RACP
Specialists. Together
EDUCATE ADVOCATE INNOVATE

Future-proofing the healthcare system - promoting sustainability, prevention and equity

Australian Government Election Statement 2019

145 Macquarie Street, Sydney NSW 2000, Australia
Telephone +61 2 9256 5444 | Facsimile +61 2 9251 7476 | Email policy@racp.edu.au

Contents

Contents 1
Executive summary 2
Priority 1: Sustainability 2
Priority 2: Prevention 4
Priority 3: Equity 5
Sustainability 8
Integrated care 8
Digital health and telehealth 9
Climate change and health 10
Prevention 12
Preventative health agency 12
Obesity 13
Alcohol and other drugs 14
Equity 16
Inequities in child health 16
Early childhood intervention 17
Indigenous health 18
Sexually transmitted infections 21

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. Accordingly, the RACP makes the following pre-election recommendations for the incoming Australian Government which are organised into the three key priorities of **sustainability**, **prevention and equity**, noting that the recommendations that have been sorted into these three key areas form a virtuous circle which reinforce each other and tend to overlap.

The virtuous circle of sustainability, prevention and equity

In this election statement, the RACP advocates for a **sustainable** healthcare system that will be appropriately equipped to manage the emerging challenge of climate change. But we also call for sustainability in the broader sense of being sufficiently prepared to deliver high value services and deal with emerging cost and capacity pressures arising from the increasing needs of the Australian population, particularly those with multiple chronic conditions.

Ensuring that patients have access to an integrated and well-coordinated health system is a key step towards enhancing sustainability in the broader sense. Better **preventative health,** including taking a whole-of-government approach towards reducing the likelihood of poor health outcomes and addressing the social determinants of health, would reduce future burden of disease and further enhance the system's sustainability.

At the same time, a more sustainable healthcare system that makes the best use of existing resources would mean more funding available for preventative health as well as managing acute conditions. It would also align with measures to promote the mitigation of anthropogenic climate change.

Finally, both sustainability and better prevention would enhance **equity** in the delivery of healthcare services because they would ensure that areas of greatest need are appropriately resourced. The health and wellbeing of individuals can be significantly impacted by circumstances over which they have no direct control, such as early childhood experiences or trauma, socio-economic status, and access to suitable housing, education and employment. Addressing inequities in the delivery of healthcare is consistent with enhanced sustainability and prevention, as evidenced by the cost-effectiveness of measures such as early childhood intervention.

Below are our key recommendations for each of these three mutually reinforcing priorities.

Priority 1: Sustainability

Integrated care

The RACP calls on the incoming government to facilitate scalable evidence-based care, for people with chronic conditions that is inclusive of specialist care by:

- Funding and fostering a model of care for management of patients with comorbid chronic health conditions. The proposed model of care would have the following features:
    - expand the interdisciplinary composition of primary care teams beyond GP services to encompass long-term roles for specialist physicians, nurses and allied health practitioners.
    - introduce greater flexibility in the scope of practice of non-physician team members.

    - move away from the 'one problem per visit basis' and other inbuilt and often unintended mechanisms that isolate practitioners and prevent collaboration.
    - be evaluated as a two-year trial, with ongoing monitoring, evaluation and reporting on the trial's outcomes.
- Considering reforms to the Medicare Benefits Schedule (MBS) or other financial incentives to better incentivise direct communications between general practitioners (GPs) and specialists in the management of patients with chronic disease. Supported communications could include provision for:
    - case conferences to include more than one specialist (not of the same specialty).
    - enabling specialists to modify and have specific input into chronic care management planning and,
    - direct health professional communications (with and without the patient present) outside of case conferences.
- Facilitating greater use of specialists in ambulatory care including through the provision of practice incentives to specialist community-based services and funding for practice nurses to be used by specialist services.
- Progressing through the Council of Australian Governments (COAG) the Productivity Commission proposal for joint Commonwealth and state contributions from their respective shares of hospital activity-based funding to a Prevention and Chronic Condition Management Fund (PCCMF) in each local health district.

Digital health and telehealth

The RACP calls on the incoming government to extend the availability and effectiveness of digital health and telehealth to support more equitable access to specialist care by:

- Making available 'provider readiness' incentives comparable to those currently provided to GPs (i.e. the Practice Incentives Program e-health incentive) to specialist physicians to sign up and participate in My Health Record.
- Delivering the funding needed to progress the National Digital Health Strategy project to develop minimum interoperability standards, with the goal of an agreed vision and roadmap for interoperability between all public and private health and care services in Australia.
- Removing the distance requirement from the MBS items supporting specialist telehealth consultations.

Climate change and health

The RACP calls on the incoming government to tackle climate change by:

- Continuing to pursue efforts towards targets for cutting emissions to which Australia agreed in the Paris Accord and take strong action to meet this commitment.
- Developing a national climate change and health strategy for Australia, including meaningful mitigation and adaptation targets, effective governance arrangements, professional and community education, effective intergovernmental collaboration and a strong research capacity.
- Implementing rigorous domestic policies to address the adverse health effects of climate change and realise the health co-benefits of action, including adaptation and mitigation measures, as set out in the national climate change strategy.
- Establishing a national healthcare sustainable development unit. The unit would draw on local best practice as well as leading international models, such as the Sustainable Development Unit 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 to implement the strategy.

Priority 2: Prevention

Preventative health agency

The RACP recommends that the incoming government:

- Prioritise prevention by re-establishing and appropriately funding a national preventative health body to set nationwide goals, direct strategic investment, coordinate implementation of initiatives and evaluate the evidence for the cost-effectiveness of population-wide preventative health interventions.

Obesity

The RACP calls on the incoming government to prioritise obesity prevention and treatment by:

- Implementing an effective tax on sugar-sweetened beverages to reduce consumption, using generated revenue to facilitate access to healthy diets and culturally relevant initiatives to improve health equity.
- Committing appropriate funding to develop and implement the national strategy on obesity recently announced by COAG which would focus on primary and secondary prevention and social determinants of health, especially in relation to early childhood and rural and regional issues and would do so over an extended period.
- Establishing a national taskforce including sustained funding, regular and ongoing monitoring and evaluation of key measures and regular reporting on targets. This recommendation is aligned with a recommendation of the December 2018 final report of the Select Senate Committee on the obesity epidemic in Australia.
- Committing to secure, long-term funding for 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, updating 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.
- Providing hospital funding to state and territory governments specifically geared towards delivering equitable access to bariatric surgery for public hospital patients.
- Introducing regulations to restrict the advertising and marketing of unhealthy foods and beverages to children and young people.
- Revising the nutrient profile algorithm of the Health Star Rating system to give stronger weight to sugar content and making the labelling mandatory if there is not widespread uptake by the end of 2019, to encourage consumers to choose healthier options and motivate food manufacturers to reformulate and develop healthier products.

