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A Healthy Future for all Australians:

RACP Pre-Budget Submission 2018-2019

January 2018

Executive Summary

The Royal Australasian College of Physicians (RACP) trains, educates and advocates on behalf of more than 25,000 physicians and trainee physicians across Australia and New Zealand.

The RACP represents a broad range of medical specialties who work at both the individual and population level, and at all stages of the lifecycle: from infancy and childhood, through adolescence and adulthood, to old age and the end of life; including paediatrics and child health; cardiology; respiratory medicine; neurology; oncology; public health medicine; occupational and environmental medicine; palliative medicine; sexual health medicine; rehabilitation medicine; geriatric medicine and addiction medicine.

Beyond the drive for medical excellence, The RACP is committed to developing policies, programs and initiatives which will improve the health of communities. Not only must we ensure that patients have access to an integrated and well-coordinated health system, but policies must take a whole-of-government approach to reduce the likelihood of poor health outcomes and support governments in addressing the social determinants of health.

This is especially important because we know that the health and wellbeing of individuals can be significantly impacted by circumstances over which they have no direct control, such as through early childhood experiences or trauma, socio-economic status, and access to suitable housing, education and employment.

The RACP therefore makes the following recommendations for the 2018-19 Federal Budget currently being developed by the Australian government:

Recommendation Summary

Integrated Care

- Invest in a trial of models of care that integrate care across primary care, hospital and community-based specialist care and allied health; possibly as an expansion to the Health Care Homes initiative. This needs to include:
    - A funded stage to scope, design and model the trial, consult with stakeholders, explore and recommend funding and payment structures, and plan for the digital health records and communications needs.
    - Funding for a 2 year trial of the model of integrated care.
    - Ongoing monitoring, evaluation and reporting on the trial's outcomes.

Telehealth

- Remove the distance requirement from the MBS items supporting specialist telehealth consultations.
- Fund the promotion of extended access to telehealth to the community, healthcare professionals and health services organisations.

Inequities in Child Health

- Immediately reinstate the Australian Health Ministers' Advisory Council (AHMAC) subcommittee on child and youth health.
- Commit to new investment in paediatric child health services that are universally available, but with a scale and intensity that is proportionate to the level of disadvantage so that health policies, programs and initiatives funded by the Commonwealth Government can begin to address inequities in child health.
- Fund expanded home visit programs, particularly in rural and remote areas, in order to overcome barriers to access that can affect the health and wellbeing of children.
- Establish annual public reporting from relevant Departments against the AIHW's Children's Headline Indicators, and an annual Federal Government report that is also made public, to keep governments accountable and promote the health, development and well-being of all children.
- Commit additional funding to support all levels of government, service providers and paediatricians to address issues arising from the reporting on the Children's Headline Indicators.
- Develop Equitable Access Indicators in relation to child health that are reported on annually by the AIHW, along with additional funding to address specialist service access issues identified from this reporting.
- Commit funding to establish and maintain an *Inequities in Child Health Alliance*, in conjunction with a number of leading Australian universities, policy groups and health services, to;
    - build the evidence-base on responses to inequities in child health
    - assist in the development of equitable access indicators in relation to child health on which government will report;
    - collect and publish data from various jurisdictions on inequities in child health; and,
    - provide paediatricians with an easily accessible, reliable and rigorous source of current evidence in relation to inequities in child health and how it can be addressed in their practice.
- Conduct and publish evaluations on the implementation and effectiveness of:
    - The National Framework for Child and Family Health Services - secondary and tertiary services (2015)
    - Healthy, Safe and Thriving: National Strategic Framework for Child and Youth Health (2015).
- Fund the provision of a minimum schedule of universal preventative health care interventions, to be delivered at point of vaccination to both babies and mothers, including links to the relevant maternity and immunisation registers and MBS items designed to be used at the time of immunisation.
- Fund research into further opportunities for universal preventative health initiatives in early childhood.

Adolescent and Young People's Health

- Expand the eligibility of the Medicare Benefits Schedule health assessment items 701, 703, 705 and 707 to include adolescents and young adults aged 10-24 year to facilitate early identification of risks and needs.
- Invest in the development of specialised adolescent health services which address the unique physical, mental and sexual health challenges of adolescence and build the capacity of adolescents to self-manage chronic disease.
- Funding and supporting prevention and treatment through new and existing networks and services, such as child and family health, community services and other paediatric mental health services.
- Funding regular national surveys of children's and young people's mental health to monitor indicators of child and adolescent health, as well as their economic and social determinants;
- Provide sustained funding for accessible adolescent sexual and reproductive health services, including funding for clinical education and training to support the delivery of these services.
- Greater access to bulk-billed STI screening for children and young people through:
    - Ensuring children and young people can receive a full rebate for short GP consultations, regardless of their location; and
    - Funding full-service sexual health clinics in underserved areas.

