



RACP
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2020 – 2021 Pre-Budget Submission

December 2019

About The Royal Australasian College of Physicians (RACP)

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

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

Foreword and Recommendations

The RACP has over 21,000 Australian based members (14,000 practising consultant physicians and paediatricians; and 7,500 trainees) who contribute expert specialist care across the Australian health care system. Members work in:

- primary healthcare settings and community care programs (such as paediatrics, palliative and rehabilitation care);
- special purpose community facilities such as residential aged care facilities;
- hospital services; and
- post-acute care (such as rehabilitation).

The RACP has prepared a constructive set of healthcare recommendations for the consideration of Government, based on the experience of RACP members working across the public and private sectors.

We ask that the 2020-2021 Budget look longer term. More needs to be done to address the joint needs of investment in prevention (and preventing condition exacerbation) and deep-seated health reform to better connect and sustain the health system. For example, many health issues can be addressed before an emergency department presentation or an acute hospital visit takes place. This submission addresses:

- the need for prevention strategies on obesity and overweight, prevention of alcohol-related harms and early intervention in mental and physical health of infants and children.
- **for the need for more integrated approaches to care, in particular, the significant gap in complex care required by patients with chronic, complex and co-morbid chronic conditions.**
- the need for fundamental reform and redesign of the aged care system through providing better support, particularly palliative care, to residents of Residential Aged Care Facilities, as well as better meeting the end-of-life care needs of older Australians.

Recommendations

The RACP recommends that the Australian Government:

A strategy to prevent disease and support health

- 1) Implement and fund a national population-wide preventative health strategy. Monitoring and evaluating the effectiveness of preventative health interventions must be part of the resourcing. This strategy should also incorporate concerted action to reduce rates of Type 2 Diabetes Mellitus and its downstream complications and include targeted primary and secondary prevention to retain young people and their carers in populations at risk in ongoing follow-up.
- 2) Prevent further increases in the rate of obesity in the Australian population through a national COAG-led strategy on obesity. The College recommends a tax on sugar-sweetened beverages to reduce consumption and dedicated funding for states and territories to provide equitable access to bariatric surgery for public hospital patients.
- 3) Reduce alcohol-related harm to health by replacing the current Wine Equalisation Tax (WET) and rebate system with a volumetric taxation scheme for all alcohol products.
- 4) Allocate a proportionate percentage of the revenue raised from volumetric taxation to funding alcohol and other drug prevention and treatment services as part of a coordinated national response to substance use disorders.
- 5) Invest in alcohol and other drug treatment sector reform through multidisciplinary workforce development, investment in the physical infrastructure and addressing unmet demand for treatment.
- 6) Set a national best-practice policy for a minimum price per standard drink to be implemented through states and territories in Australia.

Chronic comorbidities: resources for a gap in care

- 7) Fund a model of care for the management of patients with comorbid chronic health conditions, that formalises and supports the integration of consultant physician care (the RACP Model of Chronic Care Management or a variation). The Government's implementation should be staged, starting from a small number of proof of concept sites, with outcomes monitored, as part of a comprehensive evaluation plan.
- 8) Designate and resource a new chronic care coordinator role (nursing role) initially in proof of concept sites (refer above), as a point of contact to multidisciplinary teams and patients.
- 9) Address infrastructure gaps to support patient access to physician services in ambulatory settings, such as:
 - Medicare Benefits Schedule (MBS) reforms or other financial incentives to support direct communications between GPs and specialists in the management of chronic disease patients (for example, with and without the patient present) outside of case conferences.

Consultant physician services can be more accessible through digital health and telehealth

- 10) Provide a modest Practice Incentive Payment for consultant physicians to support better digital infrastructure for inter professional/organisational communication. The Australian Digital Health Agency could play a role ensuring interoperability and consistent standards to deliver fully integrated services.
- 11) Remove the distance requirement from the MBS items supporting specialist telehealth consultations.
- 12) Consider further measures to reduce the barriers for physicians to use telehealth because of the infrastructure requirements – these might include additional technology and administrative support (telehealth equipment, scheduling software, mechanisms to collate and email patient records and investigation results).