Alcohol and other drugs

The RACP recommends that the incoming government work to reduce harmful alcohol consumption by:

- Introducing a volumetric taxation system for all alcohol products and abolish the Wine Equalisation Tax (WET) and rebate.
- Allocating a proportion of the increased revenue raised from volumetric taxation to funding alcohol and other drug treatment and prevention services as part of a coordinated national response to alcohol and other drug use disorders.
- Substantially increasing funding for alcohol and other drug treatment services, including for appropriate and multidisciplinary workforce development, capital works to improve the physical infrastructure and the development of appropriate needs-based planning models and suitable models of care to address unmet demand for treatment.
- Increasing funding for prevention services to reduce the incidence of alcohol and other drug use disorders.

Priority 3: Equity

Inequities in child health

The RACP calls on the incoming government to address inequities in child health care by:

- Immediately reinstating the Australian Health Ministers' Advisory Council (AHMAC) subcommittee on child and youth health.
- Committing 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 Australian Government can begin to address inequities in child health.
- Funding 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.
- Establishing annual public reporting from relevant departments against the Australian Institute of Health and Welfare's (AIHW) Children's Headline Indicators.
- Developing Equitable Access Indicators in relation to child health that are reported on annually by the AIHW and provide additional funding to address specialist service access issues identified from this reporting.
- Committing funding to establish and maintain an Inequities in Child Health Alliance, in conjunction with several 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 governments 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.
- Conducting and publishing 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).
- Funding 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.
- Funding research into further opportunities for universal preventative health initiatives in early childhood.

Early childhood intervention

The RACP calls on the incoming government to prioritise early childhood health by:

- Increasing the delivery and uptake of a minimum schedule of universal preventive child health care, including links to the relevant maternity and immunisation registers as well as relevant MBS items.
- Improving coordination between primary/secondary and specialist mental health services for infants and children that include promotion, prevention, early intervention and treatment if required.
- Providing antenatal parental education about foods and other items (alcohol, drugs including prescription and non-prescription drugs) which carry risks to the foetus, as well as infectious food-borne organisms such as listeria, and toxoplasmosis.
- Funding healthy pre-school nutrition and activity programmes and ensuring that parents receive evidence-informed advice about healthy nutrition for pre-school children as well as recommended sleep duration for children.

Indigenous health – Access to specialist care

The RACP calls on the incoming government to address inequitable access to specialists by:

- Legislating for guaranteed long-term funding to progress the strategies and actions identified in the National Aboriginal and Torres Strait Islander Health Plan (NATSIHP) Implementation Plan commensurate with the burden of disease.
- Committing to secure, long-term funding for the Rural Health Outreach Fund (RHOF) and Medical Outreach Indigenous Chronic Disease Program (MOICDP) commensurate with the burden of disease.
- Committing to sustained, secure funding for the evidence-based, locally-delivered Tackling Indigenous Smoking program to address the number one modifiable risk factor in the burden of disease in Indigenous communities.
- Building and supporting the capacity of Aboriginal and Torres Strait Islander health leaders by committing secure long-term funding to the Indigenous National Health Leadership Forum.
- Developing systems and mechanisms to drive regional collaboration in identifying and planning specialist healthcare service provision for Aboriginal and Torres Strait Islander peoples involving the Local Health Networks and Primary Health Networks.
- Establishing an Aboriginal Health Authority to oversee health service delivery, professional training and policy and accreditation processes that impact on Aboriginal and Torres Strait Islander health. This authority would develop a validated assessment tool to identify, measure and monitor institutional racism and introduce it into reporting requirements across the health system.
- Reinstating 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.
- Scaling up immediate community-led responses and investing in addressing the long-term suicide drivers of poverty, intergenerational trauma and lack of self-determination.

Sexual health in Aboriginal and Torres Strait islander communities

The RACP calls on the incoming government to improve sexual health of Aboriginal and Torres Strait Islander communities by:

- Committing to secure, long-term funding for primary health care, community-led sexual health programs and specialised sexual health services to deliver sexually transmitted infections (STI) and blood borne viruses (BBV) services as core primary health care activity, and to ensure timely and culturally supported access to specialist care in all regions, to achieve low rates of STIs and good sexual health care for Indigenous Australians.
    - Within this framework explore with state and territory governments reciprocal funding arrangements whereby Commonwealth contributions are reciprocated with commitments by state and territory governments to fund specialist services to complement, augment and support primary health care in the provision of sexual health services.
- Investing in and supporting a long-term multi-disciplinary sexual health workforce and integrate with primary health care to build longstanding trust with communities.
- Funding the implementation plans of the National Blood Borne Virus and Sexually Transmissible Infection Strategies to ensure the implementation plan activities are delivered and targets achieved.

Indigenous child health

The RACP calls on the incoming government to improve Indigenous child health outcomes by:

- Addressing Indigenous child health inequities as a matter of priority and,
- Engaging and consulting with the Aboriginal Community Controlled Health Sector and the RACP to utilise specialist expertise and clinical knowledge in reducing Indigenous child health inequities.

Sexually transmitted infections

The RACP calls on the incoming government to address inequities in sexual health by:

- Exploring with state and territory governments reciprocal funding arrangements whereby Commonwealth contributions are reciprocated with commitments by state and territory governments to fund specialist services to complement, augment and support primary health care in the provision of sexual health services wherever they are needed.
- Funding point-of-care STI tests in remote areas through an appropriate Medicare item number.
- Committing to secure, long-term funding for accessible adolescent sexual and reproductive health services, including funding for clinical education and training to support the delivery of these services.
- Improving 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.
- Working with the states and territories to ensure access to sexuality education programs starting at age 10, including Commonwealth-funded community-led programs in high-prevalence regional and remote areas that reach high-risk, out-of-school youth.