Aboriginal and Torres Strait Islander Health

- Allocate secure long-term funding to progress the strategies and actions identified in the National Aboriginal and Torres Strait Islander Health Plan (NATSIHP) Implementation Plan.
- Provide secure, long-term funding for the Rural Health Outreach Fund (RHOF) and Medical Outreach Indigenous Chronic Disease Program (MOICDP).
- Build and support the capacity of Aboriginal and Torres Strait Islander health leaders by committing secure long-term funding to the Indigenous National Health Leadership Forum.
- Reinstate funding for a clearinghouse modelled on the previous *Closing the Gap* clearinghouse, in line with the recommendations of the Fifth National Mental Health and Suicide Prevention Plan.
- Allocate sufficient funding for the implementation of the Fifth National Aboriginal and Torres Strait Islander Blood-Borne Viruses (BBV) and Sexually Transmissible Infections (STI) Strategy.
- Fund the syphilis outbreak short-term action plan and coordinate this response with long term strategies.
- Allocate long-term funding for primary health care and community- led sexual health programs to embed STI/BBV services as core primary health care (PHC) activity, and to ensure timely and culturally supported access to specialist care when needed, to achieve low rates of STIs and good sexual health care for all Australians.

- Invest in and support a long-term multi-disciplinary sexual health workforce and integrate with PHC to build longstanding trust with communities.
- Allocate funding for STI and HIV point of care testing (POCT) devices, the development of guidelines for POCT devices and Medicare funding for the use of POCT devices.

End-of-Life

- Provide secure, long-term funding to improve the co-ordination of and delivery of community palliative care services, including integration with hospital services.
- Commit to secure, long-term funding to develop and implement projects that improve the availability of palliative and supportive care services, with particular focuses on non-cancer services in hospitals and in non-hospital settings such as residential aged care facilities, and in rural and remote communities.
- Endorse palliative and supportive care, including end-of-life care, as a COAG priority.

Obesity

- Prioritise obesity prevention by:
    - Establishing a national taskforce including sustained funding, regular and ongoing monitoring and evaluation of key measures and regular reporting around targets.
    - Allocating long-term sustainable funding to evidence-based prevention measures for overweight and obesity and ensuring primary prevention interventions focus on those most affected by overweight and obesity.
    - Allocating funding to the development, implementation, update and monitoring of comprehensive and consistent national guidelines on diet, physical activity and weight management, with a focus on critical periods in the life course.
- Introduce regulations to restrict the advertising and marketing of unhealthy foods and beverages to children and young people.
- Revise the nutrient profile algorithm of the Health Star Rating system to give stronger weight to sugar content, and that the labelling be made mandatory if there is not widespread uptake by 2019, to encourage consumers to choose healthier options and motivate food manufacturers to reformulate and develop healthier products.
- Provide hospital funding to State and Territory Governments specifically geared towards providing equitable access to bariatric surgery for public hospital patients.

Drug and Alcohol Policy

- Increase funding for alcohol treatment, including appropriate and multidisciplinary workforce development, to address unmet demand for treatment.
- Increase funding for prevention services to reduce the incidence of alcohol use disorders.
- Introduce a volumetric taxation system for all alcohol products and abolish the Wine Equalisation Tax (WET) and rebate.

- Allocate a proportion of the increased revenue raised from volumetric taxation to funding alcohol treatment and prevention services.

Climate Change and Health

- Establish a national Healthcare Sustainability Unit. The unit would draw on local best practice as well as leading international models, such as the Sustainable Development Unit (SDU) in the UK. The first tasks of the unit would be to;
    - consult with stakeholders;
    - establish appropriate metrics and measure the total carbon footprint of the health sector in Australia;
    - work with health stakeholders to develop an environmental sustainability strategy; and,
    - support health services in their jurisdiction to implement the strategy.
- Develop a national climate change and health strategy in Australia, including meaningful mitigation and adaptation targets, effective governance arrangements, professional and community education, effective intergovernmental collaboration, and a strong research capacity.

