed across the Tasmanian population.

Not all health inequity affects children, but some groups of children are particularly at increased risk of experienced health inequities beyond socio-economic disadvantage:

- Aboriginal and Torres Strait Islander children
- Children of refugee and asylum seeker families
- Children from culturally and linguistically diverse backgrounds
- Children living in rural and remote communities
- Children living in out of home care
- Children born in to poverty
- Incarcerated children and young people
- Children with disabilities, especially given the shortage of community paediatrics, and given the rising rate of outpatient referrals for behavioral and developmental problems.

Similarly, the burden of adult chronic illness falls inequitably across the Tasmanian population. We have previously highlighted:

- inequitable disability services (both NDIS and non-NDIS services)
- inequitable access to drug and alcohol treatment services and harm prevention efforts (see below)
- inequitable access to medical specialists by Aboriginal and Torres Strait Islander people.

Over and above working to address these specific inequities, the incoming government should:

- Develop a dedicated effort to increase these and other inequities throughout the state, especially in the north-west.
- Consider partnering with Tasmanian health researchers and academics to publish an internal Tasmanian Atlas of Variation, which would serve to uncover inequities and supply a solid baseline for measuring efforts to address them.
- Consider funding more Tasmania specific research.
- Advocate to the Commonwealth to preserve appropriate COVID-19 era telehealth items, which have improved access to some (but not all) health services and specialties.
- Develop a state-specific action plan to utilize telehealth facilities, where clinically appropriate, to maximise outpatient care.

Priority 4 - Reducing the harms of alcohol, including by minimum unit pricing

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. This is a cost of between \$604 and \$1450 per person per year. Data from 2014-15 showed that in Tasmania 72,700 people (18.6% of persons aged 18 years and over) exceeded the lifetime risk guidelines of no more than two standard drinks on any day, and 178,700 Tasmanians (45.7%) exceeded single-occasion risk guidelines. In addition to shouldering the significant burden of disease caused by alcohol misuse, Tasmania has recently gone from below to above the national average in illicit drug use and has Australia's second highest death rate due to prescription and illicit drugs after Western Australia.⁵

While the prevalence of Fetal Alcohol Spectrum Disorders (FASD) in Australia is unknown, seminal studies in Australia have established high prevalence. Nationally alcohol is the most common preventable cause of neurodevelopmental disability. Qualitative reporting shows that many children who had been exposed to prenatal alcohol are experiencing learning and emotional difficulties. A large number of affected young people are coming into contact with the juvenile justice system.⁶

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.⁷

Evidence shows that a coordinated public health approach to reducing alcohol consumption is required to comprehensively tackle the harms associated with alcohol. 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. Minimum unit pricing (MUP) can be the next major public health reform in Tasmania. Its time has come. Since heavy drinkers of alcohol and young people are sensitive to changes in the price of alcohol, MUP can be used to:

- cut rates of underage alcohol consumption
- reduce both regular consumption of large volumes of alcohol and episodic binges, and
- encourage safer consumer choices.⁸

Physicians are passionate about minimum unit pricing because where it has been tried in Australia, it works. After one year of MUP in the Northern Territory, the data shows:

- reduced emergency department presentations
- reduced alcohol-related assaults
- reduced alcohol-related domestic violence.⁹

The incoming government should use price signals and targeted investment to amplify harm minimization by:

- Introducing minimum unit pricing.^{10 11 12}
- Investing in alcohol and other drug treatment sector reform through access to a multidisciplinary workforce and increasing workforce capacity through professional development, investment in physical infrastructure, addressing unmet demand for treatment, and providing for a range of treatment models.
- Increasing funding for prevention services to reduce the incidence of alcohol and other drug misuse.

The Way Forward

We look forward to working collaboratively with the incoming government and all successful candidates to improve the health of all people in Tasmania.

To provide us with a response to these election priorities or to seek more information about the RACP and the Tasmanian Regional Committee, please contact Pavitra Gurumurthi, Senior Executive Officer, by emailing TAS@racp.edu.au.

¹ As of 30 June, 2020

² National Mental Health Survey of Doctors and Medical Students (beyondblue, 2013, [dataset and executive summary available by request](#)).

³ See [Respectful Behavior in College Training Programs](#), and [Statement on Safe and Respectful working environment](#) (7 February 2019).

⁴ For example, the Fair and Healthy Tasmania Strategic Review (2011); the work of the Premier's Health and Wellbeing Advisory Council; aspects of Health Workforce 2040; the Tasmanian Parliament's Joint Select Committee Inquiry into Preventative Health; and work by organisations such as the RACP (e.g. our Inequities in Child Health Position Statement and our Indigenous Child Health Position Statement).

⁵ For references, see the RACP [Submission](#) on Consultation Draft of the Reform Agenda for Alcohol and Drug Services in Tasmania (2018).

⁶ See Bower C, Watkins RE, Mutch RC, et al, Fetal alcohol spectrum disorder and youth justice: a prevalence study among young people sentenced to detention in Western Australia BMJ Open 2018;8:e019605. doi: 10.1136/bmjopen-2017-019605 which found FASD prevalence of 36%.

⁷ The Royal Australasian College of Physicians, [Alcohol Policy](#). Our [alcohol advocacy webpage](#) includes additional recommendations to reduce the rates of FASD and other alcohol-related physical and psychological health outcomes connected to alcohol use in pregnancy and breastfeeding; recommendations to strengthen licensing provisions; and recommendations so that better data collection can ensure targeted and evidence-based policy.

⁸ The small increase in the cost of alcohol that might affect moderate drinkers must be seen in the context of the total health, social and economic costs of excessive alcohol use. Minimum unit pricing preserves consumer choice while promoting healthier options. Under MUP, alcohol will remain widely accessible in Australia and adults will remain free to make their own choices. The idea is to reduce the hazardous levels of use by the heaviest consumers and support healthier choices for all users.

⁹ Specifically, the Northern Territory [Alcohol Harm Minimisation Action Plan August 2019 Update](#), shows:

- a 17.3% reduction in emergency department presentations in July 2018 to June 2019 compared to the same period in 2017-2018
- In Katherine, a 42.5% reduction in alcohol-related assaults in April-June 2019 compared to October-December 2017
- In Alice Springs, there were 45% fewer alcohol-related assaults, 37% fewer alcohol-related domestic violence assaults and 33% fewer alcohol-attributable emergency presentations between 2017-2018 and 2018-2019.

¹⁰ See RACP [Fact Sheet on minimum unit pricing](#).

¹¹ See RACP [select bibliography on minimum unit pricing](#).

¹² See [The Case for a Minimum \(Floor\) Price for Alcohol in Western Australia](#), WA Alcohol and Youth Coalition