Sustainability

Integrated care

There is an urgent need to reconfigure health services, given that an increasing proportion of the community is living with multiple chronic conditions (i.e. multi-morbidities).[1] [2] [3] This is because care for chronic conditions cannot be confined to one part of the health sector – these increasingly prevalent conditions often require care at various times at each of the primary, secondary and tertiary sectors. Better communication and interaction between practitioners across these sectors will benefit both the health care providers and consumers for whom the health care system has been established.[4]

Fundamental to this goal is 'system supported connectivity' between primary care and specialist services and a genuine placement of patients at the centre of the care design. The RACP therefore recommends funding for a model of comprehensive care for patients with multi-morbidities (that goes beyond Health Care Homes). This should be underpinned by a broader set of reforms to the existing health service delivery framework, particularly with respect to the role of healthcare professionals in the care management of chronic disease patients, including urgent action on chronic and complex disease in children and geriatric patients.

Specialists are an integral part of the primary health care treatment system, yet specialist expertise has not been included in recent federal funding approaches to patients with chronic conditions. Ideally, specialists should have a role to play in primary care and community settings in diagnosing and managing patients with chronic conditions and preventing chronic disease exacerbations. This would require, among other things, more opportunities for specialists to collaborate with GPs in an ambulatory care setting, whether through actual physical spaces for devolved hospital services or by virtual collaborations supported by technology.[5]

With few notable exceptions, Commonwealth-funded Primary Health Networks (PHNs) and state government local health and hospital networks have relatively immature linkages. These linkages should be strengthened, providing the means for jointly planned and localised regional healthcare. The most sustainable means to strengthen such linkages to achieve better integrated care for patients with multi-morbidities is through funding reforms to better pool Commonwealth and state healthcare funding streams. The Productivity Commission has proposed that both tiers of government (Commonwealth and state) direct a modest share (2 to 3%) of their current activity-based funding for hospitals into a Prevention and Chronic Condition Management Fund in each local health district to be jointly managed by the Local Hospital Network and Primary Health Network.[6]

The RACP calls on the incoming government to facilitate scalable evidence-based care for people with chronic conditions that is inclusive of specialist care by:

- Funding and fostering a model of care for management of patients with comorbid chronic health conditions. The proposed model of care would have the following features:
    - expand the interdisciplinary composition of primary care teams beyond GP services to encompass long-term roles for specialist physicians, nurses and allied health practitioners
    - introduce greater flexibility in the scope of practice of non-physician team members.

[1] Australian Institute of Health and Welfare. (2018). Chronic Disease Overview. https://www.aihw.gov.au/reports-statistics/health-conditions-disability-deaths/chronic-disease/overview

[2] Caughey, GE., Vitry, AI., Gilbert, AL. & Roughead, EE. (2008). Prevalence of comorbidity of chronic diseases in Australia. BMC Public Health. 8(1):221. https://bmcpublichealth.biomedcentral.com/articles/10.1186/1471-2458-8-221

[3] Harrison, C., Henderson, J., Miller, G. and Britt, H. (2016). The prevalence of complex multimorbidity in Australia. *Australian and New Zealand journal of public health*, *40*(3), pp.239-244.

[4] Sampson, R., Barbour, R. & Wilson, P. (2016). The relationship between GPs and hospital consultants and the implications for patient care: a qualitative study. BMC Family Practice, 17(1), p.45.

[5] Rahman, F., Guan, J., Glazier, R.H., Brown, A., Bierman, A.S., Croxford, R. & Stukel, T.A. (2018). Association between quality domains and health care spending across physician networks. https://journals.plos.org/plosone/article?id=10.1371/journal.pone.0195222 *PloS one*, *13*(4), p. e0195222.

[6] Productivity Commission. (2018). Shifting the Dial: 5-year productivity review. https://www.pc.gov.au/inquiries/completed/productivity-review/report

    - move away from the 'one problem per visit basis' and other inbuilt and often unintended mechanisms that isolate practitioners and prevent collaboration
    - be evaluated as a two-year trial, with ongoing monitoring, evaluation and reporting on the trial's outcomes.
- Considering reforms to the Medicare Benefits Schedule (MBS) or other financial incentives to better incentivise direct communications between general practitioners (GPs) and specialists in the management of patients with chronic disease. Supported communications could include provision for:
    - case conferences to include more than one specialist (not of the same specialty)
    - enabling specialists to modify and have specific input into chronic care management planning and
    - direct health professional communications (with and without the patient present) outside of case conferences.
- Facilitating greater use of specialists in ambulatory care including through the provision of practice incentives to specialist community-based services and funding for practice nurses to be used by specialist services.
- Progressing through the Council of Australian Governments (COAG), the Productivity Commission proposal for joint Commonwealth and state contributions from their respective shares of hospital activity-based funding to a Prevention and Chronic Condition Management Fund (PCCMF) in each local health district.

Digital health and telehealth

Digital health is about electronically connecting the points of care so that health information can be shared securely. It is therefore fundamental to facilitating integrated care. Strategic use of digital health and telehealth can help address major challenges to the health system, such as inequitable access, an ageing population, the gap in Indigenous health outcomes, chronic disease and workforce issues.[7]

The My Health Record (MHR) initiative is the Australian Government's major investment in digital health. However, among clinicians, incentives are currently only provided to GPs to sign up and participate in MHR.

The quick and efficient sharing of patient information between GPs and specialists would constitute one of the benefits of the MHR. However, this benefit is unlikely to be achieved without better engagement and buy-in from specialist physicians. Comparable incentives to those currently provided to GPs should also be available to community-based physicians (many of whom are also engaged in the public hospital sector), if the goal is to maximise broad clinician uptake and fully leverage the benefits of MHR.

The College also supports initiatives such as the National Digital Health Strategy project to develop minimum interoperability standards, with the goal of an agreed vision and roadmap for interoperability between all public and private health and care services in Australia. At present, lack of such interoperability is a significant barrier to better connected care.

Since its introduction, telehealth has increased patient access to specialist medical advice. However, telehealth has been restricted to patients who live within a 15 km distance from a specialist service. There would be significant benefits – for patients, health services and healthcare providers as well as for government budgets – in removing the current MBS item limitation on telehealth services. This restriction, which has not been amended since 2012, unnecessarily limits the provision of specialist care when there may be valid reasons for a telehealth consultation within the 15 km distance from a service. Removal of the restriction might benefit people with chronic conditions, those with carer responsibilities, ambulatory limitations, transport difficulties, time limitations and condition-related impairments.