Integrated Care

Australia shares the challenges faced by many countries, of how to improve the effectiveness and efficiency of its health system to ensure it can continue delivering high quality care and good patient outcomes. With an increasing proportion of the population facing multiple, chronic and often complex health issues, improving the integration and coordination of health services is vitally important.

Addressing problems of fragmentation and duplication of services in the healthcare system will only be possible if a cross-discipline, cross-sector approach is taken. It is a concern that the Health Care Homes (HCH) trial in Australia has not considered the integration of specialist care within its model, when the target population of patients being registered are frequently referred to, or will already be receiving, treatment from one or more specialists.

Data from 2015-16 shows that 36% of people saw a medical specialist in the previous 12 months, many of which went two or more times[1]. 16% of people saw three or more health professionals for the same condition. The health professional most likely to coordinate care was a GP (61%), followed by a medical specialist (24%)[2].

It is worth noting that the medical home model in the United States is being expanded to include specialist care and the American College of Physicians highlights that specialists are integral to primary health care led models of care[3]. Examples of Medical Neighbourhoods or Health Care Houses (extended health care home styled models of care) that are operating internationally include models for gastroenterology[4] and nephrology[5].

It is a logical and strategic step to allocate funding to develop an extended health care homes model to build on and appropriately extend the work that has been undertaken with the consideration and design of the HCH trial. Within this, it will be vital that there be effective cross-jurisdictional collaboration. A number of Australian state governments have also invested in developing integrated care models and trials, and there will be lessons to be learned from these trials and foundations that can be built on.

The RACP recommends that the Australian government:

- Invest in a trial of models of care that integrate care across primary care, hospital and community-based specialist care and allied health; possibly as an expansion to the Health Care Homes initiative. This needs to include:
    - A funded stage to scope, design and model the trial, consult with stakeholders, explore and recommend funding and payment structures, and plan for the digital health records and communications needs:
    - Funding for a 2 year trial of the model of integrated care.
    - Ongoing monitoring, evaluation and reporting on the trial's outcomes.

[1] 2015-16 ABS Patient Experience Survey [http://www.abs.gov.au/ausstats/abs@.nsf/mf/4839.0] Accessed 10/8/2017
[2] Ibid
[3] American College of Physicians, (2010) The patient centred medical home neighbour, the interface of the medical home with specialist and subspecialist practices. American College of Physicians Position Paper, accessed https://www.acponline.org/advocacy/current_policy_papers/assets/pcmh_neighbors.pdf
[4] In Illinois a gastroenterology group expanded the medical home model in 2014 and successfully lowered cost by 10 % and reduced hospitalization payments by 57 %. Achieving these savings was through a multidisciplinary approach to the management of a chronic disease. http://www.beckersasc.com/gastroenterology-and-endoscopy/illinois-gastroenterology-group-s-crohn-s-medical-home-shows-10-cost-reduction-7-things-to-know.html
[5] Smith, Zoe G., et al. "Medical Neighbourhood Model for the Care of Chronic Kidney Disease Patients." American journal of nephrology 44.4 (2016): 308-315.

Telehealth

Investment in telehealth has been extremely worthwhile for the Australian Government and has increased patient access to medical advice in rural and regional areas. Specifically, telehealth has increased patient access to specialist medical advice. Medicare specialist telehealth service items have increased by 33% between June 2015 to June 2017; from 49,935 to 66, 225 (Item numbers 99, 112, 149, 389, 3015, 13210; MBS Online August 2017). By supporting telehealth based services, the Australian Government has been able to respond to inequitable service distribution and reduce travel costs paid for specialist travel, as well as ease the burden on patients, and often their carers, in travelling often long distances to access care.

Whilst we welcome the benefits provided to those living in rural and regional areas, there are other patients who also face many difficulties in travelling to see doctors; for example, those with mobility issues, frail and older people, and parents with young children.

Given that video-consultations have clearly demonstrated their worth in enhancing access to tertiary hospital-based specialist care[6], there appears to be little basis for continuing the limitation to patients living a minimum of 15km from the specialist service, and 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.

The current restriction of a 15 km separation between the consultant and the patient (introduced in 2012) at the time of the consultation unnecessarily limits the provision of specialist care when there may be valid reasons for a telehealth consultation *within* a 15 km separation. Those patients living within the 15 km distance requirement also face barriers to accessing face-to-face consultations with specialist physicians, such as those with carer responsibilities, ambulatory limitations, transport difficulties, time limitations, and condition related impairments.

