AMA NEW SOUTH WALES

VISION FOR A HEALTHIER NSW

ELECTION PRIORITIES 2019

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FROM THE **PRESIDENT**

Ongoing investment in health is key to the overall wellbeing and welfare of NSW residents. We must continually strive for a health system that is patient-centred, equitable, integrated and innovative.

NSW residents have access to one of the best healthcare systems in the world, but we can do better. Successive governments, at both the State and Federal level, have failed to consider our health system as a whole. However, both the State and Federal Government have an opportunity to strategically invest in health at what is one of the most critical points in NSW's history – where the State's population growth intersects with an ageing demographic, that is increasingly at risk of chronic disease due to the prevalence of overweight and obesity. We must act now to adequately resource both preventive health and clinical treatment.

Government must look for new solutions to old problems – how can we better utilise primary care to keep people out of hospitals? How can we incorporate technology to improve health outcomes? These are the types of questions to which there are no easy answers. However, by working collaboratively and engaging stakeholders throughout the healthcare supply chain we can forge a new path that embraces a bold vision for better healthcare in NSW.

AMA (NSW)'s 2019 Election Priorities highlights three areas of priority: Healthy Hospitals, Healthy Systems, and Healthy Communities.

Dr Kean-Seng Lim
AMA (NSW) President

AMA NEW SOUTH WALES

SUMMARY

1. HEALTHY HOSPITALS

Increased hospital demand is affecting the ability of medical professionals to cope, and patient care is being compromised. We need a plan to address workforce shortages urgently, and we need to recognise and value the contribution of doctors-in-training.

RECOMMENDATIONS	NSW	FEDERAL
A commitment to develop a medical workforce plan to deliver the health system we need.	✔	✔
Create new, substantive positions to ensure a continuation of the public and private service model.	✔	
A commitment to an 85% occupancy rate of acute overnight hospital beds.	✔	
Increase transparency of real waiting times by elective surgery patients by reporting the time from first referral by a general practitioner to the first occasion of treatment.	✔	
SUPPORTING DOCTORS-IN-TRAINING		
Allow doctors-in-training to conduct a work value case to assess the current value of their contribution to the NSW public health system.	✔	
Provide doctors-in-training with access to exam and conference leave. Access to such leave would allow for better planning by health systems and would recognise the stress associated with undertaking exams.	✔	
Provide doctors-in-training with financial support towards training.	✔	
Review and implement best practice policy for on call, call back, and protection from excessive hours.	✔	
Unaccredited registrars should not be rostered on less favourable terms than accredited registrars.	✔	
Establish specified facilities, including break rooms, sleeping spaces, and secure accommodation for doctors-in-training.	✔	
DOCTORS' HEALTH AND WELLBEING		
Review mandatory reporting laws to improve doctors' health and wellbeing.	✔	

2. HEALTHY SYSTEMS

There is a strong need for integration and collaboration on the delivery of health services in NSW. We need a strategic approach to health planning and greater investment in technology to support better communication.

RECOMMENDATIONS	NSW	FEDERAL
HEALTH PLANNING		
Create a framework for obstetric transfers, interventional radiology, burns and trauma, with a focus on integration and collaboration on the delivery of these health services.	✔	✔
Establish an independent review into paediatrics to examine how best to deliver services in NSW.	✔	
HEALTH IT		
The State and Commonwealth should work together to plan for and invest in a comprehensive IT strategy that integrates hospital and specialist, GP and other health practitioner services.	✔	✔
The Commonwealth should provide incentives to increase computerisation among specialist practices.		✔
Continue to invest in health IT infrastructure, resources and training to improve patient care and the efficiency of the health system.	✔	✔
Develop new health IT systems with clinician engagement and finalise with end user approval.	✔	✔
The provision of after-hours access to public hospital diagnostic and imaging services to allow GPs to provide some after hours or emergency care through their practices.	✔	✔
Local Health Districts' key performance measures should include effectiveness of handover of care.	✔	✔
Local Health Districts' key performance measures should include coordination with primary care services in the community.	✔	✔
Phase out the fax machine by 2022.	✔	✔
Investigate a secure, two-way communication system to replace pagers in public hospitals.	✔	✔
Fix compatibility problems between software systems being used in public hospitals and primary care.	✔	✔
Require pathology labs to transmit results electronically in both private and public systems.	✔	✔

SUMMARY (CONTINUED)

3. HEALTHY COMMUNITIES

Underpinning healthy communities is an adequately resourced and integrated primary care sector. We also need greater focus on mental health and ensuring equitable health access for rural and regional residents, Indigenous Australians, and prisoners.

RECOMMENDATIONS	NSW	FEDERAL
GENERAL PRACTICE AND THE PRIMARY CARE SYSTEM		
Time for 10. Funding for primary care should be increased from 8% of the total health budget to 10%. This must be in the form of new money.		✔
Redesign Health Care Homes with adequate funding and clinical input.	✔	✔
Chronic disease management funding for enhanced management of priority chronic diseases.	✔	✔
Funding for general practice pharmacists.	✔	✔
Funding to encourage and support multidisciplinary primary care teams.	✔	✔
Increase PIP QI Incentive to build quality practice.	✔	✔
Support development of enhanced models of care.	✔	✔
Create Commonwealth and State agreements to improve population health.	✔	✔
Local Health Districts and Primary Health Networks should share responsibility to improve population health outcomes.	✔	✔
INTEGRATED CARE		
Funding to secure increased GP involvement in public hospitals.	✔	✔
Develop regional budgets funded by both State and Federal Governments.	✔	✔
Make integrated care a core priority of Local Health District funding.	✔	✔

RECOMMENDATIONS	NSW	FEDERAL
RURAL HEALTH		
Continued support for the RDA Settlement Package to recognise the value of GP and specialist services to rural communities.	✔	
A commitment to work with Colleges to establish more vocational training positions in regional NSW.	✔	✔
A requirement for regional Local Health Districts to develop and implement senior medical workforce staffing plans consistent with clinical service plans and to publish those plans.	✔	
Implementation of strategies that address other barriers to long-term rural practice.	✔	
Support measures to reduce rates of developmental vulnerability in children living in rural and remote communities. This includes developing a strategy to support childhood development, increasing funding directed to preventative and early intervention services, integrate health, education and social services to support children with developmental vulnerabilities, and invest in tele-health / tele-allied services.	✔	✔
MENTAL HEALTH		
Cooperation between the Commonwealth and State to address fragmented care and gaps in service delivery.	✔	✔
Funding for mental health should be commensurate with its prevalence in the community and its link to significantly worse levels of morbidity, or premature mortality.	✔	✔
There is a critical shortage in mental health professionals. A strategic workforce plan must be implemented.	✔	✔
Provide appropriate funding to support longer GP consultations for patients with mental illness who often have complex and multiple physical and mental health issues.	✔	✔
Additional and timelier access to acute care in public hospitals is required.	✔	

SUMMARY (CONTINUED)

RECOMMENDATIONS	NSW	FEDERAL
INDIGENOUS HEALTH		
Aboriginal community controlled centres should be supported and appropriately resourced in recognition of demonstrated effectiveness in providing appropriate and accessible health services to a range of Aboriginal communities and their roles as major providers within the comprehensive primary health care context.	✔	✔
That all health services provided specifically for Aboriginal and Torres Strait Islander people should be designed, developed and controlled by the communities they serve in collaboration with mainstream processes.	✔	✔
That all health personnel training programs, including specialist training colleges, should include components on Aboriginal and Torres Strait Islander health, including cultural awareness and safety.	✔	✔
That government provide additional fully funded training to address the total shortfall of health professionals providing services to Aboriginal and Torres Strait Islander people.	✔	✔
That government recognise the need for Aboriginal and Torres Strait Islander people to be represented at the same level as they are in the population in all health-related professions and support professions.	✔	✔
Implement measures to increase Aboriginal and Torres Strait Islander peoples access to the Pharmaceutical Benefits Scheme (PBS).		✔
That Government explore incentives for medical officers working in Aboriginal Medical Services and seek support from the medical Colleges for registrars to be available and credentialed for working in Aboriginal Medical Services to ensure there are sufficient health staff available.	✔	
National or template tri-lateral expenditure agreements should be made at the national level, and in each jurisdiction, with Aboriginal and Torres Strait Islander health leaders and leadership bodies specifying the roles, responsibilities, and expenditure obligations for each Commonwealth, State and Territory Government.	✔	✔

RECOMMENDATIONS	NSW	FEDERAL
JUSTICE HEALTH		
Health care services in criminal justice settings should be equivalent to those available in community settings.	✔	
Given the prevalence of mental illness among prisoners, AMA (NSW) recommends the NSW Government invest $43.2 million over four years to increase bed capacity for forensic patients and $12 million over four years for transitional housing.	✔	
Increased alternatives must be developed to involuntary treatment in custody.	✔	
Increase medical staffing.	✔	
Increase access to forensic mental health beds in NSW – particularly medium secure and low secure beds.	✔	
Overrepresentation of Aboriginal and Torres Strait Islander people must be urgently addressed. A Justice Target should be included among the Closing the Gap targets.	✔	✔

SUMMARY (CONTINUED)

RECOMMENDATIONS	NSW	FEDERAL
OBESITY		
Maintain Premier's Priority to reduce overweight and obesity rates of children by 5% over 10 years.	✔	✔
Develop a strategic national plan that includes commitments to specific national goals for reducing obesity.	✔	✔
Continue funding education and physical activity programs.	✔	✔
Provide targeted support to population groups with relatively low breastfeeding initiation and duration.	✔	✔
Provide education, training and support for healthcare professionals in the assessment and management of childhood obesity, along with developing standardised models of care and health pathways to facilitate management and enable improved and greater equitable access to care.	✔	✔
Provide flexible funding for childhood obesity assessment and management.	✔	✔
Open school grounds and public access to public spaces to increase opportunities for physical activity.	✔	✔
Prohibit junk food advertising on State-owned or State-leased property.	✔	✔
Bariatric surgery may be appropriate in certain circumstances for older adolescents aged 15-18 and adults, and should be made available publicly and privately.	✔	✔
Create healthy communities by supporting planning regulations governing housing, urban development, and transport infrastructure that facilitate physical activity.	✔	✔
Support and implement taxation of sugar sweetened beverages.	✔	✔
Prioritise measures that seek to reduce obesity and overweight in high risk or vulnerable groups, such as Aboriginal or Torres Strait Islander peoples and those from lower income groups.	✔	
Support the establishment of MBS numbers for GP consultations on overweight and obesity, as well as shared medical appointments.	✔	✔
Greater funding and resources should be dedicated to weight management services in hospitals.	✔	✔
Increase funding to expand the Western Sydney Beating Diabetes Together program across NSW.	✔	

1 HEALTHY HOSPITALS

While much needed, the focus on hospital infrastructure cannot take the place of adequately resourcing hospitals. Hospital emergency departments are swamped by increasing numbers of patients. The increased demand is affecting the ability of medical professionals to cope, and patient care is being compromised. There is no longer reserve in the system and doctors fear the hospitals are at breaking point. We need better solutions, and we need to address workforce shortages.

1

HEALTHY HOSPITALS

HOSPITALS ARE **GETTING BUSIER**

BACKGROUND

A significant portion of the NSW Government's Election Commitments 2015-2019 for Health focused on infrastructure. The Government pledged to spend more than $5 billion to build and upgrade more than 60 hospital and health services over the following four years.[i]

NSW Health's full year capital expenditure for 2016-17 (excluding capital expensing) was $1.3 billion for works in progress and completed works.[ii]

Redevelopment of our State's ageing hospitals was much-needed. The renovation of Prince of Wales Hospital, for example, was the hospital's first substantial upgrade in two decades. Almost 60% of the hospital's buildings were more than 30 years old.

AMA (NSW) commends the State Government for following through on its election promise to invest in hospital redevelopments. However, whilst we have bigger buildings and more physical beds, workforce shortages mean hospitals are not operating to their full potential and patient care is compromised as wait times increase.

RECORD DEMAND

The NSW Government's Election Commitments 2015-2019 for Health promised to employ 3,500 full-time equivalent positions over four years (2015-2019), including 2,100 extra nurses and midwives, 700 doctors, and 300 allied health professionals and 400 hospital support staff.[iii] In 2017, that figure was increased, and the Government pledged to add 1000 to the State's health workforce, including another 150 doctors.

AMA (NSW) recognises that the Government is employing more doctors. However, we are concerned recurrent funding for equitable resourcing across the State's hospitals and appropriate workforce levels are not keeping pace with demands from a growing and aged population, that is presenting with increasingly complex, chronic conditions.

This will continue to be a challenge. The NSW population is predicted to grow by 14% across the next 10 years from 2017-18 to 2027-28.[iv] Meanwhile, the 65-year-old demographic is expected to grow by 33%, and will make up nearly one fifth of the NSW population in 2026.[v] Workforce planning needs to take this into account.