[7] Wilson, L. (2017). National Digital Health Strategy. https://conversation.digitalhealth.gov.au/australias-national-digital-health-strategy

Telehealth has the additional benefit of minimising disruption within the home, school or work (for example for 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 calls on the incoming government to extend the availability and effectiveness of digital health and telehealth to support more equitable access to specialist care by:

- Making available 'provider readiness' incentives comparable to those currently provided to GPs (i.e. the Practice Incentives Program e-health incentive) to specialist physicians to sign up and participate in MHR.
- Delivering the funding needed to progress the National Digital Health Strategy project to develop minimum interoperability standards, with the goal of an agreed vision and roadmap for interoperability between all public and private health and care services in Australia.
- Removing the distance requirement from the MBS items supporting specialist telehealth consultations.

Climate change and health

The health impacts of climate change are a pressing global public health concern. Urgent action on climate change represents an opportunity to simultaneously reduce the harms and risks of climate change and improve health outcomes for Australians, New Zealanders and the world.

Anthropogenic climate change is real and urgent action is warranted to stop warming at 1.5°C, as evidenced in the 2018 Intergovernmental Panel on Climate Change (IPCC) *Special Report on Global Warming of 1.5°C*.[8] The risks posed by climate warming are comprehensive, affecting not only the environmental and health fronts, but also national, regional and global economic and social settings.

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 will put pressure on healthcare personnel and delivery of healthcare services because of increasing frequency and intensity of extreme weather events. In this respect, climate change can be regarded as a health emergency warranting urgent and decisive government action to address what will be a growing contribution to mortality and morbidity.[9]

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. The RACP published three position statements in relation to climate change and health in 2016: *Climate change and health,*[10] *Environmentally sustainable health care*[11] and *Health benefits of mitigating climate change*.[12]

Australia has lagged in its climate policy and as a result it needs to urgently take clear and concrete action on climate change. The RACP calls on the incoming government to commit to developing and implementing a comprehensive national climate and health strategy to reduce the risks to health and realise the health benefits of adaptation and mitigation. The strategy should be closely aligned with efforts to reduce obesity and prevent chronic disease, as incentivising fresh vegetable intake, reducing consumption of meat and processed food and fostering healthier consumption culture will result in amplified population-wide health and environmental outcomes.[13]

---

[8] Intergovernmental Panel on Climate Change Special Report on Global Warming of 1.5°C. https://www.ipcc.ch/sr15/

[9] Solomon, CG & LaRocque, RC. (2019). Climate Change — A Health Emergency. N Engl J Med 2019; 380:209-211

[10] RACP Position on climate change and health. (2016). https://www.racp.edu.au/docs/default-source/advocacy-library/climate-change-and-health-position-statement.pdf?sfvrsn=5

[11] RACP Position on environmentally sustainable health care. (2016). https://www.racp.edu.au/docs/default-source/advocacy-library/environmentally-sustainable-healthcare-position-statement.pdf?sfvrsn=4

[12] RACP Position on health benefit of mitigating climate change. (2016). https://www.racp.edu.au/docs/default-source/advocacy-library/health-benefits-of-mitigating-climate-change-position-statement.pdf?sfvrsn=5

[13] Willett, W, Rockstrom, J at al, Food in the Anthropocene: the EAT–Lancet Commission on healthy diets from sustainable food systems, Lancet, Volume 393, issue 10170, p447-492, February 02, 2019

The RACP also calls on the incoming government to continue to enable Pacific Island countries and territories to develop their medical workforce and support development of prevention/mitigation and response measures to climate change. The impact of severe weather events in the Pacific Islands, including health impacts due to rising sea levels and biosecurity concerns, will be of growing importance in the years to come.

Given that the core business of healthcare is to promote and protect human health, there is also an imperative for the health sector to reduce its own carbon emissions. The carbon footprint of the Australian health sector has been estimated at 7% of Australia's total, evidencing the need for effective measures to lower the impact of health-care services on the environment, including reducing its own carbon emissions.[14]

An environmentally sustainable healthcare system is one that has no cumulative harmful impacts on the natural environment or society, while providing high-quality healthcare. '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.

There are other recommendations in the submission that will realise positive environmental benefits in addition to improved health outcomes; these include the recommendation for a wide-ranging national obesity strategy that would encourage improved physical activity environments (including support for public transport) and boost sustainable food production and consumption practices that mitigate the effects of climate change. This reinforces the case for a whole-of-government approach to population-level policy issues that can take account of health and environmental interdependencies.

The RACP calls on the incoming government to tackle climate change by:

- Continuing to pursue efforts towards targets for cutting emissions to which Australia agreed in the Paris Accord and take strong action to meet this commitment.
- Developing a national climate change and health strategy for Australia, including meaningful mitigation and adaptation targets, effective governance arrangements, professional and community education, effective intergovernmental collaboration and a strong research capacity.
- Implementing rigorous domestic policies to address the adverse health effects of climate change and realise the health co-benefits of action, including adaptation and mitigation measures, as set out in the national climate change strategy.
- Establishing a national healthcare sustainable development unit. The unit would draw on local best practice as well as leading international models, such as the Sustainable Development Unit 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 to implement the strategy.

[14] Malik, A, Lenzen, M, et al, The carbon footprint of Australian health care, Lancet, 2018. https://www.thelancet.com/journals/lanplh/article/PIIS2542-5196(17)30180-8/fulltext

Prevention

Preventative health agency

The need for nationally coordinated preventative health measures has never been greater. The increasing pressures on the Australian health system caused by the burden of chronic disease are widely recognised. Australia faces significant and growing problems with potentially preventable disorders such as obesity, diabetes and cardiovascular conditions due to factors such as smoking, sedentary lives, unhealthy diet and alcohol misuse. Approximately 31% of Australia's total burden of disease can be attributed to modifiable risk factors.[15]

There is incontrovertible evidence that long-term, sustained and targeted preventative health measures are highly effective. Some approaches promote health and cut overall costs because of the reduced need to treat expensive diseases, others allow Australians to live longer and better-quality lives at a reasonable cost to the system.[16]

In 2016-17, Australia spent nearly $181 billion on health, 69% of it funded by Australian governments.[17] By comparison, in recent years it was estimated that Australia spent only $2 billion, or $89 a year, per person, on prevention. This amounts to a mere 1.34% of all health spending, considerably less than the UK, NZ and Canada.[18] Many people are missing out on access to prevention, early detection and quality care, with the expanding needs of Indigenous Australians, people in rural and remote areas, people with mental health issues and the growing cohort of older Australians – to name a few – presenting urgent and cumulative challenges to health and welfare systems.