Telehealth has the additional benefit of minimising disruption within the home, school or work, (for example, considering families with high care responsibilities, people with work responsibilities, and children at school). The use of telehealth could be further supported within the palliative care and pain management specialties as part of an integrated model of care.

The RACP recommends that the Australian government:

- Remove the distance requirement from the MBS items supporting specialist telehealth consultations.
- Fund the promotion of extended access to telehealth to the community, healthcare professionals, and health services organisations.

[6] 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

Inequities in Child Health

Child health inequities are differential outcomes in children's health, development and well-being that are unjust unnecessary, systematic and, most importantly, preventable. In Australia, this means that a large number of children will not have the same health, wellbeing and developmental outcomes as their more socially advantaged peers.

Many inequities start early in childhood and increase along a clear social gradient. This means that the greater a child's disadvantage, the worse their health, development and well-being. These gaps widen as children progress across the life trajectory resulting in adverse adult health, educational and vocational outcomes, with increased subsequent mortality and morbidity.

Not only will addressing inequities in child health have the societal benefit of achieving more equitable health and developmental outcomes for children across Australia, but it will also decrease the burden on the health system by avoiding adverse health outcomes throughout the lifespan and decrease the intergenerational health effects of inequality.

Children also have a right to a universal package of preventative health care, and some children in Australia are still unable to access a regular schedule of services including immunisation, health and development checks. The 2011 AHMAC report for National Framework for Universal Child and Family Health Services[7] recommended that the schedule of contacts be based on:

1. Alignment to immunisation schedules to encourage participation in both programs
2. Critical periods of child development
3. Opportunities to identify families at risk and offer timely family support services
4. Opportunities for targeted anticipatory guidance (parental advice)
5. Aligning contacts with the child's birthday (particularly over 18 months).

Australia has implemented robust policies to ensure that all children are immunised but there are few policy provisions in place to ensure that pregnant women, infants and children receive the other components of the minimum preventative health care package. Policy approaches such as the USA Women Infant and Child (WIC) incentive programme have been shown to increase the uptake of essential preventative health care, and could be investigated further for ensuring universal coverage of woman and child focussed support.

The RACP recommends that the Australian government:

- Immediately reinstate the Australian Health Ministers' Advisory Council (AHMAC) subcommittee on child and youth health.
- Commit to new investment in paediatric child health services that are universally available, but with a scale and intensity that is proportionate to the level of disadvantage so that health policies, programs and initiatives funded by the Commonwealth Government can begin to address inequities in child health.
- Fund expanded home visit programs, particularly in rural and remote areas, in order to overcome barriers to access that can affect the health and wellbeing of children.
- Establish annual public reporting from relevant Departments against the AIHW's Children's Headline Indicators, and an annual Federal Government report that is also made public, to keep governments accountable and promote the health, development and well-being of all children.

[7] Australian Health Minister's Advisory Council (2011) *National Framework for Universal Child and Family Health Services*, p.16 https://www.health.gov.au/internet/main/publishing.nsf/Content/AFF3C1C460BA5300CA257BF0001A8D86/%24File/NFUCFHS.PDF

- Commit additional funding to support all levels of government, service providers and paediatricians to address issues arising from the reporting on the Children's Headline Indicators.
- Develop Equitable Access Indicators in relation to child health that are reported on annually by the AIHW, along with additional funding to address specialist service access issues identified from this reporting.
- Commit funding to establish and maintain an *Inequities in Child Health Alliance*, in conjunction with a number of leading Australian universities, policy groups and health services, to;
    - build the evidence-base on responses to inequities in child health
    - assist in the development of equitable access indicators in relation to child health on which government will report;
    - collect and publish data from various jurisdictions on inequities in child health; and,
    - provide paediatricians with an easily accessible, reliable and rigorous source of current evidence in relation to inequities in child health and how it can be addressed in their practice.
- Conduct and publish evaluations on the implementation and effectiveness of:
    - The National Framework for Child and Family Health Services - secondary and tertiary services (2015)
    - Healthy, Safe and Thriving: National Strategic Framework for Child and Youth Health (2015).
- Fund the provision of a minimum schedule of universal preventative health care interventions, to be delivered at point of vaccination to both babies and mothers, including links to the relevant maternity and immunisation registers and MBS items designed to be used at the time of immunisation.
- Fund research into further opportunities for universal preventative health initiatives in early childhood.