Long term funding needed for Aboriginal and Torres Strait Islander health

- 13) Legislate for guaranteed long-term funding to progress the strategies and actions identified in the National Aboriginal and Torres Strait Islander Health Plan (NATSIHP) Implementation Plan commensurate with the burden of disease.
- 14) Commit to secure, long-term funding for the Rural Health Outreach Fund (RHOF) and Medical Outreach Indigenous Chronic Disease Program (MOICDP) commensurate with the burden of disease.
- 15) Commit to secure, long-term funding for comprehensive primary health care, community-led sexual health programs and specialised sexual health services to deliver Sexually Transmitted Infections (STIs) and Blood Borne Viruses (BBVs) services, and to ensure timely and culturally supported access to specialist care in all regions.
 - Within this framework, explore with State and Territory governments reciprocal funding arrangements whereby Commonwealth contributions are matched by commitments by State and Territory governments to fund specialist services to complement, augment and support comprehensive primary health care in the provision of sexual health services.

**Safer, effective
care for older
persons**

- 16) Fund the implementation plans of the National Blood Borne Virus and Sexually Transmissible Infection Strategies to ensure the implementation plan activities are delivered and targets achieved.
- 17) Guarantee continued funding for subsidised access to Comprehensive Geriatric Assessments (CGA) and specifically cover Aboriginal and Torres Strait Islander people over the age of 50, as they are eligible for aged care services.
- 18) Provide accessible multidisciplinary comprehensive assessments for older patients in hospital and community care settings. The assessment services should have strong links with Geriatric Evaluation and Management (GEM) Units; existing geriatric services; and have a clear point of contact.
- 19) Work jointly with State and Territory governments to train community based multidisciplinary teams which can undertake assessment services of dementia and delirium, accompanied by an appropriate management strategy for all hospitals and Residential Aged Care Facilities (RACFs). The number of community based, fully resourced dementia and delirium assessment and management services available in metropolitan and rural areas must be increased.
- 20) Consider provision of My Aged Care support personnel to assist with navigating the system, allocation of funding, and selection of service providers.
- 21) Enhance investments in the healthcare of older for Aboriginal and Torres Strait Islander older people by:
 - Establishing models of medical service provision and sustainable funding which ensure equitable and appropriate access for Aboriginal and Torres Strait Islander older people to consultant physician, palliative medicine and geriatric medicine services, across varying locations.
 - Reduce the barriers Aboriginal and Torres Strait Islander older people experience in relation to health services (including through investing in improving the cultural competency of healthcare professionals).
 - Provide additional funding for palliative care services for Aboriginal and Torres Strait Islander older people, especially in non-urban areas.
- 22) Invest in additional research into dementia care.
- 23) Increase the availability of Home Care Packages (HCPs) to eliminate delays in access which frequently lead to progressive impairment and loss of independence.
- 24) Enhance funding to ensure adequate training in dementia care to all service providers.
- 25) Establish and recurrently resource Primary Care Dementia Nurses positions in primary healthcare with the view towards also deploying these positions to purpose-built dementia units for those with significant Behavioural and Psychological Symptoms of Dementia (BPSD) who cannot be managed by non-pharmacological means and/or are aggressive and physically able.
- 26) Review and improve the design of RACFs to more effectively customise their services to the population being served, for example, by delivering appropriate physical facilities where the majority of older persons have intellectual disabilities.
- 27) Ensure there is sufficient funding to meet the needs in ambulatory and community settings (including RACFs) for appropriately qualified palliative medicine, geriatric medicine and other physicians and advanced trainees.
- 28) Work with State and Territory governments to develop and fund better integrated and co-ordinated care between primary care and secondary care for older patients. For example, this could include integrated care models such as that described in the RACP Model of Chronic Care Management.
- 29) Prioritise end-of life-care as part of COAG's agenda and establish collaborative arrangements with the States and Territories to address the urgent need for population-based integrated models of care to ensure access to appropriate end-of-life care for all Australians;
- 30) Address the existing gaps in service delivery by providing secure, long-term funding to:
 - increase the volume, and improve the coordination and delivery of community specialist palliative care services across the lifespan in ways that support integration with hospital services and primary care services and are delivered in conjunction with equitable, accessible, flexible and responsive social and community services and
 - develop and implement models of care that improve the availability of palliative and supportive care services across all age groups, with a focus on non-cancer services in hospitals and in other settings such as residential aged care facilities, people's homes, in rural and remote communities (including via telehealth) and among other underserved populations.
- 31) Substantially expand the Comprehensive Palliative Care in Aged Care package to fund additional specialist doctors and nurses across Australia to meet the unmet needs of patients who would

**Good end-of-life
care is not
meeting demand**

benefit from the delivery of high-quality palliative and end-of-life services in residential aged care settings.