The current piecemeal, reactive response to preventable public health crises is leaving many Australians behind. To successfully deal with the escalating public health challenges, Australia needs a national health body dedicated to planning, strategic investment and leading the implementation of a coordinated, evidence-based public health agenda for the whole of Australia. This Australian Government-led independent body would have a clear nationwide remit to define long-term strategic goals for tackling chronic diseases, including their environmental and social determinants, and coordinate and scale up all relevant preventative health action across jurisdictions and partnered research institutes, universities and non-government organisations.

In addition to setting national preventative health priorities, the agency would advise on the most effective and cost-effective ways to implement and fund them, as well as evaluating progress based on need and evidence. The key role of the agency would be to apportion the spheres of responsibility to government jurisdictions and associated bodies and to hold them accountable for the delivery on these responsibilities.

To ensure its effectiveness, the agency and its work of health prevention must be appropriately resourced over a sustained period. Regardless of the exact design and funding model for this agency, it is clear that to deal with the increased burden of preventable health disease in our country, Australia must significantly increase our spending on prevention.

The RACP recommends that the incoming government:

- Prioritise prevention by re-establishing and appropriately funding a national preventative health body to set nationwide goals, direct strategic investment, coordinate implementation of initiatives and evaluate the evidence for the cost-effectiveness of population-wide preventative health interventions.

[15] AIHW. (2011). Australian Burden of Disease Study: impact and causes of illness and death in Australia 2011, https://www.aihw.gov.au/getmedia/d4df9251-c4b6-452f-a877-8370b6124219/19663.pdf.aspx?inline=true
[16] Jackson, H & Shiell, A. (2017) Preventive health: How much does Australia spend and is it enough? Canberra: Foundation for Alcohol Research and Education., p.8 http://fare.org.au/wp-content/uploads/Preventive-health-How-much-does-Australia-spend-and-is-it-enough_FINAL.pdf
[17] AIHW. (2018)., Health expenditure Australia 2016-17. https://www.aihw.gov.au/getmedia/e8d37b7d-2b52-4662-a85f-01eb176f6844/aihw-hwe-74.pdf.aspx?inline=true
[18] Jackson, Shiell. Preventive health. p.7.

Obesity

The growing rate of obesity in Australia is an issue of serious concern. Obesity is associated with a range of health problems and consequences, including many non-communicable diseases such as cardiovascular disease, type II diabetes and high blood pressure.

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 our obesogenic environment.[19]. People suffering from obesity are entitled to receive the same standard of care; 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% of Australian adults over 20 were obese; by 2013, obesity rates for adults over 20 had increased to 28%. Trends are replicated for children and young people under 20: in Australia in 1980, 3.5% of children had obesity, increasing to 7% in 2013.[20] 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 carer costs, was around $58 billion.[21]

The National Health and Medical Research Council's clinical practice guidelines published in 2013 state 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".[22]

The RACP's *Position Statement Action to prevent obesity and reduce its impact across the life course*[23] and accompanying *Evidence Review*[24] call on the incoming government to lead a concerted effort to address the many causes and complications of obesity. The development and implementation of a comprehensive, evidence-based national strategy to address obesity, as proposed in October 2018, by the Council of Australian Governments, remains an urgent priority. Such a strategy must contain measures to address factors including, but not limited to, challenging and changing societal and cultural norms; food and physical activity environments; the availability, affordability and marketing of energy-dense, nutrient-poor foods and beverages; individual behaviours and biological factors. The strategy must capitalise on the synergies between interventions to reduce overweight and obesity and other health-related interventions, such as the introduction of a uniform volumetric tax on alcohol[25] and evidence-based practices for sustainable food production and consumption that mitigate the effects of climate change.[26] A crucial aspect of the strategy's effectiveness will be that it be whole-of-government, robustly designed and appropriately and consistently funded.

An obesity strategy must also address the contribution of sugary drinks to obesity. Sugary drinks have been directly linked to weight gain and obesity. Many countries including Mexico, France and Belgium have already implemented a tax on sugary drinks while the UK, Ireland and Portugal rolled out a tax

---

[19] Lake A & Townshend, T. (2006). Obesogenic environments: exploring the built and food environments. J R Soc Promot Health.126(6). 262-7.
[20] Global Burden of Disease 2013 Obesity Collaboration; Ng, M, Fleming T, Robinson M, Thomson B, Graetz N, Margono C. (2014). Global, regional and national prevalence of overweight and obesity in children and adults 1980-2013: A systemic analysis. Lancet. 384(9945):766-78. http://condor.depaul.edu/bsykes1/Publications_files/Obesity_Lancet_2014.pdf
[21] Access Economics. (2008). The Growing Cost of Obesity in 2008: Three Years On, Diabetes Australia, Canberra. https://static.diabetesaustralia.com.au/s/fileassets/diabetes-australia/7b855650-e129-4499-a371-c7932f8cc38d.pdf
[22] 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.
[23] RACP. (2018). *Position Statement Action to prevent obesity and reduce its impact across the life course*. https://www.racp.edu.au/docs/default-source/advocacy-library/racp-obesity-position-statement.pdf
[24] Ibid.
[25] Assessing Cost-effectiveness of Obesity Prevention Policies in Australia, ACE-obesity policy 2018.
[26] Willett, W, Rockstrom, J at al. (2019). *Food in the Anthropocene: the EAT–Lancet Commission on healthy diets from sustainable food systems*, Lancet, Volume 393, issue 10170, p447-492, February 02, 2019.

in 2018. The evidence to date has shown that taxes on sugary drinks may be a cost-effective mechanism to reduce consumption of these drinks and encourage manufacturers to reformulate their products. Revenue generated by the implementation of a sugar-sweetened beverage tax should facilitate access to healthy diets, culturally relevant community initiatives and improve health equity.

Considering the above, the RACP commends the important commitment made by the COAG Health Ministers in October 2018 to develop a national strategy on obesity with a "strong focus on the primary and secondary prevention measures, social determinants of health, especially in relation to early childhood and rural and regional issues".[27]

The RACP calls on the incoming government to prioritise obesity prevention and treatment by:

- Implementing an effective tax on sugar-sweetened beverages to reduce consumption, using generated revenue to facilitate access to healthy diets and culturally relevant initiatives to improve health equity.
- Committing appropriate funding to develop and implement the national strategy on obesity recently announced by COAG which would focus on primary and secondary prevention and social determinants of health, especially in relation to early childhood and rural and regional issues and would do so over an extended period.
- Establishing a national taskforce including sustained funding, regular and ongoing monitoring and evaluation of key measures and regular reporting on targets. This recommendation is aligned with a recommendation of the December 2018 final report of the Select Senate Committee on the obesity epidemic in Australia.
- Committing to secure, long-term funding for 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, updating 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.
- Providing hospital funding to state and territory governments specifically geared towards delivering equitable access to bariatric surgery for public hospital patients.
- Introducing regulations to restrict the advertising and marketing of unhealthy foods and beverages to children and young people.
- Revising the nutrient profile algorithm of the Health Star Rating system to give stronger weight to sugar content and making the labelling mandatory if there is not widespread uptake by the end of 2019, to encourage consumers to choose healthier options and motivate food manufacturers to reformulate and develop healthier products.