ACROSS AUSTRALIA

Hospitals are increasingly required to meet the healthcare needs of more and more Australians. Between 2011-12 and 2015-16 the number of separations rose

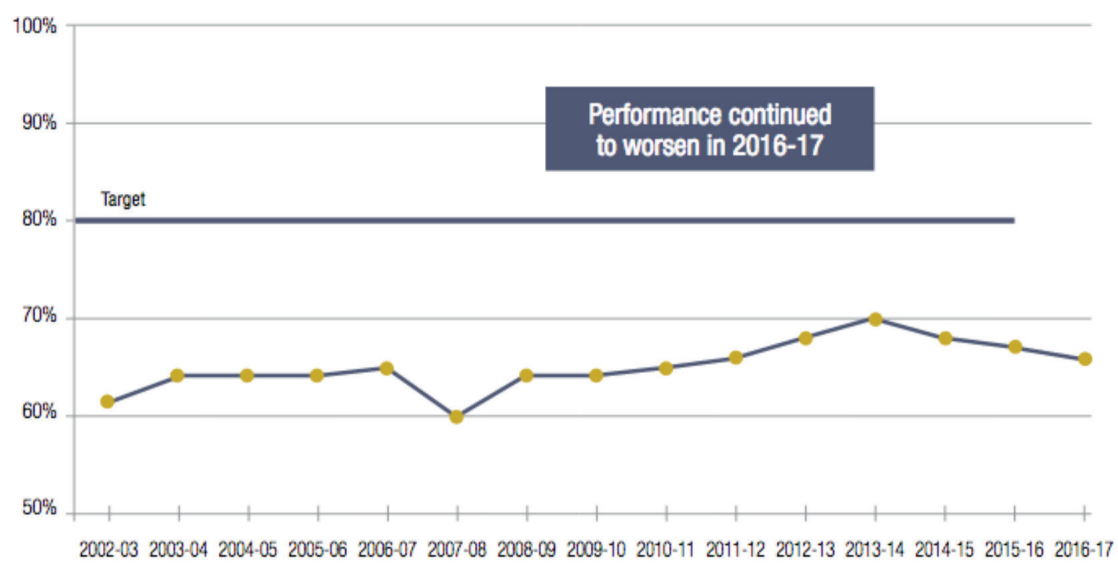
by 3.3% on average each year,[vi] more than double the average population growth of 1.6% over the same period.

The increased demand is putting pressure on emergency department waiting and treatment times. In 2016-17, there were 7.8 million presentations to Australian public hospital emergency departments.[viii] The number of presentations has risen on average 2.6% each year between 2012-13 and 2016-17.[ix] The stress on public hospitals is shown in the performance statistic in Figure 2. Nationally, in 2016-17, only 66% of emergency presentations classified as urgent were seen within the recommended 30-minute timeframe.[x] This is down from 67% the previous year. One third of the 2.8 million patients who needed urgent treatment were not seen within the recommended 30 minutes.[xi]

WHAT DOCTORS **ARE SAYING**

> In the past 12 months, nearly every day sees my ED operating in 'crisis mode'. There always seems to be an explanation provided by hospital management or the Ministry of Health. These include, amongst others: 'it's flu season, it's Monday, it's Friday afternoon and the GP clinics are closing, there is an ice epidemic, there is a surge in mental health presentations before the holidays'. To a degree, these are valid statements to explain surges in patient presentations. However, in many ways, these 'surge explanations' become excuses to deflect attention away from the crisis. My emergency department always operates at maximal capacity or above.

FIGURE 2. ACROSS AUSTRALIA - PERCENTAGE OF CATEGORY 3 (URGENT) EMERGENCY DEPARTMENT PATIENTS SEEN WITHIN RECOMMENDED TIME



Source: The State of our Public Hospitals (DoHA 2004-2010); AIHW Australian Hospital Statistics: Emergency Department Care (2010-11 – 2016-17)

ACROSS NSW

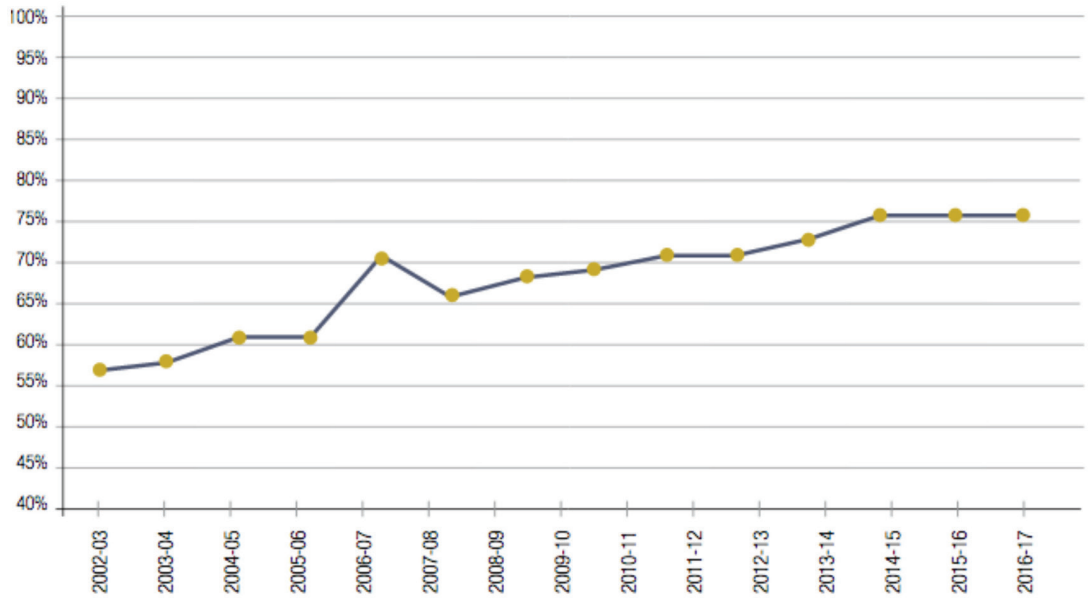
The figures in NSW reflect this overall growth in demand. Year on year, our State hospitals are experiencing higher numbers of patients in triage categories 1 through 4. From April to June 2018, 673,192 patients presented to emergency departments in NSW – up 1% from the same period in 2017. This is incredible growth considering the 2017 figures for that same quarter were 4.6% higher than 2016.[vii]

The message the BHI quarterly survey results are sending is that hospitals are facing record or near-record demand at all times of year and that this pressure is continuous, unrelenting, and building.

The demand for hospital services is not only growing, but patients are arriving to hospital sicker or more gravely injured. In NSW, there was an 8.8% increase in Triage 1 presentations in April to June 2018, compared to the same period in 2017, and a 5.4% increase in Triage 2 presentations for the same periods.

In NSW, 25% of patients who need urgent treatment were not seen within the recommended 30 minutes. (Figure 3)

FIGURE 3. NSW - PERCENTAGE OF CATEGORY 3 (URGENT) EMERGENCY DEPARTMENT PATIENTS SEEN WITHIN RECOMMENDED TIME (<30 MINUTES) – NSW



Sources: The State of our Public Hospitals (DoHA, 2004 – 2010); AIHW Australian Hospital Statistics: emergency department care (2010-11 – 2016-17)

OUTER METRO HOSPITALS

The demand in outer metro hospitals needs to be examined more closely. Figures indicate that rapidly increasing population growth combined with a higher disease burden and ageing population is affecting healthcare outcomes in these hospitals. The BHI figures for Nepean Hospital reveal emergency department performance is sliding significantly, particularly in the triage 2 category.

NEPEAN HOSPITAL – HEALTHCARE QUARTERLY

Emergency department performance			Apr-Jun 2018	Apr-Jun 2017	Difference
Time to treatment by triage category	T2: Emergency	Median time to treatment	13m	9m	4m
		90th percentile time to treatment	53m	32m	21m
		% started treatment on time	42%	58.7%	-16.7 percentage points
	T3: Urgent	Median time to treatment	37m	27m	10m
		90th percentile time to treatment	2h 23m	1h 49m	34m
		% started treatment on time	42.7%	55.2%	-12.5 percentage points
	T4: Semi-urgent	Median time to treatment	36m	29m	7m
		90th percentile time to treatment	2h 11m	1h 48m	23m
		% started treatment on time	67.7%	75.1%	-7.4 percentage points
	T5: Non-urgent	Median time to treatment	35m	27m	8m
		90th percentile time to treatment	2h 08m	1h 50m	18m
		% started treatment on time	88.3%	91.8%	-3.5 percentage points
Patients starting treatment on time %			56.0%	67.9%	-11.9 percentage points
Median time to leave the ED			3h 27m	3h 34m	-7m
90th percentile time to leave the ED			9h 53m	10h 21m	-28m
Patients leaving the ED within four hours of presentation			63.0%	60.5%	2.5 percentage points
Transfer of care	Median transfer of care time (minutes)		12m	11m	1m
	90th percentile transfer of care time (minutes)		32m	28m	4m
	Percent on target		88.2%	91.2%	-3.0 percentage points

Source: BHI Quarterly reports

MEDICAL **WORKFORCE**

SPECIALISTS WORKFORCE PLANNING

Transformation and strategic planning is necessary if NSW is to adequately meet the future healthcare demands of residents. There are currently 31 specialties listed as 'oversubscribed' (more applications than training positions).[xii]

Conversely, there are 19 specialties currently 'undersubscribed', and just three listed as 'in balance' – endocrinology, obstetrics & gynaecology, and public health medicine.

Careful planning needs to be done to ensure NSW Health meets its objective to deliver 'the right care, in the right place, at the right time.'

AMA (NSW) also recommends greater support and funding for GP training in hospitals, as a means of improving care for patients.

Workforce projections show the following specialties will be in shortage in 2025 compared with their current position, if recent trends in supply and demand continue[xiii]:

i. Obstetrics and gynaecology
ii. Ophthalmology
iii. Anatomical pathology
iv. Psychiatry
v. Diagnostic radiology
vi. Radiation oncology

The situation is particularly dire with respect to psychiatry and surgery. Projections provided by the Department of Health indicate a future undersupply of 125 by 2030 for the psychiatry workforce. The modelling is based on an anticipated 2% increase per year (from 194 in 2015 to 234 by 2030) on the first year intake to the program. The projections also included the high reliance on overseas trained doctors (OTDs) continuing, with OTDs being projected at 55 new Fellows per year. To meet the expected undersupply projected by 2030, the new intake would need to increase from the projected 197 to 200 in 2016 up to 269 in 2025, which equates to an average annual increase of 3.3%. Local workforce and training needs must be taken into consideration for any strategy to be effective, which requires partnership between governments, employers, the college and trainees.[xiv]

Surgery is another specialty where there is a predicted undersupply. It is conservatively estimated that 264 new surgeons will be needed each year between now and 2025. That is, in addition to the 184 new surgeons currently graduating each year, a further 80 will have to graduate alongside them. Given the logistics and expense of such an increase in training, this represents an unprecedented challenge to Australian governments, hospitals and Fellows of the Royal Australasian College of Surgeons.[xv]

Aside from positions of shortage, NSW needs a workforce plan to ensure new specialists are able to access appropriate appointments in our public hospitals. These should be new, substantive positions to ensure a continuation of the public and private service model.

CAPACITY

In AMA (NSW)'s 2018 survey, doctors highlighted that the demands on emergency departments is compounded by the lack of beds.

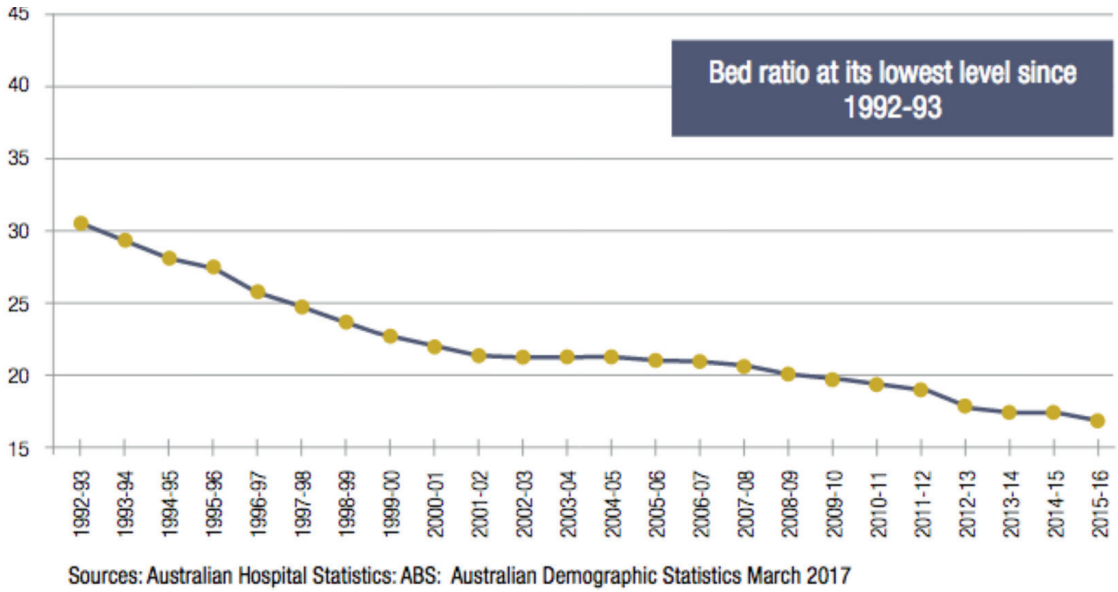
The AMA Public Hospital Report Card 2018 reveals that nationally, the number of hospital beds grew by 617 in 2015-16. However, in 2015-16, bed numbers as a ratio per 1000 of the general population was static at 2.6 (2.56) – practically unchanged from 2.57 the previous year (2014-15).[xvi]

The likelihood of requiring a hospital bed increases with age. On this measure, the ratio of public hospital beds for every 1000 people aged older than 65 years decreased in 2015-16 to 16.9, from 17.2 the previous year. The new low in 2015-16 continues the 23-year trend of year-on-year decline.

Public hospital capacity is not keeping pace with population growth and is likely, therefore, to not be able to match the growing demand for hospital services.