Adolescent and Young People's Health

Without a commitment to adolescent and young adult health, we risk forfeiting hard won improvements in infant and early childhood health. Adolescence presents an opportunity for health professionals to positively influence young people's health for the rest of their life. The onset of puberty begins a period of profound physical growth and neurological development. Establishing healthy habits in adolescence, when health behaviours related to non-communicable diseases are adopted, contributes to significantly improved health outcomes and reduced health costs throughout adulthood.

Funding and support for prevention services are particularly important for young people, as well as investing in their capacity to self-manage chronic disease. Expanded access to GPs and paediatricians will allow adolescents and young adults to have their needs and risk factors identified early. This will help facilitate reduced risk-taking, chronic disease, substance abuse and improved mental health.

Young people have the right to information, education and clinical care that supports healthy sexual development and informed choices, and minimises the risk of coercion, unplanned pregnancy, sexually transmitted infection and other unwanted or unintended consequences, including emotional, psychological, social and cultural consequences. Sexual and reproductive health care for young people is delivered in a range of settings including primary care, community and hospital-based adolescent and young adult health services, community controlled Aboriginal Health Services, sexual health centres and family planning clinics, school-based services and justice health services. Optimal care is culturally, age and developmentally appropriate and delivered from a youth-friendly perspective.

The RACP recommends that the Australian government:

- Expand the eligibility of the Medicare Benefits Schedule health assessment items 701, 703, 705 and 707 to include adolescents and young adults aged 10-24 year to facilitate early identification of risks and needs.
- Invest in the development of specialised adolescent health services which address the unique physical, mental and sexual health challenges of adolescence and build the capacity of adolescents to self-manage chronic disease.
- Funding and supporting prevention and treatment through new and existing networks and services, such as child and family health, community services and other paediatric mental health services.
- Funding regular national surveys of children's and young people's mental health to monitor indicators of child and adolescent health, as well as their economic and social determinants;
- Provide sustained funding for accessible adolescent sexual and reproductive health services, including funding for clinical education and training to support the delivery of these services.
- Greater access to bulk-billed STI screening for children and young people through:
    - Ensuring children and young people can receive a full rebate for short GP consultations, regardless of their location; and
    - Funding full-service sexual health clinics in underserved areas.

Aboriginal and Torres Strait Islander Health

Aboriginal and Torres Strait Islander people continue to experience poorer health outcomes than non-Indigenous Australians. The latest 'Closing the Gap' report found that 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 21 percent between 1998 and 2015, while there was a 13 per cent decline for non-Indigenous Australians in the same period[8].

To address these inequities and improve access to care, continuing and strengthened focus and appropriate long-term funding is required. It is imperative that there is secure funding for the *National Aboriginal and Torres Strait Islander Health Plan 2013-2023* (NATSIHP) Implementation Plan. Funding uncertainty and frequent changes create significant issues that impact the continuity of services to patients and organisations in their ability to retain and build their capacity.

The RACP strongly supports existing programs that improve access to specialist care, including the Rural Health Outreach Fund (RHOF) and Medical Outreach Indigenous Chronic Disease Program (MOICDP). The RACP recommends that the Australian Government continue its investment in these programs, undertaking evaluation to ensure the programs are targeted at the most appropriate issues and achieving positive health outcomes for Aboriginal and Torres Strait Islander peoples.

Aboriginal and Torres Strait Islander health leadership and authentic 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 where ever possible. The sector must have long-term, sufficient and secure funding to both retain and grow their capacity.

Given the recent focus by the Australian government on improving mental health and reducing suicide rates in Aboriginal and Torres Strait Islander communities, The RACP supports the analysis, reporting and implementation of evidence-based solutions, with input from and led by these communities, to improve the quality and delivery of mental health promotion and suicide prevention services. The RACP recommends the establishment of clearinghouses which enable effective access to relevant, high quality information and resources to support these efforts.

Sexual Health

There continue to be ongoing outbreaks of infectious syphilis across Australia affecting Aboriginal and Torres Strait Islander people, which has occurred in the context of increasing rates of other Sexually Transmitted Infections (STIs) and some Blood Borne Viruses (BBVs) in some Aboriginal and Torres Strait Islander communities. STIs are endemic in some regions; an unprecedented syphilis epidemic in Queensland began in 2011 and extended to the Northern Territory, Western Australia and South Australia.