Invest in children's health – build integrated, accessible, multidisciplinary care

- 32) Fund the provision of a minimum schedule of universal preventative health care interventions, to be delivered at point of vaccination to both babies and mothers.
- 33) Invest in paediatric child health services that are universally available and with a scale and intensity that is proportionate to the level of disadvantage.
- 34) Fund expanded home visit programs, particularly in rural and remote areas, and for families who experiencing high levels of stress or disadvantage. The programs should include implementing a universal sustained postnatal home visiting programme and providing support to all parents for the first 10 days after birth, with the possibility to extend the programme for families experiencing high levels of stress or disadvantage to the infant health check at 6 weeks. These must be combined with wrap-around or "child team" multiagency integrated service delivery approaches.
- 35) Commit funding to establish and maintain an Inequities in Child Health Alliance, in conjunction with several leading Australian universities, policy groups and health services.
- 36) Develop, implement and appropriately fund better coordination between primary/secondary and specialist mental health services or infants and children, including funding for promotion, prevention, early intervention and treatment if required.
- 37) Fund antenatal and postnatal parental education about foods, micronutrients and items which carry risks to the foetus.
- 38) Fund the development, implementation, evaluation and scaling up of integrated early childhood programmes designed to improve access to child and allied health, as well as social care services.
- 39) Commit to long-term, sustainable funding of the National Partnership on Universal Access to Early Childhood Education beyond 2020–2021 for all Australian children and expand it to start at three years old.
- 40) Immediately reinstate the Australian Health Ministers' Advisory Council (AHMAC) principal committee on child and youth health to provide strategic guidance on the prioritisation and delivery of child and youth health programs.
- 41) Extend paid parental leave policy to provide up to 6 months (26 weeks) of paid parental leave (taken by either parent) and continue to fund the childcare support system to assist families with the cost of child care and to ensure that lower income families will not be disadvantaged.
- 42) Strengthen health service accessibility and reach for adolescents, through funding and supporting appropriate prevention and treatment services. Achieve this through expanded telehealth GP, specialist and counselling services and building education and health promotion strategies that target risky behaviours.
- 43) Invest in developing physical and sexual health services for adolescents which complement the Government's funding of the Headspace network and build the capacity of adolescents to self-manage chronic disease in a holistic, patient-centred way.
- 44) Support relationships and good sexual health by providing sustained funding for accessible adolescent sexual and reproductive health services, including updating and harmonising delivery of sex education information, resources and tools implemented in schools, community and health settings across Australia.
- 45) Fund greater access to bulk-billed STI screening for children and young people through:
 - Ensuring children and young people can receive a full rebate for short GP consultations, regardless of their location; and
 - Funding full-service sexual health clinics in underserved areas.
- 46) Harmonise support for children and young people with chronic conditions by expanding the eligibility of the Medicare Benefits Schedule health assessment items 701, 703, 705 and 707 to include adolescents and young adults aged 10-24 year to facilitate early identification of risks and needs.

Adolescent and Young People's health – gaps in prevention and chronic care management along a health care continuum

**Specialist Training Positions
National Disability Insurance Scheme (NDIS) – improved access and processes needed**

- 47) Allow for some case by case medical specialty variations to the rural training requirement of Specialist Training Program (STP) positions.
- 48) Provide a health care provider-initiated entry pathway into the NDIS to improve the timeliness of the application process and ensure that participants and their families, who are often under time and financial pressure dealing with the disability, have support in navigating a complex system.
- 49) Invest in the development of integrated, interagency models of care that will ensure that NDIS participants and their families don't need to retell their stories over again; effectively coordinate intervention, especially for those people with complex needs or vulnerabilities.
- 50) Fully implement the National Framework for Quality and Safeguards in order to protect NDIS participants from potential abuse by service providers.