WHAT DOCTORS **ARE SAYING**

> "The emergency department I work in is now completely overwhelmed most of the time by the on average 30 admitted patients in the department that cannot be moved to ward beds. This leads to many patients being seen in corridors, sitting in chairs for up to 30 hours waiting for ward beds, inability to even basically look after patients and incredibly substandard care that we 'get away with' time and again."



Sources: Australian Hospital Statistics: ABS: Australian Demographic Statistics March 2017

HIDDEN WAITING LISTS

The latest figures from the Bureau of Health Information reveal there were 475,050 admitted patient episodes to NSW hospitals in the April to June 2018 quarter and a total of 59,176 elective surgical procedures were performed, up 2.2% compared with the same quarter last year.

Median waiting times for elective surgery were 11 days for urgent procedures (unchanged), 45 days for semi-urgent procedures (up one day) and 234 days for non-urgent procedures (up nine days).[xvii]

What these figures don't tell us is the 'hidden waiting list' – or the time between the issuing of a referral by a GP and the appointment at the clinic. It is only after patients have seen the specialist that they are added to the official waiting list. This means that the publicly available elective surgery waiting list data actually understate the real time people wait for surgery. Some people wait longer for assessment by a specialist than they do for surgery.

AMA (NSW) notes there was a comprehensive pre-2011 election commitment by the Government to measure the 'real' waiting time for patients who need elective surgery by:

"a. Completing a state-wide review of hospital waiting lists to establish how many patients should be on the waiting list, their accurate classification, and to introduce improvements which ensure that doctors, nurses and health administrators are able to properly plan to meet surgical demand.

b. Abolishing the policy which restricts doctors from putting patients on the waiting list to ensure that unmet patient demand for elective surgery is known and is able to be managed.

c. Introducing additional patient outcome targets for elective surgery including measuring the time it takes from the date of a specialist appointment where surgery is determined to be necessary, surgery outcomes and recovery times."

At present, there is still no administrative system that captures data on how many patients are waiting for these appointments, and how long they are waiting for them. However, AMA (NSW) notes AIHW is developing a process to collect and publicise this data.

FUNDING

Changes to arrangements for annual increases in public hospital funding have changed substantially under different governments.

Under COAG's 2020 hospital agreement, which NSW signed in February 2018, the Commonwealth will fund 45% of the efficient price of hospital services delivered, with Federal funding growth capped at 6.5% a year for the five-year life of the deal.

The challenge with current funding arrangements is they don't account for volume growth. Increases in hospital admissions is driving growth in total expenditure. As previously cited, between 2011-12 and 2015-16 the number of separations rose by 3.3% on average each year[xviii], more than double the average population growth of 1.6% over the same period. This will continue to put pressure on States.

DOCTORS' **HEALTH** AND **WELLBEING**

MANDATORY REPORTING

AMA (NSW) conducted its second annual Hospital Health Check survey last year, which surveyed 1351 doctors-in-training in NSW about conditions at their hospitals.

Doctors-in-training gave two different hospitals a failing grade in reference to staff wellbeing. These are notable not just because they are failing grades but because they are the first Fs awarded by the HHC in NSW.

Westmead and Wollongong were both given Fs for wellbeing, which relates to bullying, support for mental health issues, and reporting of inappropriate behaviour.

Clearly, more work needs to be done to improve wellbeing in NSW.

The recent focus on doctors' health and wellbeing has also highlighted the flaws that exist with our current mandatory reporting laws.

We accept that the aim of mandatory reporting laws is to protect patients and ensure public safety. However, the unintended consequence of mandatory reporting laws is that many doctors fear seeking help for mental illness, which contributes to a culture of silence.

The Government made a commitment to amend the current legislation in the JMO Wellbeing and Support Plan published in November 2017. Changes to mandatory reporting was identified as the first of 10 priority initiatives the Ministry pledged to implement – an acknowledgement of the significance of this issue – particularly for junior doctors.

NSW Health agreed to "Action amendments to the mandatory reporting legislation to exempt treating practitioners from the mandatory reporting notification requirements in cases of impairment" with the clearly defined aim "to remove a barrier to seeking help".

While we acknowledge the efforts to reform National Law and the commitments of Ministers, AMA (NSW) recommends NSW review a new model governing mandatory reporting to remove the barriers for doctors with mental illness seeking proper medical care.

We accept that the aim of mandatory reporting laws is to protect patients and ensure public safety. However, the unintended consequence of mandatory reporting laws is that many doctors fear seeking help for mental illness, which contributes to a culture of silence.

SUPPORTING **DOCTORS**-IN-TRAINING

Doctors-in-training are the front line of our health system and our future leaders. The way they are supported will impact the next generation of health practitioners.

Doctors-in-training in NSW work under an outdated employment contract – the Public Hospital (Medical Officers) Award. This document outlines working conditions, payment, overtime and on call requirements, and leave allowances (including study leave). It hasn't been updated in 30 years and it is not fit for doctors-in-training working in 2019.

In 2012, the NSW Government introduced a new wages policy which has severely restricted any prospect of modernising the Public Hospital (Medical Officers) Award.

The changes in policy and regulation prohibit NSW Health from changing conditions of employment which will increase salary-related costs by more than 2.5% without equivalent cost offsets. The independent arbiter – the Industrial Relations Commission of NSW – is also restricted and not allowed to change Awards or make orders which are inconsistent with this policy.

While this policy has implications for all hospital doctors, the impact has been most significant on doctors-in-training. This is a major barrier to creating a safe and fair working environment for doctors-in-training.

The Coalition Government has taken steps to improve industrial arrangements, particularly in relation to the impact of excessive hours of work and improved policies relating to unrostered overtime.

However, issues such as access to appropriate facilities (accommodation, common areas, sleeping spaces) within hospitals, financial support for training, and access to leave, remain unresolved.

We call on the parties to recognise the important contribution of doctors-in-training in terms of both service delivery and as part of our future specialist workforce. To support this, the industrial arrangements for doctors-in-training should be improved to:

- Allow doctors-in-training to conduct a work value case to assess the current value of their contribution to the NSW public health system.
- Provide doctors-in-training with access to exam and conference leave. NSW is the only State in Australia to provide no support to doctors-in-training for

professional development. Every other State provides doctors-in-training with dedicated leave. Access to such leave would allow for better planning by health systems and would recognise the stress associated with undertaking exams.

- Provide doctors-in-training with financial support towards training. Doctors-in-training in the ACT are able to access up to $6,124 per annum in training expenses; in South Australia, they can access up to $8,000 per annum. In NSW, doctors fund even the most basic of training requirements.
- Ensure appropriate arrangements for supporting doctors-in-training while they are on-call. There are no current protections for NSW doctors-in-training on call. Victoria and WA have detailed Award protections to limit excessive hours and on-call and call back requirements. NSW should review and implement best practice policy for on-call, call back, and protection from excessive hours.
- Unaccredited registrars should not be rostered on less favourable terms than accredited registrars.
- The doctors-in-training should have rights to specified facilities, including break rooms, sleeping spaces, and secure accommodation.

REFERENCES

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2 HEALTHY SYSTEMS

There is a strong need for integration and collaboration on the delivery of health services in NSW. Healthy systems involve taking a strategic approach to health planning, as well as building the technological infrastructure to support better communication.

2

HEALTHY SYSTEMS

HEALTH **PLANNING**

STATEWIDE SERVICES

AMA (NSW) recognises the benefits of the NSW Government's policy to devolve authority and responsibility to Local Health Districts (LHDs). This transfer of management has allowed LHDs to deliver healthcare services appropriate for their local populations and removed unnecessary management.

However, certain health services require a coordinated approach.

Specifically, AMA (NSW) has identified the need to create a framework for these crucial services:

- Obstetric transfers
- Interventional radiology
- Burns
- Trauma

There is a strong need for integration and collaboration on the delivery of these health services.

The health system needs strategic planning, with an emphasis on forecasting service requirements as the population of NSW grows.

PAEDIATRICS

The 2016 Census revealed there were more than 4.3 million children (ages 0-14) living in NSW, representing 18.5% of the State's population.

Children and families in NSW deserve quality care that can be delivered close to home.

The crisis in paediatrics was identified in 2008 by Peter Garling SC in his report to the Special Commission of Inquiry, which noted:

"The specialist children's hospitals become overloaded, and this delays the delivery of tertiary care to the babies and children who really need it. Surgery and other types of treatments are consequently being delayed."

In 2014, NSW Health developed the "Surgery for Children in Metropolitan Sydney: Strategic Framework" in response to the Garling report.

However, the problems first noted more than a decade ago continue to plague the system.

AMA (NSW) strongly recommends an Independent Review into paediatrics be established to examine how to best deliver services in NSW.

JOINT MATERNAL, NEONATAL AND PAEDIATRIC EMERGENCY CONSULTATION AND TRANSPORT SERVICE

AMA (NSW) has been a strong advocate for a service that combines Neonatal and paediatric Emergency Transport Service (NETS) and the Pregnancy and newborn Services Network (PSN).

The new entity would provide all of the current functions of NETS and PSN, with additional maternity roles; including expanded responsibility for referral and consultation processes and the addition of a maternal transport capability. The new service would:

- Become the default source of high-level obstetric advice for women in whom inter-hospital transfer is being contemplated
- Expand the current limited hours of high level obstetric consultants to become available 24/7 to provide advice and offer evidenced-based and early response to any clinical problem in the state
- Carefully assess and support decisions around emergency inter-hospital maternal transfer
- Be inclusive of appropriate specialists in designated perinatal referral hospitals in teleconferences about patients
- Add a 24-hour roster of transport midwives to offer timely skilled maternal transfer between hospitals by road and air
- Work with NETS to selectively send a dual neonatal/maternity team to complex clinical problems or where delivery is imminent
- Provide opportunity for strategic workforce planning for registrars and fellows

Most importantly, the focus would be on solving clinical problems rather than transport as an end in itself.

2

HEALTHY SYSTEMS

HEALTH IT: **NEW SOLUTIONS**

Continued reliance on old technology is compromising communication between healthcare providers. State investment is needed to replace legacy software and increase IT change management.

BUILDING A BETTER SYSTEM: OVERARCHING PRINCIPLES

We live in an information age where there should be no excuse for delays in clinical decision-making because of delayed access to important information.

Patients and doctors expect a system that allows healthcare providers to communicate with each other in a glitch-free, secure and seamless fashion.

AMA (NSW) strongly supports the vision for a central digital repository of patient health information, which would give doctors access to relevant clinical information at the time of diagnosis or treatment. Improved health technology not only reflects Australia's modern and world-class health system, but it improves patient safety and provides better clinical decision-making.

Patient safety and quality of care can be enhanced if treating doctors can quickly and easily access reliable, accurate patient information.

A digital platform allows for better coordination of patient care across healthcare settings. When health providers have access to the same set of patient information, they can avoid ordering duplicate tests, prescribing contraindicated medications, prescribe more effective treatments, and improve the overall quality of care.

My Health Record works as a compilation of a patient's information, but it is not a curated file. While My Health Record works as an additional source of summary healthcare data, it doesn't replace data in a GP's clinical system.

We need the capacity to have secure messaging; interface with My Health Record; and share data outside of hospitals.

To achieve this, we need improved software interface design in hospitals, and interoperability.

To get the best outcomes, software must be fit for purpose. Design needs clinical input from end users to ensure it appropriately addresses clinical workflows.

CONNECTED SYSTEMS

The State and Commonwealth should work together to plan for and invest in a comprehensive IT strategy that integrates hospital and specialist, GP and other health practitioner services.

The Commonwealth should provide incentives to increase computerisation among specialist practices, and continue to invest in health IT infrastructure, resources and training to improve patient care, and the efficiency of the health system.

AMA (NSW) also recommends the provision of after-hours access to public

hospital diagnostic and imaging services to allow GPs to provide some after hours or emergency care through their practices.

The State and Commonwealth should encourage continuity of care through key performance measures. Local Health Districts' (LHDs) key performance measures should include effectiveness of handover of care, as well as coordination with primary care services in the community. An evaluation of post discharge care is needed.

IMPROVE COMMUNICATION: THE FAX MACHINE

The health system's ongoing reliance on the fax machine as a secure means of communication is confounding, given the technological advancements that have been embraced by Australian society in almost every other facet of life. AMA (NSW) recommends the State Government relegate the fax machine to medical museums.

The transmission of information through fax machines is secure, but security and patient privacy cannot be guaranteed once that information has been printed on paper and left on the fax machine in-tray. Hospital doctors often need the same information faxed multiple times because they have not been sitting at a fax machine when the information was sent through and someone else has picked it up accidentally, misplaced the paper, or thrown it out.

A modern health system demands a means of communication that is instant, secure, paperless, and allows for two-way communication. At best, fax machines meet half that criteria.

AMA (NSW) recommends the fax machine be phased out by 2022, and replaced by a secure messaging system.

IMPROVE COMMUNICATION: THE PAGER

In addition, AMA (NSW) recommends the State Government look at alternatives to pagers, which are also considered relics of a bygone telecommunications era. From a practical standpoint, pagers do not facilitate two-way communication thus limiting their appeal in light of better alternatives. They are also not a fail-safe back up. Should other devices be used to replace pages, investment into Wifi is needed to ensure doctors can reliably connect.

Anecdotal evidence suggests doctors are using alternative methods, such as WhatsApp, to communicate. A secure application, which could be used within hospitals to share necessary patient details and photos, should be a priority. Ideally, the solution would enable users to send photos securely to a hospital's medical records department to upload into a software product such as Cerner, or the solution would allow for automatic uploads to the software product being used.