Alcohol and other drugs

Alcohol Taxation

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.[28] 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.[29] 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.[30] Cheap

[27] COAG. (2018). Health Council Communiqué 12 October 2018.
[28] RACP & RANZCP. (2016). Alcohol Policy. pp11.https://www.racp.edu.au/docs/default-source/advocacy-library/pa-racp-ranzcp-alcohol-policy.pdf?sfvrsn=6.
[29] Ibid. p.17.
[30] Ibid. p.28.

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.
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.[31]

Recent research also demonstrates that a uniform volumetric tax on alcohol is the most cost-effective policy for preventing obesity.[32] This suggests that there are strong synergistic public health benefits from reducing alcohol consumption through volumetric taxation.

Alcohol and other drug treatment

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.[33] 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.

Increased investment in evidence-based alcohol and other drug treatment services is crucial. Research indicates that for every dollar invested in alcohol and other drug treatment, society saves seven dollars.[34] Investing in alcohol and other drug treatment services clearly yields high returns. Treatment has been shown to reduce substance 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 and other drug treatment services and harm prevention and minimisation programs.

The RACP recommends that the incoming government work to reduce harmful alcohol consumption by:

- Introducing a volumetric taxation system for all alcohol products and abolish the Wine Equalisation Tax (WET) and rebate.
- Allocating a proportion of the increased revenue raised from volumetric taxation to funding alcohol and other drug treatment and prevention services as part of a coordinated national response to alcohol and other drug use disorders.
- Substantially increasing funding for alcohol and other drug treatment services, including for appropriate and multidisciplinary workforce development, capital works to improve the physical infrastructure and the development of appropriate needs-based planning models and suitable models of care to address unmet demand for treatment.
- Increase funding for prevention services to reduce the incidence of alcohol and other drug use disorders.

[31] Australian Productivity Commission. (2017). Shifting the Dial: 5-year productivity review, 2017.
[32] Ananthapavan. J, Sacks. G, Brown. V, Moodie. M, Nguyen. T.M.P, Barendreg. J, Veerman. J.L, Herrera. A.M.M, Lal. A, Peeters. A & Carter. R. (2018). Assessing cost-effectiveness of obesity prevention policies in Australia. https://apo.org.au/node/210491.
[33] NDARC. (2014). New Horizons: The review of alcohol and other drug treatment services in Australia, p. 13. https://ndarc.med.unsw.edu.au/resource/new-horizons-review-alcohol-and-other-drug-treatment-services-australia.
[34] Ibid.

Equity

Inequities in child health

All children, no matter where they live or who they are, should have the same opportunity to fulfil their potential. Child health inequities are differential outcomes in children's health, development and wellbeing 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 wellbeing. These gaps widen as children progress across the life trajectory, resulting in adverse adult health, educational and vocational outcomes and increased subsequent mortality and morbidity. This can have an intergenerational effect with inequity passed on to the next generation. Health inequities also have high costs to society – the cost of inaction on the social determinants of health on productivity and expenditure in Australia has been estimated to be as high as $14 billion per year.[35]

By tackling health inequities, societies achieve better overall health and the social gradient flattens with a 'spill over' effect on non-health outcomes such as social, educational and workforce inclusion and crime reduction. Significant economic benefits flow from providing strong and truly universal child health and education services that are proportionate to a population group's needs, with those children most at need having the greatest access to quality services.

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 Australian Health Ministers' Advisory Council (AHMAC) report for National Framework for Universal Child and Family Health Services recommended that the schedule of contacts be based on:

- Alignment to immunisation schedules to encourage participation in both programs
- Critical periods of child development
- Opportunities to identify families at risk and offer timely family support services
- Opportunities for targeted anticipatory guidance (parental advice) and
- 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 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's *Position Statement – Inequities in Child Health*[36]*,* calls on all governments to take sustained and meaningful action to achieve fairer access to healthcare and more equitable health outcomes for all Australian children.

The RACP calls on the incoming government to address inequities in child health care by:

- Immediately reinstating the Australian Health Ministers' Advisory Council (AHMAC) subcommittee on child and youth health.
- Committing 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

[35] Brown. L. (2012). The cost of inaction on the social determinants of health. University of Canberra: National Centre for Social and Economic Modelling. https://www.cha.org.au/images/CHA-NATSEM%20Cost%20of%20Inaction.pdf
[36] RACP. (2018). Position Statement: Inequities in Child Health. https://www.racp.edu.au/docs/default-source/advocacy-library/racp-inequities-in-child-health-position-statement.pdfn

policies, programs and initiatives funded by the Australian Government can begin to address inequities in child health.

- Funding 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.
- Establishing annual public reporting from relevant departments against the Australian Institute of Health and Welfare's (AIHW) Children's Headline Indicators.
- Developing Equitable Access Indicators in relation to child health that are reported on annually by the AIHW and provide additional funding to address specialist service access issues identified from this reporting.
- Committing funding to establish and maintain an Inequities in Child Health Alliance, in conjunction with several 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 governments 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.
- Conducting and publishing 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).
- Funding 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.
- Funding research into further opportunities for universal preventative health initiatives in early childhood.

Early childhood intervention

There is substantial evidence that investment in the early years of children's health, development and wellbeing is the most cost-effective means of tackling long-term health conditions and adult health inequity.

Population-level early interventions aimed at children and their families such as high quality antenatal care and high quality early childhood education produce better health, wellbeing and development outcomes, particularly for disadvantaged children.[37] [38] Targeted nurse home visiting, parenting programs and effective early childhood education services can also have a similar effect. Long term and collectively, these interventions have been shown to reduce adult morbidity and mortality, high school dropout rates and criminal behaviour and to increase employment and delay childbearing.