Since 2011 there have been six fatalities in Northern Australia from congenital syphilis, and a further three babies are living with serious birth defects in the Northern Territory. In addition, there has been one reported case of congenital syphilis so far in 2017 in South Australia. Despite the existence of a number of Federal and state-level sexual health strategies, the situation remains dire.

Appropriate funding needs to be allocated to the implementation of the Fifth National Aboriginal and Torres Strait Islander Blood-Borne Viruses and Sexually Transmissible Infections Strategy

[8] 2017 Close the Gap Report - http://closingthegap.pmc.gov.au/sites/default/files/ctg-report-2017.pdf

and sexual health services; particularly to ensure sufficient capacity for the delivery of core STI/BBV services within models of care that provide comprehensive primary health care services (particularly Aboriginal and Torres Strait Islander community controlled health services). People should have access to specialist care when needed, through integration with comprehensive primary health care services to ensure sustainable and culturally appropriate service provision.

We welcome the plans to activate a short-term response across the state and territories on the continuing syphilis outbreaks, coordinated by the Federal Department of Health. However, whilst this Action Plan and short-term funding is urgently needed; the short-term activities need to be coordinated with and contribute to longer-term strategies and investments.

The RACP recommends that the Australian government:

- Allocate secure long-term funding to progress the strategies and actions identified in the National Aboriginal and Torres Strait Islander Health Plan (NATSIHP) Implementation Plan.
- Provide secure, long-term funding for the Rural Health Outreach Fund (RHOF) and Medical Outreach Indigenous Chronic Disease Program (MOICDP).
- Build and support the capacity of Aboriginal and Torres Strait Islander health leaders by committing secure long-term funding to the Indigenous National Health Leadership Forum.
- Reinstate funding for a clearinghouse modelled on the previous *Closing the Gap* clearinghouse, in line with the recommendations of the Fifth National Mental Health and Suicide Prevention Plan.
- Allocate sufficient funding for the implementation of the Fifth National Aboriginal and Torres Strait Islander Blood-Borne Viruses (BBV) and Sexually Transmissible Infections (STI) Strategy.
- Fund the syphilis outbreak short-term action plan and coordinate this response with long term strategies.
- Allocate long-term funding for primary health care and community- led sexual health programs to embed STI/BBV services as core primary health care (PHC) activity, and to ensure timely and culturally supported access to specialist care when needed, to achieve low rates of STIs and good sexual health care for all Australians.
- Invest in and support a long-term multi-disciplinary sexual health workforce and integrate with PHC to build longstanding trust with communities.
- Allocate funding for STI and HIV point of care testing (POCT) devices, the development of guidelines for POCT devices and Medicare funding for the use of POCT devices.

End of Life

It is widely acknowledged that too often, end-of-life care is not meeting the needs of patients and their loved ones. If patients nearing the end of life are not identified and their needs and wishes are not respected, inappropriate and even harmful investigations and treatments may be provided in the last weeks, days or even hours of life. This can increase or prolong suffering for the patient and cause distress for the families, carers and health professionals. There are a number of barriers to good end-of-life care, including systemic and cultural issues.

Good end-of-life care is patient-centred, culturally appropriate, coordinated and focused on rational investigation, symptom management and de-prescribing. It involves early identification, assessment and treatment of pain, and enables patients nearing the end of their lives to live as well as possible, and without unnecessarily prolonging the dying process.

The RACP recognises the important contribution of national palliative care projects, and welcomes the most recent funding allocated to palliative care, namely through the *National Specialist Palliative Care and Advance Care Planning Advisory Services* project, the *Greater Choice for At Home Palliative Care Measure* and the new funding allocated to the National Palliative Care Projects grants initiative. These measures will help to greatly improve quality, coordination and access to palliative care. However, we call on the Australian government to commit to secure, long-term funding to facilitate progress in end-of-life workforce development and quality of care, and ensure that national palliative care initiatives continue.

To ensure that these investments lead to sustained improvement in end-of-life care, it is imperative that all state and territory governments endorse palliative care and end-of-life care as a key priority for the COAG Health Council agenda. As palliative care spans across multiple sectors, including health, aged care, community care, disability care and mental health, endorsement from COAG will be important to improve access to palliative care across a range of settings in accordance with consumer-directed care.

It is crucial that adequate resources are allocated towards supporting patients wishing to die at home, in a hospice or in a residential aged care facility. The RACP calls on the Australian Government to support the development of models of care that improve the provision of palliative care services in non-hospital settings, in particular ensuring that aged care facilities are equipped to provide the high levels of care required by residents at the end of their lives.