The health system's ongoing reliance on the fax machine as a secure means of communication is confounding, given the technological advancements that have been embraced by Australian society in almost every other facet of life. AMA (NSW) recommends the State Government relegate the fax machine to medical museums.

IMPROVE WORKFLOWS

Compatibility between existing software systems appears to be lacking. The amount of time wasted trying to access relevant patient information is a source of significant frustration among hospital doctors and administrative staff.

Examples of this include the incompatibility between PowerChart and eRIC, which has a different eMEDS system. Another example is eMaternity, which isn't compatible with PowerChart. It's not just a nuisance for clinicians – there is a real danger that vital patient information will accidentally be omitted when clinicians are forced to switch between systems.

The utility of software programs is compromised when they don't work seamlessly together. Clinicians note that in some circumstances it's slower to use electronic documentation systems than it is to write clinical notes on paper.

Time lost logging in and out of programs is another complaint. Despite widespread use of the product Cerner across hospitals, many computers don't have the application installed locally. As a result, clinicians must access Cerner via a Citrix system. Valuable time is wasted, as each interaction with the software takes an additional three to four minutes. In an era of instant connectivity, and in an environment where response to patients is time critical, this delay is unacceptable.

We need a system that offers interoperability, as well as common data protocols to enable sharing of data between hospital systems and primary care.

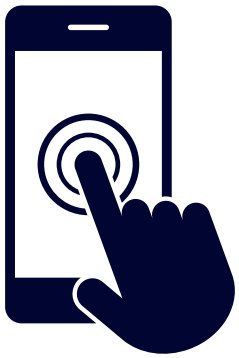
Any new systems should be designed with clinician input and developed to accomodate workflows. Clinician approval of systems is also key to the success of future systems.

In addition to investing in infrastructure, AMA (NSW) suggests there needs to be a similar investment in training.

LAB RESULTS

Most laboratories have the capability to send results electronically, but not all do. As a result, doctors report it is sometimes quicker to retest, rather than chase results via fax or mail. Making it compulsory for public and private labs to transmit results electronically would significantly cut down on some of the redundancy within the system. This failure to use available technology is also a problem for some hospitals which have the capability to send discharge letters electronically to GPs, but do not have updated details of the recipient.

While it is easy to identify what doesn't work, AMA (NSW) acknowledges that it is harder to find cost-effective solutions to these problems.



Anecdotal evidence suggests doctors are using alternative methods, such as WhatsApp, to communicate. A secure application, which could be used within hospitals to share necessary patient details and photos, should also be a priority.

CONTINUED INVESTMENT

AMA (NSW) acknowledges the NSW Government for committing $536 million over eight years to eHealth, including $29 million for electronic medications management, $6 million for corporate systems and $4.5 million for ICT for NSW Ambulance in 2017-18, as well as $73 million for the year for the continued roll-out of the Cerner electronic medical record (eMR), the HealtheNet clinical data repository and upgrading digital infrastructure.

Despite this, AMA (NSW) is concerned by delays of major health IT projects, including eRIC, HealthRoster, Corporate System 2B, and the Incident Management System.

AMA (NSW) will be following the Auditor-General's performance audit on the effectiveness of the HealthRoster system in delivering business benefits. The NSW Auditor-General's Report on Health 2017 noted, "Health entities need to dedicate sufficient resources to IT change management."

Our members have echoed this sentiment, noting that the eHealth system has potential, but more emphasis on the intranet / state hospital shared notes system is needed for it to be more useful for clinicians. AMA (NSW) would like to see further investment in health IT across the State, as well as increased funding for training and implementation to ensure success of these systems.

SHARED CARE

One area to pilot a shared IT solution would be in maternity shared care. This care is often shared over GPs, hospital clinics, hospital and private pathology, hospital and private radiology, and sometimes private specialist practice. Women still carry around a yellow card and providers are required to duplicate entry of data on to their individual systems. A platform that works seamlessly across all providers' systems would be a good solution.

3 HEALTHY COMMUNITIES

There are many aspects to building healthy communities. Increasing the availability of nutritional food, opportunities for exercise, wellbeing awareness – these are just a few of the critical components to maintaining the overall health of NSW residents. Just as critical as providing and supporting these aspects of health, is the need to ensure access to these essentials is equal, and extends to residents in rural and regional communities, Indigenous Australians and those in the justice system. Underpinning all of this is a strong primary care sector.

3

HEALTHY COMMUNITIES

GENERAL PRACTICE & THE **PRIMARY CARE** SYSTEM

Primary health care (PHC) is the front line of the healthcare system and the first level of contact. It is scientifically sound, universally accessible and constitutes the basis for a continuing healthcare process. It provides comprehensive, coordinated and ongoing care by a suitably trained workforce comprised of multi-disciplinary teams supported by integrated referral systems.

Primary healthcare includes community development, health promotion, patient advocacy, illness prevention, and treatment and care of the sick (including supportive management of chronic disease, palliative and end of life care, and rehabilitation).

Primary healthcare services are delivered in settings such as general practices, community health centres, Aboriginal community controlled health centres, and allied health practices. Importantly, primary healthcare supports and educates people in the community to better manage their chronic health conditions, improving their quality of life and reducing their risks of disease progression and complications. Strong primary care is central to an efficient, equitable and effective health system.[i]

General practice is the cornerstone of successful primary healthcare, which underpins population health outcomes and is key to ensuring we have a high-quality, equitable and sustainable health system into the future. General Practitioners (GPs) are registered specialists in the discipline of general practice recognised by the Australian Health Practitioner Regulation Agency.

The World Health Organisation has found that the populations in those countries with strong general practice have:[2]

- Lower all cause morbidity (lower rates of ill-health) and mortality
- Better access to care by all members of the community
- Lower rates of people being readmitted to hospital after treatment
- Fewer consultations with consultant specialists
- Less use of emergency services[3]
- Better detection of adverse effects of medication interventions

Thirty-five percent of Australians – over 7 million people – have a chronic condition, and an increasing number have multiple conditions, making care more complex and requiring input from a number of health providers or agencies. The Australian Institute of Health and Welfare (AIHW) reported in mid-2015 that approximately 20% of the population have two or more chronic conditions (multiple morbidity). This population group has different service needs depending on the level of complexity of their conditions.[4]

With the growing burden of disease from obesity, and chronic illness, it is vital that there be a strong investment in primary care to enable better management in the community. This requires targeted investment in building quality and capacity.

Poor access to primary care has been associated with avoidable deaths and increased ill health.

In the last 10 years, the contribution of individuals to healthcare costs has almost doubled from just over $15 billion in 2004-

05 to just under $30 billion in 2014-15.

In 2014-15, nearly 70% of this was money spent on visits to general practice.

Successive Federal Governments have been driving up the cost of seeing a GP by leaving the Medicare rebate frozen.

The current Commonwealth Government's actions on the Medicare rebate in last year's Budget will not significantly improve affordability for most Australians. It is deeply disappointing that the Federal Government has constrained its contribution to Medicare in such a way.

There can be no doubt that this layering of mismanagement and policy misjudgments on primary care is contributing to the problems experienced by the NSW hospital system.

Primary care funding represents approximately 8% of the total Government spending on health and has stayed at this level for years, despite a growing workload. AMA (NSW) joins Federal AMA in calling for Government spending on primary care to be lifted to 10%, as part of an effort to re-orientate the health system to focus more on primary care, with long term savings to the health system anticipated in return. This increase in funding should be new money and not come at the expense of hospital funding.

FUNDING GENERAL PRACTICE

Australia needs a comprehensive national primary care framework to improve patient care and prevention. There should be formal agreements between the Commonwealth and States to improve system management; and new funding, payment and organisational arrangements to help keep populations healthy and to provide care for the increasing number of older Australians who live with complex and chronic conditions.[5]

WASTED **OPPORTUNITIES**

There have been too many measures, such as expanded roles for pharmacy, that fragment care and increase costs across the system. We need to be supporting co-ordinated team-based care. Data shows this is best for our patients.

The Commonwealth needs to deliver real resources to frontline GP services. Simple reforms to Australia's health system could help save more than $320 million a year on avoidable hospital admissions and provide better care for people with diabetes, asthma, heart disease and other chronic conditions.[7]

PATIENT CENTRED MEDICAL HOME

The Patient Centred Medical Home (PCMH) is a team-based healthcare service delivery model, providing comprehensive, continuous and coordinated primary care to patients with a framework of quality and safety.

The Core principles of PCMH are:

- Patient Centredness
- Accessibility
- Continuity
- Comprehensiveness
- Coordination
- Accountability

There are clear benefits to improving primary care systems. International studies have demonstrated very strong benefits in terms of improving health outcomes through:

- Reduced cost of care
- Reduced use of emergency departments
- Reduced hospital admissions
- Improved patient satisfaction

The Federal Government's Health Care Homes Trial, which was launched in October 2017 across 200 general practices and Aboriginal Community Controlled Health Services in 10 Primary Health Network regions of Australia will run until November 2019.

This presented a valuable opportunity to inprove patient care, which was squandered through high levels of bureaucracy and inadequate funding. Nonetheless, the principles of improving care through accessibility, coordination, comprehensiveness, continuity in a team-based, patient-centred approach should be supported.

The program's success will also depend on communication and support between the Commonwealth-funded PHS and State Government local health and hospital networks.

AMA (NSW) echoes some of the recommendations made in the report prepared by Consumers Health Forum of Australia, The George Institute for Global Health, and the University of Queensland for MRI Centre for Health System Reform and Integration - "Snakes and Ladders: The Journey to Primary Care Integration".[xi]

The report calls for a review of the implementation and regulatory requirements for the current trial of Health Care Homes to better understand the challenges to date. The report also calls for Phase 2 of the roll-out to be commenced with greater flexibility in the funding and delivery model.

AMA (NSW) recommends support for general principles of Health Care Homes,

but a redesign of the trial with adequate funding and clinical input.

As in the CHF report, we call for more equitable access to the PCMH model. While participation is to remain voluntary, support structures should be established to assist practices interested in transitioning.

The State Government has an opportunity to strategically co-invest in integrated care which will alleviate some of the burden placed on the hospital system.

To create sustainable integrated care, the State Government and the Federal Government must establish formal agreements with Primary Care Networks and Local Hospital Networks with the goal of improving regional system performance and delivering integrated care. These agreements would include a commitment for regional budgets to develop integrated primary health care projects. The focus should be on prevention and outreach support from hospitals, specialised sub-acute care, and community health services.

The State Government needs to recognise the importance of team-based care by providing funding that supports:

1. Coordination of general practices and hospitals-based specialists, who provide advice, support, education and clinics in community care settings
2. Clinical pharmacists in general practice
3. GP Liaison Officers in regional and metropolitan areas
4. Access to care coordinators, health coaches, and health system and social service navigators for patients with complex chronic conditions
5. Aboriginal and Torres Strait Islander and Culturally and Linguistically Diverse health workers in the community
6. Expanded funding for broader primary care teams

AMA (NSW) suggests the State develop a performance framework to measure the impact and outcomes of integrated care projects and services.

There should be a similar emphasis on funding and access for GP involvement in public hospitals, for instance through VMO roles in areas such as palliative care, aged care, work within medical assessment units or similar roles. There is also an opportunity to reduce the burden on public hospitals by allowing GPs after-hours access to public hospital diagnostic and imaging services, which would allow GPs to provide some after hours or emergency care through their practices. AMA (NSW) further recommends chronic disease management funding for enhanced management of priority chronic diseases.

TIME **FOR TEN**

Primary care funding represents approximately 8% of the total Government spending on health and has stayed at this level for years, despite a growing workload. AMA (NSW) joins Federal AMA in calling for Government spending on general practice to be lifted to 10%.

FUNDING PRIMARY CARE TEAMS

AMA (NSW) further recommends funding for General Practice Pharmacists, as well as increased funding for Practice Nurses and Allied health teams.

IMPROVEMENTS IN SAFETY AND QUALITY

AMA (NSW) recommends increasing the PIP QI Incentive to build quality practice, as well as establishing Practice Improvement Grants.

INTEGRATED CARE: BACKGROUND

Integrated care is a much talked about buzzword in health policy, but remains a lofty ambition. Attempts to implement integrated care are often relegated to pilot projects that are too small, too under-resourced, too vague or too undermanaged to be effective as a system-wide approach to innovative healthcare. To successfully provide coordinated, seamless care, NSW needs to develop a practical approach to implementing integrated care programs across the State, and back these programs with adequate funding and resourcing.

The healthcare system is very good at dealing with a single disease or injury. However, the complex needs of an aging population coupled with rising rates of chronic disease and multiple co-morbidities calls for more creative solutions.

Australia has been experimenting with integrated care solutions since the 1970s and the creation of community health centres (CHCs).

To achieve patient-centred integrated care we need to create multidisciplinary teams of healthcare professionals who are able to holistically address patients from birth to end of life, including their physical, psychological and social health needs.

The challenge in delivering seamless care is that it must cross organisational boundaries. Successful integration of care requires a commitment from all levels of government.

The Productivity Commission's Shifting the Dial report estimated implementation of integrated patient-centred care could be worth up to $200 billion over 20 years.

NSW has engaged in a number of initiatives to support integrated care in the State. HealthOne services for people with complex and chronic care was initially trialled in Mount Druitt. An evaluation of the program found significant improvements in care for patients, with a 26% reduction in the number of emergency visits per patients, a 52% reduction in the hours spent in emergency, and a 41% reduction in the hours spent in hospital. The success of the program resulted in the implementation of HealthOne through Local Hospital Networks at 25 locations around NSW.