Commendable progress has been made towards achieving universal access to early childhood education for three-year olds and up, including the renewed funding in 2019 under the National Partnership on Universal Access to Early Childhood Education. The RACP supports the principles underpinning the Australian Labor Party's recently announced proposal to fund the National Preschool and Kindy Program, guaranteeing access to 600 hours of preschool or kindergarten for 3 and 4-year-old Australian children. Universally accessible early childhood education services will ensure the youngest Australians can get the best possible start in life.

The incoming government must commit to improving the health and wellbeing of Australian children by creating flexible and responsive systems that are equipped to deliver preventive interventions and

[37] Victorian Department of Human Services & Brotherhood of St. Laurence. (2004). Breaking cycles, building futures: promoting inclusion of vulnerable families in antenatal and universal early childhood services: a report on the first three stages of the project

[38] Australian Child Rights Taskforce. (2016). CRC25 Australian Child Rights Progress Report 2016. p.24- 26. http://www.childrights.org.au/crc25/

respond effectively to emerging issues and challenges.[39] This will only be achieved through a multidisciplinary and cross-sector approach across multiple areas of Government including health, family and community services, housing and disability services. The incoming government has a responsibility to invest in better designed and evidence-based policies aimed at families who are at highest risk for unplanned emergency care and hospitalisation and disproportionate use of healthcare and social services later in life.

The RACP calls on the incoming government to prioritise early childhood health by:

- Increasing the delivery and uptake of a minimum schedule of universal preventive child health care, including links to the relevant maternity and immunisation registers as well as relevant MBS items.
- Improving coordination between primary/secondary and specialist mental health services for infants and children that include promotion, prevention, early intervention and treatment if required.
- Providing antenatal parental education about foods and other items (alcohol, drugs including prescription and non-prescription drugs) which carry risks to the foetus, as well as infectious food-borne organisms such as listeria, and toxoplasmosis.
- Funding healthy pre-school nutrition and activity programmes and ensuring that parents receive evidence-informed advice about healthy nutrition for pre-school children as well as recommended sleep duration for children.

Indigenous health

Access to specialist care

Australia is a rich country with quality infrastructure and a world-class health system. Australia's First Peoples, the Aboriginal and Torres Strait Islander peoples, are one of the fastest growing populations (nearing 3%), who provide a continuous link to upwards of 60,000 years of culture on this continent. Yet Australia's Aboriginal and Torres Strait Islander First Peoples continue to suffer greater incidence of chronic disease and experience disadvantage and barriers to accessing appropriate and effective health care. Despite these long-standing inequities progress has been slow in reducing the health gap and concerted, sustained action is urgently needed.

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 23% between 1998 and 2016, while during the same period non-Indigenous Australians experienced a 14% decline in cancer mortality rates.[40]

To address these inequities and improve access to care, continuing and strengthened focus and appropriate long-term legislated 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 and hamper their ability to retain and expand their capacity. Limited access to specialist care for many Aboriginal and Torres Strait Islander people is an issue of particular concern for the RACP. Data shows that Aboriginal and Torres Strait Islander people access Medicare-rebated specialist services 40% less than non-Indigenous people, notwithstanding their higher rates of chronic disease (this is the case both in urban areas as well as regional and remote settings).[41]

[39] Australian Research Alliance for Children and Youth. (2015). Better Systems, Better Chances: A Review of Research and Practice for Prevention and Early Intervention. https://www.aracy.org.au/publications-resources/command/download_file/id/274/filename/Better-systems-better-chances.pdf
[40] Australian Government. (2018). Closing the Gap Report. https://closingthegap.pmc.gov.au/
[41] Australian Institute of Health and Welfare (2017) Aboriginal and Torres Strait Islander Health Performance Framework 2017 Online data tables, Table 3.14.31.

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 incoming government continue its investment in these programs and undertake evaluation to ensure the programs are targeted at the most appropriate issues, achieving positive health outcomes for Aboriginal and Torres Strait Islander peoples, and that the funded services are culturally safe.

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; as such, service development and provision should be led by Aboriginal and Torres Strait Islander health organisations wherever possible. The sector must have long-term, legislated, sufficient and secure funding to both retain and grow their capacity.

The RACP has developed the Medical Specialist Access Framework to inform the development of systems and models that have proven successful in particular communities. While there are general principles that need to underpin the provision of services, there is no one model which will ensure timely and appropriate access to specialist care for Indigenous people across all communities and very different circumstances and cultural contexts. There are communities where there are successful models and excellent systems in place to support good access to specialist care while other communities struggle.

In line with the recent Budget submission by the Close the Gap Campaign, the RACP calls on the incoming government to ensure that the health care system is resourced to deliver culturally appropriate and safe health care that Aboriginal and Torres Strait Islander peoples have a right to expect and receive. We ask for greater transparency and accountability provisions for all service providers, including the establishment of an Aboriginal Health Authority to oversee health service delivery to Aboriginal and Torres Strait Islander peoples and the introduction of a validated assessment tool to identify, measure, monitor and report on institutional racism in the health care system.[42]

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.

The RACP calls on the incoming government to address inequitable access to specialists by:

- Legislating for guaranteed long-term funding to progress the strategies and actions identified in the National Aboriginal and Torres Strait Islander Health Plan (NATSIHP) Implementation Plan commensurate with the burden of disease.
- Committing to secure, long-term funding for the Rural Health Outreach Fund (RHOF) and Medical Outreach Indigenous Chronic Disease Program (MOICDP) commensurate with the burden of disease.
- Committing to sustained, secure funding for the evidence-based, locally-delivered Tackling Indigenous Smoking program to address the number one modifiable risk factor in the burden of disease in Indigenous communities.
- Building and supporting the capacity of Aboriginal and Torres Strait Islander health leaders by committing secure long-term funding to the Indigenous National Health Leadership Forum.
- Developing systems and mechanisms to drive regional collaboration in identifying and planning specialist healthcare service provision for Aboriginal and Torres Strait Islander peoples involving the Local Health Networks and Primary Health Networks.
- Establishing an Aboriginal Health Authority to oversee health service delivery, professional training and policy and accreditation processes that impact on Aboriginal and Torres Strait

[42] Australian Government. (2019). lose the Gap Campaign Budget submission, January 2019. https://ctgreport.pmc.gov.au/sites/default/files/ctg-report-2019.pdf?a=1

Islander health. This authority would develop a validated assessment tool to identify, measure and monitor institutional racism and introduce it into reporting requirements across the health system.
- Reinstating 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.
- Scaling up immediate community-led responses and investing in addressing the long-term suicide drivers of poverty, intergenerational trauma and lack of self-determination.