Climate Change and Health

- 51) Commit to ensure that planners and service providers are supported to develop sufficient expertise so that they may provide adequate support for participants with high or complex needs.
- 52) Fund more tailored supports to those with difficulties accessing the NDIS, including people with limited English and communication difficulties, and intellectual disability.
- 53) Introduce “immediate response” policies and procedures to ensure support for children with significant changes or deterioration in skills or behaviour.
- 54) Ensure that vulnerable groups, for example children in out-of-home care, who were given priority access under previous schemes, do not experience undue delays in accessing NDIS funded services.
- 55) Support the development of multidisciplinary services that focus on providing high quality clinical care for adults with complex needs relating to disability and associated medical and mental health conditions by:
 - Developing specific MBS item numbers for the assessment and management of adult patients living with a disability and with complex medical care needs. This would be in line with, but an expansion of, the existing MBS 132/133 Consultant Physician Attendances for patients with chronic co-morbidities and would reflect the increased time and complexity associated with assessing and managing such patients.
 - Developing a block funding arrangement (in line with those used for rural hospitals and defined programs such as readmission prevention programs/HealthLinks) to encourage jurisdictions and public hospitals to develop dedicated clinical multidisciplinary services to support such patients both in the community and when in hospital
 - Developing mechanisms for cost recovery/transfer of non-medical care expenses associated with the admission of NDIS clients in public hospitals. At present admissions of NDIS clients to public hospitals can often relate, at least in part, to a failure of NDIS-funded community-based care. Such hospital admissions, particularly in clients with significant behavioural issues, can result in a need for substantial non-medical expenses required to employ non-clinical staff required to provide safety for both patients and staff. Such services would be provided by NDIS in the community and should be similarly funded when NDIS clients are admitted to hospital.
- 56) Escalate efforts to cut carbon emissions as Australia agreed to in the Paris Agreement,¹ including expediting a transition from fossil fuels to zero emission renewable energy, with support to affected communities.
- 57) Establish a national healthcare environmental sustainability unit to reduce the carbon footprint of the healthcare sector.
- 58) Develop a national climate change and health strategy for Australia, including:
 - policies to address the adverse health effects of climate change
 - policies that harness health co-benefits of action
 - strategies for heat hazard reduction
 - meaningful mitigation and adaptation targets
 - effective governance arrangements
 - professional and community education
 - effective intergovernmental collaboration
 - a strong research capacity.
- 59) Provide funding and resources to support Pacific Island countries to mitigate and adapt for climate change and to develop their medical workforce.

¹ Paris Agreement of the United Nations Framework Convention on Climate Change, opened for signature 22 April 2016 (entered into force 4 November 2016) https://unfccc.int/sites/default/files/english_paris_agreement.pdf

A strategy to prevent disease and support health

The RACP supports the Australian Government in recognising the need for a national preventative health strategy. We need strong investment in evidence-based prevention to curb the growing burden on patients and the health care system.

This is an urgent priority because:

- Nearly 40 percent of Australia's total burden of disease can be attributed to modifiable risk factors, primarily an unhealthy diet, risky substance use and or low healthy activity level;²
- The number of Australians with chronic multi-morbidities is growing;
- Australia spends only 1.34 percent of its health budget on prevention – this is considerably less than countries such as Canada, New Zealand and the United Kingdom.³

On average, for every dollar invested in prevention, up to six dollars are returned in economic benefits.⁴ To put it simply, we can no longer afford not to invest in prevention. Two serious nationwide population health problems are obesity and alcohol consumption.

1. **Obesity.** Australia has one of highest rates of obesity: nearly one in three adults are obese and being overweight or obese is now the leading preventable cause of illness. Overweight accounts for 8.6 percent of health expenditure and reduces workforce output by the equivalent of over 370 thousand full-time workers per year.⁵
 - Obesity increases the risks of significant non-communicable diseases such as type 2 diabetes, cardiovascular disease, obstructive sleep apnoea and many types of cancer; obesity-related musculoskeletal conditions, pain and osteoarthritis can make mobility and physical activity difficult.
 - People with obesity may experience mental health conditions and are at an increased risk of exposure to bullying, stigma and bias.
 - The rate of childhood obesity is growing, translating into an increasing number of people who will experience otherwise preventable conditions earlier in life, including Type 2 diabetes mellitus (T2DM), which disproportionately affects, in particular, children from Aboriginal and Torres Strait Islander backgrounds as well as children from Southeast Asian, Indian and especially Pacifica backgrounds.
 -
2. **Alcohol.** Alcohol is the most harmful drug in Australia and a leading contributor to disease.
 - Alcohol is responsible for 4.6 percent of the total disease burden and is a factor in over 30 diseases and injuries, such as alcohol use disorder, eight types of cancer, chronic liver disease, and twelve types of injuries (including road traffic injuries, suicide and self-inflicted injuries).⁶
 - The most comprehensive available data estimated that alcohol and other drug use cost Australia \$55.2 billion a year, including costs to the health system, substance-attributable crime costs, lost workplace productivity and road accidents.⁷
 - Another billion per year is needed to treat between 200,000 and 500,000 Australians who are unable to access treatment because demand is not able to be met.^{8 9}
 - Australia has one of the highest rates of Foetal Alcohol Spectrum Disorder (FASD) in the world and alcohol is the commonest preventable cause of neurodevelopmental disability.