NSW has also achieved some success with Chronic Care for Aboriginal People, which featured follow up of patients discharged from hospital within 48 hours. Preliminary results revealed follow up within 48 hours resulted in a 4% reduction in re-admission.

Other integrated care programs in the State include Hospital in the Home programs, NSW Health Chronic Disease Management program and three integrated care demonstration projects in Western Sydney, Central Coast and Western New South Wales.

The experience in NSW indicates programs that integrate across primary care and the hospital sector result in greater reduction in health costs.

WHAT DOCTORS **ARE SAYING**

> For every new project or service we need to be asking, 'how does this fit with the rest of the health system'?

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3

HEALTHY COMMUNITIES

RURAL, REGIONAL AND REMOTE **HEALTH**

About 45% of the population of NSW lives outside of the Sydney area, with 1.9 million residents living in regional or rural areas. People living in regional and rural communities tend to have worse health outcomes than those living in metropolitan areas. While there are a range of factors contributing to poor health outcomes, one of the key elements is access to medical care. A major funding commitment from the NSW Government is required to enable regional LHDs to address the inequities between regional and metropolitan access to specialist services.

Rural, regional and remote residents in NSW have poorer health, shorter lives and more illness than people in major cities. A baby boy born in a remote or very remote area in 2012 can expect to live 70 years, while a baby boy born in a major city can expect to live for 81 years.[i]

People in rural locations face higher road injury and fatality rates, higher reported rates of high blood pressure, diabetes and obesity, higher death rates from chronic disease, higher prevalence of mental health problems, higher rates of alcohol abuse and smoking, and poorer dental health.

It should be noted Indigenous people represent a higher proportion of the population in outer regional and remote areas. Indigenous people have a lower life expectancy and higher rates of cardiovascular disease and chronic disease.

Despite an increase in full time equivalent registered medical practitioners in recent years, there remains significant healthcare workforce shortages in rural areas. Factors such as an ageing workforce, difficulties attracting new graduates, recruitment and retention of mid-career professionals have contributed to this doctor deficit.

The shortage of doctors in regional and rural areas forces patients to travel longer distances to access services, particularly specialist services.

Travelling long distances for healthcare impacts on patients' time and also creates greater financial burden. As a result, regional and rural patients may delay accessing services, or wait longer to access services, resulting in poor health outcomes.

Visiting health professionals help to lessen the travel burden on patients and offer important respite to local doctors. However, they do not provide the same benefits as a local medical workforce.

Regional and rural patients also have limited access to a range of allied health services, including dental health and mental health services.

DEMOGRAPHY:

As of June 2015, 2.2% of Australians lived in remote or very remote areas, compared to 70.9% of the population who resided in major cities. Almost half (44.8%) of all people in very remote areas and 17% in remote areas were Indigenous, compared with just 3% Indigenous representation of the total population. As of March 2018, there are 7.95 million residents in NSW – with about 64.5% living in Greater Sydney.

Source: www.nsw.gov.au/about-new-south-wales/population/

REMOTENESS	POPULATION
Major cities	5,807,499
Inner regional	1,452,922
Outer regional	442,700
Remote	30,252
Very remote	5,901

Source: www.healthstats.nsw.gov.au/indicator/dem_pop_aria

Socioecomonic characteristics by LHD and remoteness category, NSW

		Life expectancy (years)		Persons aged 65+ years		% aged 15–64 years with weekly income <$600	% of population who are Aboriginal people
		MALE	FEMALE	Number	% of population		
Remoteness	Major cities	81.7	85.8	784,088	14.0	41.2	1.8
	Inner regional	79.5	84.1	280,750	19.5	47.2	4.7
	Outer regional	78.9	84.3	92,097	20.4	51.5	8.3
	Remote	70.3	71.9	5,074	16.4	47.7	26.2
	Very remote	–	–	1,075	12.8	49.1	39.3
Rural local health districts	Far West	76.4	81.0	5,997	19.3	50.1	11.7
	Hunter New England	79.0	84.0	164,853	18.2	46.3	5.4
	Mid North Coast	79.7	84.1	48,182	22.7	53.2	5.8
	Murrumbidgee	79.8	84.5	44,727	18.6	46.1	4.8
	Northern NSW	78.9	84.3	61,469	20.9	52.8	4.8
	Southern NSW	79.8	84.4	38,518	19.1	42.3	3.5
	Western NSW	78.3	83.2	48,215	17.3	45.9	11.1
Urban local health districts	Central Coast	79.9	84.3	65,852	19.9	46.1	3.4
	Illawarra Shoalhaven	80.5	84.4	74,519	18.8	48.1	3.4
	Nepean Blue Mountains	80.4	84.0	47,822	13.3	41.3	3.2
	Northern Sydney	83.7	87.5	137,362	15.4	34.7	0.3
	South Eastern Sydney	83.0	87.0	125,908	14.3	35.4	0.9
	South Western Sydney	81.1	85.1	115,492	12.5	48.4	1.8
	Sydney	81.7	86.4	74,627	12.1	37.7	1.1
	Western Sydney	81.0	85.1	101,130	11.2	43.6	1.7

Source: Centre For Epidemiology and Evidence. Health Statistics of New South Wales. NSW Ministry of Health. Available at www.healthstats.nswgov.au

HEALTH STATUS OF REMOTE AUSTRALIANS

Higher risk factors – A higher proportion of remote Australians have risk factors, such as smoking, obesity and physical inactivity, that contribute to poor health and the development of chronic diseases.

Higher death rates – Mortality rates from major causes of death are higher in remote communities compared to major cities:

- 3x the number of deaths from diabetes
- 40% more deaths from coronary heart disease
- 60% higher death rate from chronic obstructive pulmonary disease
- 40% more deaths from lung cancer
- Twice the number of deaths from suicide
- 5x the number of deaths from land transport accidents[ii]

HEALTHCARE ACCESS IN REMOTE COMMUNITIES (COMPARED TO MAJOR CITIES)

- 20% less Medicare funded GP activity compared to the same population in the city[iii]
- One-third the number of dentistsiv
- 42% fewer pharmacists
- 65% fewer psychologists
- 68% fewer podiatrists
- 51% fewer physiotherapists
- 68% fewer optometrists
- 65% fewer occupational therapists
- 80% fewer specialists[v]

INDIGENOUS HEALTH IN REGIONAL, RURAL AND REMOTE COMMUNITIES

Indigenous people represent a higher proportion of the population in outer regional and remote areas. About 60% of the NSW Indigenous population lives in a rural LHD. Indigenous people have greater health needs. The significant gap in health outcomes for Indigenous people must be considered in assessing healthcare for rural, regional and remote NSW residents.

CHILDREN'S HEALTH IN REGIONAL, RURAL AND REMOTE COMMUNITIES

Children living in rural and remote areas face poorer health outcomes and higher rates of developmental vulnerabilities than children living in major cities.

In addition to facing social, economic and environmental conditions that adversely impact health and development, children in rural and remote communities have limited access to appropriate health services.[vii]

A 2017 Position Paper by Royal Far West found children in remote Australia are five times more likely to suffer developmental problems when compared to children in major cities.[viii]

The report also found 32% of children living in regional, rural and remote areas are unable to access the health services they need, while allied health workers in rural and remote areas service a population at five times greater than urban counterparts.

Early development is a critical period in life when developmental plasticity is at its greatest. Learning is dependent on laying these crucial foundations and connections. Developmental problems can lead to chronic health problems, learning and behavioural problems, and mental health issues.

An analysis by the Royal Far West found of the 10 LGAs in NSW identified as having the greatest risk of poor developmental outcomes in children, six are located in the Western NSW District.[ix] The report identifies several commonalities between the areas with the highest number of children with developmental vulnerabilities.

To appropriately address these issues, AMA (NSW) supports the Royal Far West's recommendations. These include developing integrated, coordinated, child-centred services for children and their families.

Greater access to early childhood intervention services, allied health services, paediatricians and mental health services is needed. Tele-health services could help fill in some of the service gaps; however, many remote areas lack the necessary broadband connection to facilitate these services. As well, telecommunication is not always appropriate for children with a disability/developmental vulnerability.

Indigenous children are more likely to experience adverse conditions that impact health and development and are also significantly more likely than their non-Indigenous counterparts to live in remote and rural areas. In 2016, there were a total of 27,582 Aboriginal children under five years of age in NSW, representing 5% of all children under five years in NSW. While smaller numbers of Aboriginal children live in outer regional and remote areas, they represent a higher proportion of the population.

As a result, Indigenous children experience adverse developmental outcomes at disproportionately higher rates – 42% of Indigenous children are vulnerable on one or more domain – almost double the rate of non-Indigenous children.[x]

WORKFORCE SHORTAGE

Despite record numbers of Australians entering medical programs over the past 15 years, and a commensurate and considerable expansion of graduations – we still face a rural doctor drought.

In 2016, there were 1441 applications for 992 NSW PGY1 positions in 2017; of these 131 were rural preferential positions or 13% of the intern positions. The demand for rural positions is there – sometimes in excess. University of Sydney Teaching Hospitals at Dubbo, Orange and Lismore received 267 applications for 32 PGY1 positions in 2017. These numbers indicate that many graduates of existing rural medical schools want to stay in rural locations, but they can't find the training places or rotation opportunities they need.

The Integrated Rural Training Pipeline (IRTP) strategy creates rural training hubs operated by universities with established Rural Clinical Schools and Departments of Rural Health.

The rural training hubs are to coordinate across all stages of medical training, streaming medical students into rural training pathways at an early stage in their careers, and negotiating ongoing training opportunities with local health services, specialist colleges, postgraduate medical councils and other rural training stakeholders. The hubs are currently negotiating with stakeholders and Colleges to establish specialist training positions relevant to local workforce needs.

Some challenges exist with this since, for non-GP and other non-generalist specialists, the intention is that the incumbents of new rural specialist training positions will complete 66% of their training rurally. This time requirement is an obstacle, as it has not generally been agreed to by the Colleges; and it does not align with the RACP's four-year dual training pathway. It is appropriate to question whether the required depth of training can be delivered in two years at an Integrated Rural Training hub (or across multiple hubs) with one additional year of tertiary placement and yield comparable results to the current metropolitan pathways.

Also, in many cases the very reason why a specific disciplinary training position needs to be created is because there are insufficient senior staff to provide service in that discipline, and hence disciplinary supervision is lacking, thereby making that position un-accreditable.

The current initiative does not address other barriers to long-term rural practice, such as partner employment, social isolation and concerns regarding children's education. Financial incentives are not considered influential by the majority of GPs as distinct from locum-relief incentives, and work-life balance related to on-call demands disproportionately affect GPs in smaller areas along with reduced opportunities for career development.

Failure to put in place strategies that will attract and retain medical graduates to positions in rural and regional NSW is not only a loss to those residents but a waste of the money invested in medical education.

One of the key reasons doctors move to a regional area is job security. Access to work and long term certainty are critical to ensuring the recruitment and retention of regional specialists.

Doctors in regional areas generally report that they are required to give up lists or work to allow a younger specialist to take a position. This reinforces the need for state-wide coordination and planning to ensure that LHDs have the funding to consider appropriate increases to specialist workforce and infrastructure to meet long-term service needs. This should go beyond the limits of simply replacing the existing workforce, to ensuring that there is a sufficient workforce to offer a safe, sustainable and high quality practice.

LHDs would benefit from a flexible funding scheme to assist with succession planning and allow for short-term staffing overlaps so that there may be a smooth handover of services and new doctors are supported in developing their practice.

Such a scheme should also be used to encourage regional LHDs to develop and implement medical workforce plans. Again, the opportunity to address maldistribution issues will be lost if LHDs do not plan to establish and fill a senior medical workforce staffing roster that is consistent with the clinical service plan. Filling existing vacancies is not enough. Each regional LHD should be identifying the senior medical workforce staff it needs and developing a plan to train and/or recruit senior medical staff to fill the identified positions.

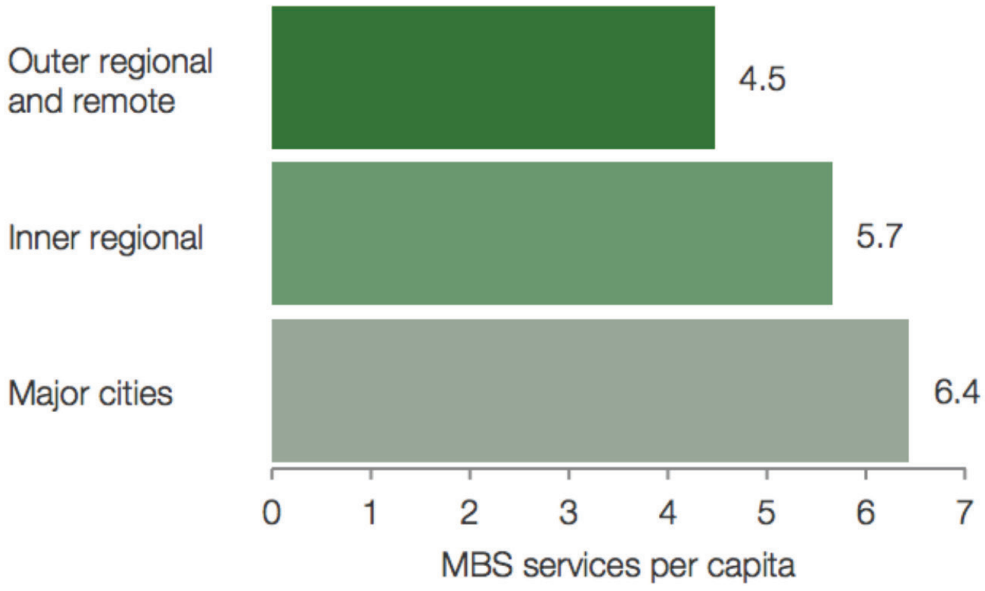
We believe there needs to be a major funding commitment from the NSW Government to enable regional LHDs to address the historical inequities between regional and metropolitan access to specialist services.