Sexual health in Aboriginal and Torres Strait Islander communities

For young Aboriginal and Torres Strait Islander people, access to sexual health information and services is critical. There continue to be ongoing outbreaks of infectious syphilis across Australia affecting Aboriginal and Torres Strait Islander people, occurring 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.[43] 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.

Government commitment to long-term investment in Indigenous sexual health programs, workforce and services is needed to end funding uncertainty. Long-term responses must be community-led and involve the Aboriginal Community Controlled Health sector.

The RACP is involved in the government-led response, the Sexually Transmissible Infections Enhanced Response Unit that is implementing an Action Plan to address the issue in the short term. We welcome the plans to activate a short-term response across the state and territories to the continuing syphilis outbreaks, to be coordinated by the Department of Health. However, while this Action Plan and short-term funding are urgently needed, the short-term activities must be aligned with, and contribute to, longer-term strategies and investments across states and territories.

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 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 sexual health care when needed through integration with comprehensive primary health care services to ensure sustainable and culturally appropriate service provision.

The RACP calls on the incoming government to improve sexual health of Aboriginal and Torres Strait Islander communities by:

- Committing to secure, long-term funding for primary health care, community-led sexual health programs and specialised sexual health services to deliver sexually transmitted infections (STI) and blood borne viruses (BBV) services as core primary health care (PHC) activity, and to ensure timely and culturally supported access to specialist care in all regions, to achieve low rates of STIs and good sexual health care for Indigenous Australians.
    - Within this framework explore with state and territory governments reciprocal funding arrangements whereby Commonwealth contributions are reciprocated with commitments by state and territory governments to fund specialist services to complement, augment and support primary health care in the provision of sexual health services.
- Investing in and supporting a long-term, multi-disciplinary, sexual health workforce and integrate with primary health care to build longstanding trust with communities.
- Funding the implementation plans of the National Blood Borne Virus and Sexually Transmissible Infection Strategies to ensure the implementation plan activities are delivered and targets achieved.

[43] Kirby Institute. (2018). Bloodborne viral and sexually transmissible infections in Aboriginal and Torres Strait Islander people: annual surveillance report 2018. Sydney: Kirby Institute, UNSW Sydney.

Indigenous child health

Aboriginal and Torres Strait Islander children and young people have poorer health outcomes than the general population, due, in large part, to preventable illnesses. The ongoing impacts of colonisation, institutional racism and the social determinants of health are significant contributing factors to this gap.

We are developing a position statement on Indigenous child health, which will help to bring an expert, experienced and evidence-based voice to issues that influence the health and wellbeing of Māori, Aboriginal and Torres Strait Islander children.

We recognise the work of the First 1000 Days Australia initiative and the leadership of Professor Kerry Arabena in developing an Indigenous-led, family-centred strategy to support young children's health and wellbeing.

The RACP calls on the incoming government to improve Indigenous child health outcomes by:

- Addressing Indigenous child health inequities as a matter of priority and
- Engaging and consulting with the Aboriginal Community Controlled Health sector and the RACP to utilise specialist expertise and clinical knowledge in reducing Indigenous child health inequities.

Sexually transmitted infections

Despite recent progress in tackling HIV and Hepatitis C, sexually transmitted infections remain a significant and increasing problem in Australia, especially for several underserviced segments of the community.

In 2017, there were an estimated 255,228 new chlamydia infections in people aged 15–29 years. While testing and diagnoses of chlamydia have increased in the past five years, almost three quarters of infections in young people remain undiagnosed and untreated, highlighting the need for testing to be routinely offered to sexually active adolescents and young adults.[44]

Gonorrhoea and infectious syphilis have been diagnosed more frequently in the past five years in gay and bisexual men, with the highest rates in younger men and in men living with HIV. The increase in the ratio of gonorrhoea diagnoses to Medicare-rebated tests among both men and women between 2013 and 2017 also suggests increasing transmission through heterosexual sex.[45]

Access to health care is the most effective method for controlling STIs at a population level, requiring adequately funded and appropriately targeted interventions to improve health promotion and access to testing and treatment amongst younger people, gay and bisexual men, sex workers, and heterosexual men and women. Only publicly-funded sexual health services have the capacity to mount public health responses to local outbreaks.

Unfortunately, sexual health services are distributed inequitably across the country. For instance, NSW has over 40[46] sexual health clinics and thus much greater capacity to accommodate the large increases in STI cases that have occurred in recent years; the one sexual health clinic in Victoria has reached capacity and can no longer provide Victorians and Medicare ineligible residents and visitors with accessible sexual health care. The limited access to sexual health services in Victoria is a likely reason that STI rates in the state are rising more rapidly than NSW.[47] South Australia, Western Australia, Tasmania, the Northern Territory and parts of Queensland similarly have very poor access

[44] Kirby Institute. (2018). HIV, viral hepatitis and sexually transmissible infections in Australia: Annual surveillance report 2018. Sydney: Kirby Institute, UNSW Sydney.
[45] Ibid.
[46] NSW Ministry of Health, NSW Sexual Health Clinics, https://www.health.nsw.gov.au/sexualhealth/pages/sexual-health-clinics.aspx
[47] Australasian Chapter of Sexual Health Medicine briefing paper for the Victorian Government election.

to publicly funded sexual health services (for instance, there is one clinic is South Australia and two small metro clinics in Western Australia). Sexual health services are especially scarce and underfunded in regional and remote areas across the country.

Young people have the right to and the clear need for information, education and clinical care that supports healthy sexual development and informed choices and minimises the risk of coercion, unplanned pregnancy, STIs and other unwanted or unintended 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 for this demographic needs to be culturally, developmentally and age appropriate and delivered from a youth-friendly perspective.

The RACP calls on the incoming government to address inequities in sexual health by:

- Exploring with state and territory governments reciprocal funding arrangements whereby Commonwealth contributions are reciprocated with commitments by state and territory governments to fund specialist services to complement, augment and support primary health care in the provision of sexual health services wherever they are needed.
- Funding point-of-care STI tests in remote areas through an appropriate Medicare item number.
- Committing to secure, long-term funding for accessible adolescent sexual and reproductive health services, including funding for clinical education and training to support the delivery of these services.
- Improving 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.
- Working with the states and territories to ensure access to sexuality education programs starting at age 10, including Commonwealth-funded, community-led programs in high-prevalence regional and remote areas that reach high-risk, out-of-school youth.