The RACP recommends that the Australian government:

- Provide secure, long-term funding to improve the co-ordination of and delivery of community palliative care services, including integration with hospital services.
- Commit to secure, long-term funding to develop and implement projects which improve the availability of palliative and supportive care services, with particular focuses on non-cancer services in hospitals and in non-hospital settings such as residential aged care facilities, and in rural and remote communities.
- Endorse palliative and supportive care, including end-of-life care, as a COAG priority.

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[9]. People suffering from obesity are entitled to receive the same standard of care as sufferers of any other chronic condition, but unfortunately this is often not the case, and stigmatisation of these patients only exacerbates the issue.

Both prevention and treatment of obesity are urgent priorities. Since 1980, obesity rates have nearly doubled in Australia. In 1980, 15 per cent of Australian adults over 20 years had obesity; by 2013, obesity rates for adults over 20 years of age had increased to 28 per cent. Trends are replicated for children and young people under 20 years: In Australia in 1980, 3.5 per cent of children had obesity, increasing to 7 per cent in 2013.

An Access Economics' report quoted by the Australian Bureau of Statistics estimated that in 2008, the total annual cost of obesity to Australia, including health system costs, loss of productivity costs and carers' costs, was around $58 billion[10].

The Australian NHMRC's clinical practice guidelines published in 2013 states that for adults, "bariatric surgery is currently the most effective intervention for severe obesity". In 2012, a prospective cohort study of over 49,000 Australians suffering from obesity stated that their "findings suggest that bariatric surgery, an MBS-listed procedure, is currently largely available only to those who can afford private health insurance and the associated out-of-pocket costs, with poor access to these cost-effective procedures in the section of the population that is most in need" and that "continuing inequity in access is likely to exacerbate existing inequalities in obesity and related health problems"[11].

The RACP recommends that the Australian government:

- Prioritise obesity prevention by:
    - Establishing a national taskforce including sustained funding, regular and ongoing monitoring and evaluation of key measures and regular reporting around targets.
    - Allocating long-term sustainable funding to evidence-based prevention measures for overweight and obesity and ensuring primary prevention interventions focus on those most affected by overweight and obesity.
    - Allocating funding to the development, implementation, update and monitoring of comprehensive and consistent national guidelines on diet, physical activity and weight management, with a focus on critical periods in the life course.
- Introduce regulations to restrict the advertising and marketing of unhealthy foods and beverages to children and young people.
- Revise the nutrient profile algorithm of the Health Star Rating system to give stronger weight to sugar content, and that the labelling be made mandatory if there is not widespread uptake by 2019, to encourage consumers to choose healthier options and motivate food manufacturers to reformulate and develop healthier products.
- Provide hospital funding to State and Territory Governments specifically geared towards providing equitable access to bariatric surgery for public hospital patients.

[9] The obesogenic environment can be defined as "the sum of influences that the surroundings, opportunities or conditions of life have on promoting obesity in individuals or populations." Lake A, Townshend T. Obesogenic environments: exploring the built and food environments. J R Soc Promot Health. 2006;126(6):262-7.
[10] Access Economics, 2008, The Growing Cost of Obesity in 2008: Three Years On, Diabetes Australia, Canberra.
[11] Korda, R. J., Joshy, G., Jorm, L. R., Butler, J. R., & Banks, E. (2012). Inequalities in bariatric surgery in Australia: findings from 49 364 obese participants in a prospective cohort study. *The Medical journal of Australia*, *197*(11), 631-636.

Drug and Alcohol Policy

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.[12] This is a cost of between $625 and $1500 per person per year. These costs vastly outweigh the amount of taxation revenue generated from alcohol sales, which is approximately $6 billion a year.[13] In effect, Australian taxpayers are subsidising the harms that result from risky alcohol consumption.

These harms take many different forms, with alcohol being a causal factor in more than 200 disease and injury conditions. Adolescents are at particular risk due to alcohol's proven impact on the development of the brain during adolescence and the tendency of young people to combine drinking with high risk activities, increasing their risk of alcohol-related injury, illness, and death.[14] Cheap alcohol contributes disproportionately to alcohol-related harms, given its affordability and availability to vulnerable groups such as adolescents and people with or at risk of alcohol dependence.