PER CAPITA EXPENDITURE

The relative spend per individual through the Medicare Benefits Schedule in 2014-15 is $536 in remote areas, compared to $910 in major cities. This is equal to approximately 10 MBS services annually for people in remote Australia compared to 17 MBS services for people in major cities.[vi]

The National Rural Health Alliance suggests, "if the difference in MBS spending between the major cities and remote communities was made to remote health providers for service delivery, it would provide an additional $193.7 million per annum based on the 2015 population estimate. Such funding could be used to expand alternative models of health service delivery which have been implemented in remote communities."

GP services provided per capita, by remoteness of residence, NSW 2014-15



Source: Australian Government Department of Health, General Practice Statistics

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3

HEALTHY COMMUNITIES

MENTAL **HEALTH**

Almost half of Australians will experience a mental health disorder in their lifetime, and yet mental health services remain underfunded, badly resourced and poorly structured. Mental health services are currently delivered by a range of health and non-health agencies. If NSW is to succeed in meeting the mental health needs of residents, it must develop a strategy that is coordinated at all service delivery levels.

Almost all Australians are affected by mental illness – either because they have experienced a mental health disorder or because a family member, loved one, colleague or neighbour has experienced mental illness. Forty-five per cent (7.3 million) of Australians aged 16 to 85 will experience a common mental health disorder (such as depression, anxiety or a substance use disorder) in their lifetime.[i] Each year, one in five people experience a mental disorder and around 25% are at risk of developing mental illness either because they have previously had a mental illness or they are experiencing early symptoms.[ii]

In NSW, 1.3 million residents will experience a mental illness and 1.8 million are at risk. A further 244,000 people will experience a severe mental illness.[iii]

Mental illness does not discriminate – it can affect anyone. However, for certain groups the burden of mental illness is higher. People from culturally and linguistically diverse backgrounds, people in the criminal justice system, people with intellectual disability, people from the lesbian, gay, bisexual, transgender, intersex and/or queer community, and Aboriginal people experience higher rates of mental illness. Additionally, women in their perinatal period, older people, people living in rural areas, and people who have experienced trauma are at increased risk of mental illness.

Despite the prevalence of mental illness, mental health and psychiatric care are substantially underfunded compared to physical health. Mental illness is linked to significantly worse levels of morbidity, or premature mortality, than the general population. Yet mental health receives less than half the funding of the comparable burden of disease funding.[iv]

COORDINATION

AMA (NSW) recognises that both levels of Government are working to improve mental health. The Productivity Commission's inquiry into mental health, which was announced in October 2018, aims to investigate the role of mental health in the Australian economy and best ways to support and improve national mental wellbeing. We note this inquiry follows a series of other inquiries into mental health. There have been 32 separate statutory inquiries into mental health between 2006 and 2012, and more since.

A Mental Health Commission was established in NSW in July 2012. The NSW Government launched a 10-year 'Mental Health Reform' (the Reform) to 2024. More recently, it released its NSW Strategic Framework and Workforce Plan for Mental Health 2018-2022 in October as part of the Reform.

AMA (NSW) suggests that while this work is important, it is crucial that reforms are made in conjunction – and coordinated with – work that is done at a national level. We need an agreed national design that facilitates both prevention and proper care for people experiencing mental health disorders. Mental health services cannot be delivered effectively in isolation from each other. The AMA has called for strategic leadership that integrates the National Disability Insurance Scheme, Primary Health Networks, General Practice, National Strategic Framework for Chronic Conditions, Aboriginal and Torres Strait Islander Health Performance Framework, and the mental health workforce.[vi] AMA (NSW) agrees with this recommendation, and calls for greater integration with NSW local health districts, Community Managed Organisations, Specialty Health Networks, and other regional providers to alleviate the fragmentation of services, close gaps, reduce duplication of services and inefficiencies in the system. As noted by AMA in its 2018 Position Statement, there is a "serious and continuing problem in the inability to link and integrate the mental healthcare provided to patients in primary care with the crisis or acute care they receive as hospital in-patients."

We are encouraged by the direction of the Fifth National Mental Health and Suicide Prevention Plan, which aims to strengthen regional integration.

WHAT DOCTORS **ARE SAYING**

> "Patients with mental illness are vulnerable, and often least able to advocate for themselves or to navigate a complex health landscape. And yet, mental health must be one of the most convoluted systems I have to manage daily. Services are siloed and it takes a concerted effort on the part of individual practitioners to keep each other up to date."

BHI Admitted patient activity – April to June 2018 - NSW

ADMITTED PATIENT ACTIVITY		APRIL TO JUNE 2018
Mental Health episodes		11,049
Avg length of stay (days)	Mental health episodes	16
Hospital bed days	Mental health bed days	176,715

Note: It's difficult to compare Bureau of Health Information figures from April to June 2018, to the same quarter in previous years, due to a new policy which changes the definition of patient stay types. A new mental health care stay type has been introduced. Previous reports included mental health patients in the acute and non-acute stay types. The policy was phased in across LHDs and health networks between 1 July 2016 and 30 June 2017. Comparisons with results from the policy phase-in period are not accurate due to the staggered approach it was implemented.

FUNDING

A well-coordinated, strategic plan must be linked with funding arrangements that are equitably balanced between providers. Significant investment is needed at all levels of service delivery. Hospital admissions can be reduced by adequately resourcing community-managed mental health services.

Community-managed mental health services have not been appropriately structured or resourced despite greater reliance on these services since the movement towards deinstitutionalisation (almost five decades ago). There is serious need to properly support and resource community-managed mental health care services to ensure access to these essential services, which include mental health nurses, psychologists, counsellors, addiction counsellors, psycho-geriatricians and other support staff.

In many communities, public hospital emergency departments are the only service option for people experiencing an acute mental health crisis. However, public hospitals are not adequately resourced to address the needs of mental health patients. People with acute mental and behavioural conditions are not treated within the clinically recommended timeframe of 30 minutes; AIHW figures reveal 90% of people presenting with acute mental health crises left emergency departments within 11.5 hours, and almost 7,000 people who sought help from emergency departments for their acute mental and behavioural condition left before finishing treatment.[vii]

Long delays in treatment reflect shortages in mental health staff and constraints on admission capacity of hospitals.

As stated in AMA's Position Statement on Mental Health, "It is never appropriate for patients presenting with mental health conditions to spend prolonged (>4-6 hours) in hospital Emergency Departments. Specialised mental health and dual diagnosis spaces or departments should be established as part of public hospitals admitting psychiatric patients."[viii]

The AMA's Position Statement on Mental Health further states people with mental illness can inappropriately end up in the non-therapeutic Emergency Department environment, with significant numbers under sedation and/or restraint. Referral to appropriate care (admitted or community) needs to be expedited and streamlined, and no patient should be discharged into homelessness.[ix]

Additional and timelier access to acute care in public hospitals is required.

Underfunding, particularly in specific areas such as Aboriginal and Torres Strait Islander mental health, regional and rural mental health, refugee and migrant mental health and adolescent mental health, must be addressed.

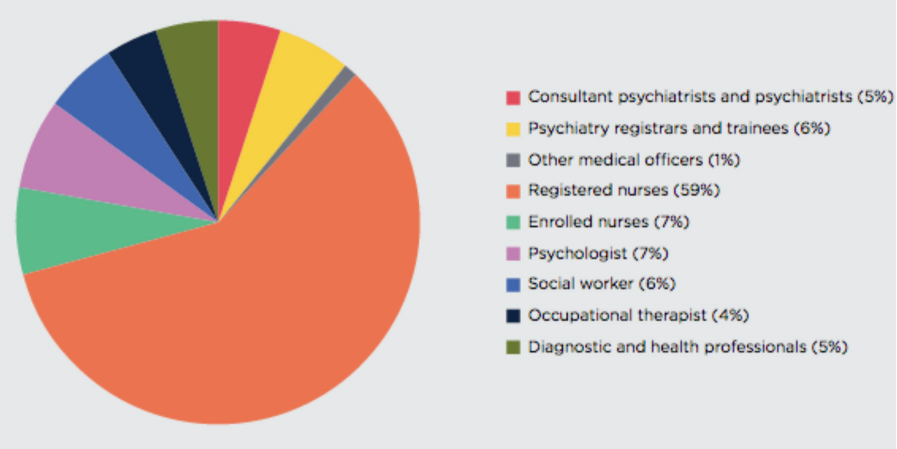
Funding should also be directed to include the expansion of services targeted to elderly people, as well as perinatal women and adolescents.

AMA (NSW) suggests transition care services need better support. Step-up and step-down high acuity residential care and resourced coordinated services under appropriate medical oversight are important alternatives to inpatient admission or for earlier hospital discharges.

AMA (NSW) calls for adequate funding to enable the delivery of coordinated, comprehensive mental health services in the community. Additionally, AMA (NSW) recommends the provision of funding for longer GP consultations for patients with mental illness who often have complex and multiple physical and mental health issues.

Private psychiatric services provide an effective alternative pathway for psychiatric care, and psychiatrists play a significant role in coordinating care to ensure patients are able to continue treatment that keeps them out of hospital and living in the community. However, we note that access to public psychiatric services is

NSW clinical mental health service composition by staff category, 2015 - 16



Source: National Mental Health Establishments Dataset 2015-16, provided by System Information and Analytics, NSW Ministry of Health

WHAT DOCTORS **ARE SAYING**

> The community teams are stretched to the point that people frequently present and re-present to hospital as they aren't followed up properly. Even when they are, they are often getting the bare minimum follow-up – usually just administration of medication – rather than evidence-based psychological therapies and social interventions which would help them be more independent and fully recover.

ED PRESENTATION CHARACTERISTICS

People presenting with acute mental and behavioural conditions to emergency departments in Australia:

- 22% aged 15-24, 21% aged 25-34, 19% aged 35-44
- 52% male and 48% female
- Presenting at higher rates per 10,000 population in remote and very remote areas (185.3), outer regional areas (128.3) and inner regional areas (126.7) – as compared with major cities (101.2)
- While Indigenous Australians make up around three per cent of the Australian population, they comprise 11 per cent of all ED mental health presentations across the country.[x]

limited, and even for patients with means to pay the waiting lists can be prohibitive. Generally, access is reserved for patients with severe, psychotic illness. Medical professionals report that direct referrals to public psychiatrists are near impossible, and patients must go through community mental health channels, which can be an obstacle.

WORKFORCE SHORTAGES

It should be noted that there currently is under-subscription to the specialty of psychiatry, and this workforce shortage situation will become even more dire as current medical professionals retire and NSW experiences a 14% population growth in the next 10 years. This is compounded by a 33% growth in the over 65 year old age group, which are at higher risk of mental illness.

AMA (NSW) backs calls for increased numbers of funded psychiatrist trainee places, along with an increased investment in workforce training and support for other mental health workers, especially mental health nurses.

Of particular concern is the mal-distribution of psychiatrists, psychologists and other mental health service providers in regional areas.

Other frontline workers, including Emergency Department staff, GPs, paediatricians, psychiatrists as well as psychologists and mental health nurses must be supported.

PREVENTION

As is the case with physical health, prevention can be superior to treatment when it comes to mental health. Prevention starts with healthy pregnancies and continues with mental health education and programs for children. Good mental health is central to child development, and there are many ways to encourage and improve children's mental health, such as developing good sleeping habits, healthy eating and regular physical activity.

Children's mental health is also influenced by outside factors, such as family relationships, bullying, learning difficulties, and body image issues, among other things.

Mental health education reduces stigma and allows for greater recognition of early symptoms of mental health problems and early intervention.

Resourcing online and telephone support services is important, as these have proven to be effective means of assisting children struggling with issues affecting their mental health. Maintaining comprehensive referral pathways is also critical to ensure patients get linked to the right service at the right time.

Funding for specific prevention and early intervention programs to target disorders such as eating and conduct disorders, anxiety, substance abuse, depression, self-harm, and support for children of parents with a mental illness is needed.

WHAT DOCTORS **ARE SAYING**

> We do have a problem generally with long waits, and patients needing inpatient care ... but we found that mental health patients are disproportionally impacted by this. These delays undermine patients' health and recovery, place considerable stress and strain on emergency department teams, and waste limited health resources," said ACEM president Dr Simon Judkins.[xi]

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3

HEALTHY COMMUNITIES

INDIGENOUS HEALTH

There remains an unacceptable disparity in health outcomes for Aboriginal and Torres Strait Islander people. AMA (NSW) is committed to working in partnership with Aboriginal and Torres Strait Islander groups to advocate for State Government investment and co-ordinated strategies to improve health outcomes for Indigenous people.

All Australians have a right to good health as defined by the World Health Organisation's Declaration of Alma Ata, which states that health is a state of complete physical, mental and social wellbeing, and not merely the absence of disease or infirmity.[i]

The Council of Australian Governments set targets aimed at closing the gap in health outcomes between Aboriginal people and non-Indigenous Australians 10 years ago. A decade after the launch of the Closing the Gap Strategy, and the life expectancy gap is actually widening – a signal that the Strategy itself is flawed.