² Australian Burden of Disease Study: impact and causes of illness and death in Australia 2015 AIHW 2019

³ Jackson H, Shiell A. Preventive health: How much does Australia spend and is it enough? Foundation for Alcohol Research and Education 2017

⁴ The Heavy Burden of Obesity: the Economics of Prevention in Australia, in The Heavy Burden of Obesity OECD 2019 <https://www.oecd.org/australia/Heavy-burden-of-obesity-Media-country-note-AUSTRALIA.pdf>

⁵ The Heavy Burden of Obesity

⁶ Impact of alcohol and illicit drug use on the burden of disease and injury in Australia: Australian Burden of Disease Study 2011 AIHW 2018

⁷ Alcohol, tobacco & other drugs in Australia AIHW 2019.

⁸ Ritter A, Berends L, Chalmers J, Hull P, Lancaster K, Gomes M. New Horizons: The review of alcohol and other drug treatment services in Australia, Final Report University of New South Wales National Drug and Alcohol Research Centre 2014

⁹ RACP calls on Government to increase investment in drug and alcohol treatment services. A RACP media release; January 2018 <https://www.racp.edu.au/news-and-events/media-releases/racp-calls-on-government-to-increase-investment-in-drug-and-alcohol-treatment-services>

The RACP recommends that the Australian Government:

- Implement and fund a **national population-wide preventative health strategy**. Monitoring and evaluating the effectiveness of preventative health interventions must be part of the resourcing. This strategy should also incorporate concerted action to reduce rates of Type 2 Diabetes Mellitus and its downstream complications and include targeted primary and secondary prevention to retain young people and their carers in populations at risk in ongoing follow-up.
- Prevent further increases in the rate of obesity in the Australian population through a **national COAG-led strategy** on obesity. The RACP recommends a tax on sugar-sweetened beverages to reduce consumption and dedicated funding for states and territories to provide equitable access to bariatric surgery for public hospital patients.
- Reduce alcohol-related harm to health by replacing the current **Wine Equalisation Tax (WET) and rebate system with a volumetric taxation scheme** for all alcohol products.
- Allocate a proportionate percentage of the revenue raised from volumetric taxation to funding alcohol and other drug prevention and treatment services as part of a coordinated national response to substance use disorders.
- Invest in **alcohol and other drug treatment sector reform** through multidisciplinary workforce development, investment in physical infrastructure and addressing unmet demand for treatment.
- Set a national best-practice policy for a minimum price per standard drink to be implemented through states and territories in Australia.

Chronic co-morbidities: resources for a gap in care

Presentations to practitioners with complex conditions are increasing¹⁰.

Over 80% of Australians are estimated to have at least one chronic condition or risk factor¹¹. As the rates of people living with complex and co-morbid conditions continue to rise, the Government is bearing the cost of unnecessary or avoidable use of high cost points of care relating to avoidable exacerbations and deterioration of conditions resulting in increased demand for hospital services as well as duplicated pathology and other services and inappropriate referrals. Delays to secondary care are associated with poorer health, and this is to be avoided, especially for high-risk populations¹².

In particular, there is a gap in the provision of effective care for intermediate risk patients who need both a general practitioner (GP) and consultant physician. These are complex patients who cannot be appropriately serviced either solely or mainly by GPs (this group are distinct from high-volume hospital service users for whom pre-emptive intervention may not have a significant impact). For the Federal budget, better addressing this gap in care may lead to a reduction in avoidable hospital admissions for this cohort¹³.

For ‘intermediate’ patients with chronic, complex and multiple healthcare needs, there must be a **new health system structure in which specialists can collaborate with other healthcare professionals** to diagnose, treat, co-manage care for these patients; and direct **connecting pathways for specialists to work in community-based** ambulatory settings. We advocate for integrated care approaches - across hospital, community and primary healthcare settings. **The RACP considers that a more integrated care system will particularly benefit currently under-serviced groups, including Aboriginal and Torres Strait Islander peoples. Indeed, the community controlled model has long shown the benefits of a culturally safe, more integrated approach to the provision of care.**

The RACP recommends that the Australian Government:

- **Fund a model of care for the management of patients with comorbid chronic health conditions**, that formalises and supports the integration of consultant physician care ([the RACP Model of Chronic Care Management](#) or a variation). The Government’s implementation should be staged, starting with a small number of proof of concept sites, with outcomes monitored, as part of a comprehensive evaluation plan.
- Designate and resource a **new chronic care coordinator role** (nursing role) initially in proof of concept sites (refer above), as a point of contact to multidisciplinary teams and patients.
- Address infrastructure gaps to **support patient access to physician services in ambulatory settings**, such as:
 - Medicare Benefits Schedule (MBS) reforms or other financial incentives to support direct communications between GPs and specialists in the management of chronic disease patients (for example, with and without the patient present) outside of case conferences.