There is a severe shortage of treatment services for individuals suffering with addiction to alcohol and other drugs. While approximately 200,000 Australians access treatment for substance dependency every year, it is estimated that a further 200,000 to 500,000 Australians requiring treatment are unable to access it.[15] Additional funding provided through the National Ice Action Strategy, while welcome, has not addressed the shortage of treatment services and did not adequately incorporate specialist expertise and input into the design and delivery of evidence-based treatment services.

Pricing measures have been shown to be the most effective, evidence-based measures for reducing risky alcohol consumption. Taxation reform provides an opportunity for the Australian Government to reduce alcohol-related harms by simultaneously limiting the availability of cheap alcohol to vulnerable groups and by raising revenue to support investment in prevention and treatment of alcohol-use disorders.

A nationally consistent, volumetric tax on alcohol products is required to replace the current system. This should include abolishing the Wine Equalisation Tax which, by taxing wine based on its wholesale value rather than alcohol content, encourages the production and consumption of cheap high alcohol wines. This change has been recommended by numerous government reviews, including most recently, the Productivity Commission in its Five Year Productivity Review.

Increased investment in evidence-based drug and alcohol treatment services is also crucial. Research indicates that for every dollar invested in alcohol or drug treatment, society saves seven dollars[16]. Thus investing in alcohol treatment services yields high returns. Treatment has been shown to reduce drug use and crime, while improving health, psychological wellbeing, and social participation.

A proportion of the additional revenue raised through volumetric taxation should be hypothecated to the health budget to fund improved access to alcohol treatment services and harm prevention and minimisation programs.

[12] The Royal Australasian College of Physicians. Alcohol Policy, p11. Available at: https://www.racp.edu.au/docs/default-source/advocacy-library/pa-racp-ranzcp-alcohol-policy.pdf?sfvrsn=6.
[13] Alcohol Policy, p17.
[14] Alcohol Policy, p28.
[15] New Horizons: The review of alcohol and other drug treatment services in Australia, p13. Available at: https://ndarc.med.unsw.edu.au/resource/new-horizons-review-alcohol-and-other-drug-treatment-services-australia.
[16] Ibid.

The RACP recommends that the Australian government:

- Increase funding for alcohol treatment, including appropriate and multidisciplinary workforce development, to address unmet demand for treatment.
- Increase funding for prevention services to reduce the incidence of alcohol use disorders.
- Introduce a volumetric taxation system for all alcohol products and abolish the Wine Equalisation Tax (WET) and rebate.
- Allocate a proportion of the increased revenue raised from volumetric taxation to funding alcohol treatment and prevention services.

Climate Change and Health

The RACP is part of a large and growing global network of health and medical organisations calling for urgent action on climate change, including other medical colleges, the World Health Organization, the World Medical Association, and the Lancet, to name but a few.

Australians are already suffering health impacts including 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. Unchecked, climate change will not only have serious impacts on human health, but on healthcare personnel and delivery of healthcare services, with increasing frequency and intensity of extreme weather events.

Taking action now represents an opportunity to simultaneously reduce the harms and risks of climate change, and improve health outcomes for Australians, our neighbours in the Pacific, and the world. The RACP calls on the Government to commit to developing and implementing a national climate and health strategy - to reduce the risks to health, and realise the health benefits of adaptation and mitigation.

Given that the core business of healthcare is to protect and promote human health, there is also an imperative for the health sector to reduce its own carbon emissions. Unlike the United Kingdom and the United States, the carbon footprint of the Australian health sector has not been measured, but given the level of healthcare expenditure emissions would be substantial.

An environmentally sustainable healthcare system is one that has no cumulative harmful impacts on the natural environment or society, while providing high-quality healthcare and being financially viable. 'Green' initiatives such as improving energy efficiency and promoting recycling are important, but healthcare organisations need to act more broadly to reduce carbon and resource use by developing integrated models of care, strengthening primary care, and optimising use of new technologies.

The RACP recommends that the Australian government:

- Establish a national Healthcare Sustainability Unit. The unit would draw on local best practice as well as leading international models, such as the Sustainable Development Unit (SDU) in the UK. The first tasks of the unit would be to;
    - consult with stakeholders;
    - establish appropriate metrics and measure the total carbon footprint of the health sector in Australia;
    - work with health stakeholders to develop an environmental sustainability strategy; and,
    - support health services in their jurisdiction to implement the strategy.
- Develop a national climate change and health strategy in Australia, including meaningful mitigation and adaptation targets, effective governance arrangements, professional and community education, effective intergovernmental collaboration, and a strong research capacity.