Despite the disease burden for Aboriginal and Torres Strait Islander people being 2.3 times greater than the non-Indigenous burden, Commonwealth Government spending is only 53% of the needs-based requirements. Remarkably, the Government is spending less per capita on those with worse health. This particularly impacts primary health care services, which notably results in increased hospitalisation costs.[ii]

The AMA is calling on the Federal Government to commit to equitable, needs-based expenditure that recognises the Aboriginal and Torres Strait Islander burden of disease is 2.3 times greater than non-Indigenous burden. By extension, the health needs of the Aboriginal and Torres Strait Islander population has 2.3 times the health needs, therefore should receive 2.3 times the health expenditure of that per non-Indigenous person.

To date, this health expenditure has not been in place. As identified in the AMA 2018 Report Card on Indigenous Health, there are significant equity shortfalls.

AMA (NSW) echoes the AMA's recommendation that "National or template tri-lateral expenditure agreements should be made at the national level, and in each jurisdiction, with Aboriginal and Torres Strait Islander health leaders and leadership bodies specifying the roles, responsibilities, and expenditure obligations for each Commonwealth, State and Territory government."

The need to create equitable health funding for Aboriginal and Torres Strait Islander people is reinforced by several NSW-focused healthcare reports.

The Bureau of Health Information's report "Healthcare in Focus 2017: How does NSW compare?", which was released
August 2018, found some notable differences in performance for Aboriginal and non-Aboriginal people.[iii]

The report stated 65% of non-Indigenous patients said their overall care in hospital was very good in 2016, while only 58% of Indigenous patients in NSW said the same. The report also noted Indigenous people were two-and-a-half times more likely to feel they'd experienced unfair treatment.

In years directly prior, these two numbers were much closer together, so the disparity in 2016 is alarming.

The report looked at more than 60 measures of healthcare, including surgery and ambulance waiting times, financial barriers to seeking treatment and time spent in emergency departments.

The report shows Aboriginal people wait longer for elective surgery. For example, Aboriginal people in public hospitals can wait on average 27 days longer for cataract extractions compared to non-Aboriginals. The gap for total hip replacements is about 23 days longer on average.

Clearly more work is needed to improve care for Indigenous Australians.

AMA (NSW) supports the principle that Aboriginal and Torres Strait Islander people have a leading role in identifying and responding to the nature and challenges of Aboriginal and Torres Strait Islander health, and that the medical profession has a responsibility to partner with and support these efforts.

When Indigenous people are empowered to shape services for their community, better health outcomes are achieved.

A good example is the Tharawal Aboriginal Corporation in Airds, near Campbelltown.

This comprehensive, community-controlled medical service serves the Indigenous community of south-western Sydney. In addition to providing medical services, it also offers a preschool, dental clinic, and multiple programs assisting new mums, people with mental health issues, drug and alcohol programs and healthy eating.

It is staffed by GPs, training GP registrars and visiting specialists, many of whom are associated with Western Sydney University.

Western Sydney University's School of Medicine also facilitates a five-week full-time clinical attachment in an Aboriginal Community-controlled Health Organisation for every senior medical student. Underpinning this requirement is the philosophy that all medical practitioners in Australia should have a degree of competence and skill in Aboriginal health.

2013-14 Commonwealth expenditure on Aboriginal and Torres Strait Islander health

	Per capita expenditure: Aboriginal and Torres Strait Islander	Per capita expenditure: Non-Indigenous	Equitable health expenditure per $1 spent on a non-Indigenous person is:	Aboriginal and Torres Strait Islander expenditure per $1 spent on non-Indigenous person:	Actual spend as percentage of equitable spend is:
Commonwealth primary health care expenditure on medical services, including Medicare Benefits Schedule	$271	$302	$2.30	$0.90	39% (Shortfall 61%)
Pharmaceutical Benefits Schedule expenditure	$471	$741		$0.63	27% (Shortfall 73%)
Total Commonwealth expenditure	$3,261	$2,698		$1.21	53% (Shortfall 47%)

Source: 2018 AMA Report Card on Indigenous Health

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3

HEALTHY COMMUNITIES

JUSTICE HEALTH

Unprecedented growth in NSW's prison population is affecting medical professionals' ability to adequately address their healthcare needs. Of particular concern is the inability to cope with patients with mental health needs. Furthermore, improving healthcare for prisoners benefits the wider community and reduces recidivism.

The disparity in health between prisoners and juvenile detainees when compared to the wider community is stark. They are a highly vulnerable population. Prisoners and detainees have significantly higher health needs than the general population. They face higher levels of serious health conditions such as cancer, heart disease and diabetes, as well as poorer dental health, and a higher prevalence of disability, communicable diseases, and mental illness.[i,ii,iii,iv]

Prisoners and detainees also tend to come from disadvantaged backgrounds marked by higher levels of unemployment, drug and alcohol addiction, and insecure housing.

Educational attainment is low and illiteracy and innumeracy are high among the prison population. The 2015 NSW Justice Health & Forensic Mental Health Network surveys revealed 72.1% failed to complete Year 10, while 11.5% had difficulty with reading and writing, and 2.6% indicated they are illiterate.[v, vi]

This population tends to have complex health needs and is increasing in number and age.

INCREASING GROWTH

The imprisonment rate in Australia has steadily increased in recent decades.[vii] The figures in NSW reflect this rise, with sharp rises experienced from 2011 to 2018. The NSW Bureau of Crime Statistics and Research (BOSCAR)'s report "Why is the NSW prison population still growing?" concluded that the growth was largely a consequence of changes in the way the courts respond to suspected or convicted offenders and partly a consequence of an increase in the number of people charged by police with serious offences.[viii] Further research into this growth points to steep increases in the number of prisoners on remand, more punitive sentencing laws and practices, and limited availability of non-custodial sentencing options.[ix,x,xi,xii]

The BOSCAR quarterly update September 2018 found the number of adult prisoners in custody at that time was 13,372, while the number of juveniles in custody is 283.[xiii]

The growth in prison populations has been concentrated in particular population groups, disproportionately affecting Aboriginal and Torres Strait Islander peoples, those with mental illnesses and individuals experiencing socio-economic deprivation.[xiv]

It is worth noting that there has been a significant increase in imprisonment of Indigenous women.

The over-representation of Aboriginal and Torres Strait Islander people in prison is of urgent concern.

Many of those who become incarcerated, have fallen through the gaps in access to community-based health and social services, including services for mental health, substance use, disability, family violence, and housing. Imprisonment can exacerbate and further entrench the social and health disadvantages that led to their imprisonment.[xv] There is an opportunity to reach people in prison who have previously been unable to access health services. Addressing these health inequalities in prison has wider benefits for the general population, as improved healthcare to those who have been in custody reduces the likelihood that they will re-offend.[xvi]

MINIMUM STANDARDS FOR PRISON HEALTHCARE

The United Nations Standard Minimum Rules for the Treatment of Prisoners Rule 24 states that:

a. The provision of healthcare for prisoners is a State responsibility. Prisoners should enjoy the same standards of healthcare that are available in the community, and should have access to necessary healthcare services free of charge without discrimination on the grounds of their legal status.
b. Healthcare services should be organised in close relationship to the general public health administration and in a way that ensures continuity of treatment and care, including for HIV, tuberculosis and other infectious diseases, as well as for drug dependence.[xvii]

The UN Mandela Rule 25 states that:

a. Every prison shall have in place a healthcare service tasked with evaluating, promoting, protecting and improving the physical and mental health of prisoners, paying particular attention to prisoners with special healthcare needs or with health issues that hamper their rehabilitation.
b. The healthcare service shall consist of an interdisciplinary team with sufficient qualified personnel acting in full clinical independence and shall encompass sufficient expertise in psychology and psychiatry. The services of a qualified dentist shall be available to every prisoner.[xviii]

Furthermore, one of the guiding principals of AMA's Position Statement "Health and the Criminal Justice System – 2012" states:

Health services in custodial settings should be resourced and designed to provide a level of care that is commensurate with the health needs of prisoners and detainees and should accommodate the diverse and complex needs of vulnerable and highly disadvantaged subgroups.

RESOURCING

The unprecedented growth in prison populations in NSW has put significant pressure on Justice Health & Forensic Mental Health Network staff to provide quality healthcare. The Network is responsible for providing healthcare for over 30,000 patients annually in a variety of settings. Its patients include adults and young people in correctional centres, courts, police cells, juvenile justice centres and the community; as well as patients within the NSW forensic mental health system. There are 42 adult correctional centres in NSW, with an additional centre (Junee) under private management. Additional correctional centres are planned to open by the end of 2020, including the privately operated New Grafton Correctional Centre.

AMA (NSW) would like to acknowledge the work of the Network and its staff in delivering healthcare in an incredibly complex environment.

But the steep increases in prison populations have put tremendous pressure on the system, and the risks that this imposes on both prisoners and staff cannot be ignored.

As noted by J. R. Paget, Inspector of Custodial Services, in his January 2015 report "Full House, The growth of the inmate population in NSW":

NSW has the lowest number of hours out-of-cell each day for inmates, and this, combined with overcrowding, presents significant risks to the correctional system. Confining two or three inmates to cells designed for one or two for prolonged periods, where they shower, eat and defecate, inevitably raises tensions in an already volatile population. The experience in other jurisdictions has been that this potentially increases the risk of assault, self-harm and suicide and more general prison disorder.

The report also highlights that the increase in prison population leads to longer waiting times and some health needs of inmates not being met. The average time an inmate will wait to see a general practitioner is over one month.

AMA (NSW) would also like to highlight that while the current resourcing for the healthcare of all prisoners and detained juveniles is inadequate, it is particularly insufficient to meet the high needs of patients with severe mental illness and forensic patients.

The Inspector notes with concern in his report the already long waiting lists to obtain mental healthcare, which are compounded by the increase in the mental health needs of inmates and the difficulty in filling mental health nursing positions. The average wait time for an inmate to see a psychiatrist is 42 days and to see a mental health nurse is 27 days.

The report highlights the ratios of nursing staff to inmates in correctional centres decreased from 4.5 FTE per 100 inmates in 2011 to 4.0 FTE per 100 inmates in 2014.

It also notes a similar decrease in the ratio of FTE clinical staff (including doctors) from 4.9 FTE per 100 inmates to 4.5 FTE per 100 inmates for the same period.

The last AIHW national survey of prisoner health found that nearly half of all prison entrants report being diagnosed with a mental health disorder.[xvix]

There is widespread concern that our prisons are becoming de facto mental health institutions.

PATIENTS WITH SEVERE MENTAL ILLNESS

AMA (NSW) believes patients with severe mental illness requiring acute treatment should be treated in psychiatric facilities outside of custody. There are reports of patients with severe mental illness locked down in a cell for 23 hours, with little company, fresh air or sunlight.[xx] Better treatment for severe mental illness is urgent. One of the most common causes of death in custody is suicide.[xxi] The re-offending rate of ex-prisoners with severe mental illness is higher than other former prisoners.[xxii] Effective treatment of patients with severe mental illness reduces recidivism and the burden on community mental health services.

AMA (NSW) supports the Royal Australian & New Zealand College of Psychiatrists Position Statement 93, which opposes the use of involuntary mental health treatment in custodial settings. Should a prisoner experience psychiatric symptoms that are so severe as to require involuntary treatment, AMA (NSW) believes that treatment should take place in a hospital.

Primary Diagnosis

The top 3 diagnosis among NSW forensic patients:

88% **Schizophrenia and other psychotic disorders**

5% **Affective disorders**

3% **Developmental disorders, including intellectual disability**

FORENSIC PATIENTS

Funding has not kept pace with the increase in the prison population, and inadequate medical staff-to-patient ratios are compounded by lack of access to beds.

There are insufficient forensic mental health beds in NSW – particularly medium secure and low secure beds. As a result, forensic patients are detained in prison without receiving appropriate treatment.

As noted by the Mental Health Review Tribunal 2017 Annual Report (MHRT) by His Honour Judge Richard Cogswell SC, President of MHRT:

It has come to the Tribunal's attention that some forensic patients are finding themselves sharing cells with two or three sentenced or remanded prisoners. There are two important observations to be made about that. First, it is unlikely to contribute to the recovery of their mental health; indeed there is a significant risk of the patient's mental health deteriorating in those circumstances. The second is that treating patients that way is more consistent with them being regarded as prisoners than as patients. Prison is an extreme measure reserved for persons charged with or convicted of serious crimes who pose an unacceptable risk in the community. It is not the place for persons with mental illnesses or mental conditions whose care, treatment and control (for the safety of them and the public) are a State responsibility.[xxiii]

Fifteen per cent of all forensic patients in NSW are detained in prisons. This is commonly due to a lack of available places in non-custodial settings.[xxiv]

Forensic bed numbers in NSW are below comparable figures in the UK and significantly below countries with a high standard of mental healthcare for forensic patients, such as the Netherlands.

The MHRT report also notes that (as of 30 June 2017), the forensic patient who has waited the longest for admission to the Forensic Hospital had spent 3½ years in custody. This included a wait of nearly two years since the court concluded that he was not guilty of an offence by reason of mental illness. Eighteen patients have been waiting in custody for more than two years for admission to the Forensic Hospital.

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3

HEALTHY COMMUNITIES

TACKLING **OBESITY**

Obesity is a national crisis and deserves a response that is commensurate with its prevalence and impact on individuals and society. Overweight and obesity was responsible for 7% of the total health burden in Australia in 2011, 63% of which was fatal burden.

CHILDHOOD OBESITY

Overweight and obesity in children has significant health impacts. Compared with healthy weight children, overweight and obesity among 6-to-13-year-olds was found to cause an extra $43.2 million in annual non-hospital costs incurred by Medicare, according to 2015 figures.[i]

Preschoolers above a normal weight are five times more likely than normal-weight children to become overweight or obese as adults. They are also at greater risk of developing chronic disease in later life. Other health risks include higher rates of asthma and obstructive sleep apnoea, bone and joint complications, accelerated onset of diabetes and heart disease, and lower self esteem.[ii, iii]

Overweight and obesity affects more than one in five children in NSW. While the number of children above a healthy weight has more than doubled since 1985, rates of overweight and obesity have remained relatively stable since 2007.[iv]

Despite a plateau in overweight and obesity rates, research suggests children are not meeting current healthy lifestyle guidelines around eating and exercise.

Only 29% of children are currently meeting physical activity guidelines, while 44% spend more than two hours per day on sedentary leisure activities.[v]

Around 58% of Australian children obtain more than one third of their daily caloric intake from unhealthy food and drinks. In NSW, one in three children are drinking a can of sugary drink and/or eating salty snack foods each day. Meanwhile, less than 5% of NSW children eat the recommended number of vegetable serves per day and less than 10% eat the recommended amount of healthy dairy foods, such as yoghurt, cheese and milk.[vi, vii]

Eating habits and levels of physical activity are influenced by many factors, including the health and behaviour of parents, genes, weight at birth, wealth, the social environment, the availability of healthy food and opportunities for activity.

As a result, a multi-pronged, whole-of-society approach is needed to adequately address this burgeoning problem.

Australia needs a strategic national plan to combat obesity that is coordinated by the Federal Government. The plan must outline specific national goals for reducing obesity and its health effects.

Government has the unique ability to influence and regulate people's behaviour through the use of taxation, financial penalties and incentives, subsidies and market interventions, policy and legislation, which can all be used to steer people into making healthier choices. In addition, Governments at all levels should use available policy, regulatory and financial levers to improve overweight and obesity rates in the community.

With this in mind, AMA (NSW) welcomes the Premier's Priority to reduce overweight and obesity rates of children by 5% over 10 years.

It is an ambitious target that requires a multi-faceted approach, requiring the participation of governments, non-government organisations, the health and food industries, the media, employers, schools, and community organisations.

AMA (NSW) recommends this commitment to reaching a specific goal for reducing obesity should remain in place regardless of any potential change in Government.

Only 29% of children are currently meeting physical activity guidelines, while 44% spend more than two hours per day on sedentary leisure activities.

Around 58% of Australian children obtain more than one third of their daily caloric intake from unhealthy food and drinks.

EARLY INTERVENTION

Prevention and early intervention should start during pregnancy, and continue during infancy and childhood. Evidence suggests that a mother's weight may affect foetal development and dispositions towards obesity. Research also indicates that interventions to prevent excessive weight gain during pregnancy (including physical and nutritional programs are effective).[viii]

NSW's Get Healthy During Pregnancy Service, which provides telephone-based coaching to women aged 16 years and over is a good initiative. AMA (NSW) recommends further resources be directed to the expansion of this program which has yet to be made available Statewide. In conjunction with this program, the State should subsidise group exercise programs for pregnant women to help them put into practice some of the advice they learn from the Get Healthy During Pregnancy Service. An exercise program would assist women who struggle financially or otherwise to improve their physical activity. As well, it would encourage pregnant women in a community to exercise together – providing greater motivation and commitment among participants.

Infant nutrition and early infant growth patterns play an important part in determining eating patterns and weight gain in later life. Breastfeeding provides many health benefits to infants, including lower prevalence of overweight and obesity. Given this, breastfeeding should be encouraged, whilst recognising that it may not be the most appropriate for all caregivers, and that both breast and bottle feeding provide opportunities for parents to meet their infant's nutritional needs.[ix]

Targeted support should be available for population groups with relatively low breastfeeding initiation and duration. Women who may benefit from increased breastfeeding encouragement and support can include: multiparous mothers with previous negative breastfeeding experience, mothers returning to work, mothers who smoke, mothers of Indigenous children and mothers from Culturally and Linguistically Diverse (CALD) backgrounds.

The antenatal experience of women from CALD backgrounds can be affected by isolation from immediate family and community support, language barriers, conflicting cultural expectations, difficulties in navigating the healthcare system, ineligibility for Medicare or cultural barriers such as male clinicians or interpreters.

Maternal and perinatal outcomes in rural and remote communities can be improved through increasing accessibility of services, provision of infrastructure for tele-support and remote consultations, and increased emotional and practical support for women who have to leave their communities to give birth.

ROLE OF MEDICAL PROFESSIONALS

Medical professionals have an important role to play in supporting children above a healthy weight. The reality is many healthcare professionals find childhood obesity a difficult and sensitive topic to broach. Education and training of healthcare professionals in the assessment and management of childhood obesity is essential, along with developing and funding standardised models of care and health pathways to facilitate management and enable improved and greater equitable access to care.

The Australian Prevention Partnership Centre identified that there is currently no national universal public health service for families of children who are already overweight or obese, despite well-established evidence about the effectiveness of these services.

The absence of a clearly defined referral and treatment pathway exacerbates doctors' reluctance to address overweight and obesity issues with patients. Also, there is not a Medicare item number to cover childhood obesity assessment and management. Nonetheless there are some community intervention programs which are changing the current landscape.

SUPPORT FOR PHYSICAL EXERCISE

The Active Kids Rebate has been well received by NSW residents, with more than $56m claimed in the first six months of the scheme. The rebates have encouraged participation in soccer, netball, rugby league, dance and swimming. AMA (NSW) supports continuation of this program.

NSW's Go4Fun program is a free 10-week healthy lifestyle program for kids aged 7-13 who are above a healthy weight focuses on improving eating habits, fitness and confidence.

An Evidence and Evaluation Summary (2011-2015) found participants made improvements in BMI units of 0.6, and a reduction of 1.6cm in waist circumference. There were also improvements in nutrition, physical activity related behaviours, cardiovascular fitness, and participants' self esteem.[x]

While successful, a review of the program by the Australian Prevention Partnership Centre found it is vulnerable to external factors such as changes in Government, funding priorities and philosophical differences.[xi]

The continued success of childhood overweight and obesity management programs is dependent on embedding them into the healthcare system.

Further evaluation is also needed on these programs to address barriers to participation.

Greater investment is required to expand these programs and increase awareness among clinical, primary health and community sectors.

Research also suggests school-based interventions may help prevent childhood obesity.

The State Government is well placed to support physical activity and healthy eating programs in schools. Current programs such as Munch & Move, and Live Life Well @ School are well established. Further promotion of healthy canteens and promotion of water consumption is encouraged. But other opportunities to improve healthy eating exist. International evidence regarding sugar-free schools suggests these policies are having a positive impact. The State should encourage schools in NSW to adopt a similar approach.

Access to school grounds on weekends and over school holidays should be allowed, particularly in communities where there is higher density housing and families do not have access to backyards or green spaces, as a means of increasing opportunities for physical activity.

FOOD MARKETING

AMA recommends the marketing of energy dense/nutrient poor food to children should be prohibited in all settings. The State has an opportunity to directly limit junk food marketing to children by prohibiting this kind of advertising from Government-owned, or State-leased property.

BARIATRIC SURGERY

The AMA does not believe bariatric surgery is appropriate for children. However, older adolescents (15-18 years of age) may be considered in certain circumstances. For suitable patients, access to bariatric surgery should be available publicly and privately.

AMA (NSW) welcomes the Premier's Priority to **reduce overweight and obesity rates of children by 5% over 10 years,** and recommends this commitment to reaching a specific goal for reducing obesity should remain in place regardless of any potential change in State Government.

ADULT OBESITY

While targeting childhood overweight and obesity should remain a strategic priority, it cannot be at the expense of resources to tackle overweight and obesity in adults. Education and raising awareness is key for prevention; however, treatment for the 63% of Australians who are already overweight and obese is urgent.[xii]

Among adults, overweight and obesity is associated with several adverse health outcomes, including a higher risk of developing many chronic conditions and death.

Certain groups are at greater risk of being overweight and obese. Indigenous Australians and those living outside major cities, or who are in lower socioeconomic groups are more likely to be overweight or obese.

Chronic diseases associated with being overweight and obese include diabetes, hypertension, high cholesterol, stroke, heart disease, certain cancers and arthritis.[xiii]

NSW has an opportunity to address overweight and obesity in adults through policy, regulatory and financial instruments. Several measures should be adopted to promote appropriate dietary behaviour and greater physical activity.

NSW needs to focus on creating healthy communities by supporting planning regulations governing housing, urban development, and transport infrastructure that facilitate physical activity. Perceived lack of safety can be a barrier to people being physically active in their community, so more effort must be made to make shared spaces safe environments for people to exercise outside.

Urban planning regulations should also ensure new housing developments include access to shops featuring fresh food, fruits and vegetables and limit the density of convenience stores and take-away / fast food restaurants.

AMA has been a vocal proponent of a sugar tax. AMA (NSW) echoes this support and recommends the State support this taxation as well. Price signals affects Australians' consumption choices. Significantly higher taxes, and therefore higher prices, should apply to products known to significantly contribute to obesity. Taxing sugar sweetened beverages and using the revenue to subsidise nutrition or physical activity programs is one way to offset the economic impacts of overweight and obesity.

As well, the price of healthy foods such as fruits and vegetables should be subsidised by governments to ensure prices are low and therefore more accessible choices for Australians, particularly in remote areas.

Measures and programs that seek to reduce obesity and overweight in high risk or vulnerable groups, such as Aboriginal or Torres Strait Islander peoples and those from lower income groups should be prioritised.

General practitioners are well placed to discuss overweight and obesity with individuals. Evidence suggests that interventions delivered by multidisciplinary care arrangements may be more effective. GP-led care can include dieticians, exercise physiologists, psychologists, diabetes educators, nurses, physiotherapists, occupational therapists, and social workers.

While GPs can offer advice around healthy eating and physical activity, they also need to be confident that patients are able to access referred weight management services in hospitals in a coordinated and timely manner where needed.

New funding needs to be available to general practices to enable a coordinated, comprehensive approach to weight management.

Patients also need to be able to access bariatric surgery in both public and private hospitals in exceptional cases.

We need to support a coordinated team-based approach at the general practice level – providing accessible, patient centred care. But most of all, it is the continuity of care that is needed.

TWO SIDES OF THE SAME COIN: **OBESITY AND DIABETES**

NSW has some of the highest rates of overweight and obese adults. Western NSW has the second highest prevalence of overweight and obesity in the country – with 71% of the population with a BMI that puts them above a healthy weight.[xiv]

In Sydney's western suburbs about 300,000 of the one million people living in that region are conservatively estimated to have diabetes or be at high risk – with more that half the population of Auburn, Blacktown, Holroyd, Parramatta and the Hills District overweight. More than a third of people with diabetes do not know they have it. There is also a lack of awareness about how serious the threat of diabetes is and how it can lead to serious health implications if undiagnosed or left unmanaged.[xv]

Wollongong University public health researcher Thomas Astell-Burt, who mapped the odds ratio of developing diabetes in different parts of Sydney, found people living in western Sydney are one-and-a-half times more likely to develop diabetes than other parts of Sydney.[xvi]

People living in Blacktown are three times as likely to develop diabetes as those living in Mosman.

Certain groups are at higher risk of developing type 2 diabetes. These groups include Indigenous people, people from Asia and Pacific Islands heritage, people with mental health problems and women in their childbearing years. Many of these groups are strongly represented in western Sydney. The area is also considered to be a diabetogenic environment – which is one where the population, community, local economy and built environment make it difficult to have a healthy lifestyle.

In response to the region's rising obesity crisis and the corresponding increase in diabetes cases, Western Sydney Local Health District chief executive Danny O'Connor said, "If we continue to consume too many calories and convert to diabetes, we will have to build factories to cut off people's toes, feet and limbs and help them when they go blind."[xvii]

The average annual financial costs of a patient with type 2 diabetes in western Sydney is estimated at $16,124. For patients with no complications, the cost is estimated at $13,766, while for those with macro vascular complications, the annual cost is estimated to be $22,156.[xviii]

The health consequences of diabetes include heart disease and stroke, eye disease, kidney disease, damage to lower limbs which may lead to amputation, mental illness, and gestational diabetes.

Western Sydney has been identified as a 'diabetes hotspot'. The Western Sydney Beating Diabetes Together document provides a comprehensive strategy to 'take the heat out' of this diabetes hotspot.

This strategy, which is a collaboration between multi-sector partners in a whole of district approach, sets out five pillars of the strategy to beat diabetes:

1. Building an Alliance and Testing the Strategy
2. Primary Prevention
3. Secondary Prevention and Management
4. Data for Decision Making
5. Mobilising Public Support

The goal is to increase the proportion of the healthy population, slow the progression towards being at risk of diabetes, and reduce the size of the at-risk population.

The approach outlined in this ambitious document is broad and thorough. AMA (NSW) would like to see this strategy adapted and implemented in other areas in NSW with high levels of overweight and obesity, and corresponding rates of diabetes.

PREVALENCE OF DIABETES

- Someone is diagnosed with diabetes every five minutes (globally)
- A person dies from diabetes every six seconds (globally)
- The number of people with diabetes in Australia is three times higher than 25 years ago
- One in four Australians aged over 25 years has diabetes or pre-diabetes

Source: Western Sydney Diabetes: Taking the Heat out of Diabetes

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