¹⁰ Braude, P., Fertleman, M. and Dhesi, J.K., 2017. Collaborative working: who is responsible?. *Future Hospital Journal*, 4(2), pp.138-141.

¹¹ Britt, H., Miller, G.C., Henderson, J., Bayram, C., Harrison, C., Valenti, L., Pan, Y., Charles, J., Pollack, A.J., Wong, C. and Gordon, J., 2016. *General practice activity in Australia 2015–16*. Sydney University Press.

¹² Huang, X. and Rosenthal, M.B., 2014. Transforming specialty practice—the patient-centered medical neighborhood. *New England Journal of Medicine*, 370(15), pp.1376-1379.

¹³ Australian Institute of Health and Welfare 2018. Australia’s health 2018. Australia’s health series no. 16. AUS 221. Canberra: AIHW

Consultant physician services can be more accessible through digital health and telehealth

Low levels of health service integration lead to gaps in care, conflicting advice or treatments, service duplication and wastage of resources. Digital health technology needs to be embedded in our health system to help address the fragmented service delivery, poor connectivity and information transfer across health sectors and organisations.

An estimated 18 percent of medical errors in Australia are due to incomplete or inaccurate patient information¹⁴, while medical tests are currently duplicated for over 10 per cent of adults with chronic conditions¹⁵. Annually, approximately 230,000 Australians are hospitalised due to medication error and adverse drug reactions.¹⁶

Strategic use of digital health and telehealth can help address major challenges to the health system, such as inequitable access, an ageing population, the gap in Indigenous health outcomes, chronic disease and workforce issues, resulting in reductions in medication errors and better access to health services. This needs strong intervention on the part of the Australian Government to deliver better real-time support to connect consultant physicians to patient care services.

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

The RACP supports the Government's drive to extend the availability and effectiveness of digital health and telehealth – it must now ensure Australians (of all age groups, including families) have more equitable access to specialist care.

The RACP recommends that the Australian Government:

- Provide a modest Practice Incentive Payment for consultant physicians to support better digital infrastructure for inter professional/organisational communication. The Australian Digital Health Agency could play a role in ensuring interoperability and consistent standards to deliver fully integrated services.
- Remove the distance requirement from the MBS items supporting specialist telehealth consultations.
- Consider further measures to reduce the barriers for physicians to use telehealth because of the infrastructure requirements– these might include additional technology and administrative support (telehealth equipment, scheduling software, mechanisms to collate and email patient records and investigation results).

¹⁴ Jolly, R. 2011, The e health revolution - easier said than done, Parliamentary Library Research Paper, 17 November, 3, Department of Parliamentary Services.

¹⁵ Schoen C, Osborn R, How SK, Doty MM, Peugh J. In chronic condition: experiences of patients with complex health care needs, in eight countries, 2008. Health Aff (Millwood). 2009 Jan-Feb;28(1):w1-16

¹⁶ Australian Commission on Safety and Quality in Health Care. (2013). Literature Review: Medication Safety in Australia. ACSQHC, Sydney

Long term funding needed for Aboriginal and Torres Strait Islander health

Australia is a rich country with high quality infrastructure and a world-class health system.

Aboriginal and Torres Strait Islander peoples provide a continuous link to upwards of 60,000 years of culture on this continent.

Yet Australia's Aboriginal and Torres Strait Islander people continue to suffer an unacceptable incidence of chronic disease and experience disadvantage and barriers to accessing appropriate and effective health care. Despite these long-standing inequities, progress has been slow in reducing the health gap and concerted, sustained action continues to be urgently needed. Short term funding allocations do not help as they undermine the ability to build capacity to respond effectively to Aboriginal and Torres Strait Islander health issues.

A recent challenge has been ongoing outbreaks of syphilis across Australia affecting Aboriginal and Torres Strait Islander people, occurring in the context of increasing rates of other sexually transmitted infections (STIs) and some blood borne viruses (BBVs)¹⁷. Long term funding is therefore needed to address high rates of sexually transmissible infections in these communities.

The RACP recommends that the Australian Government:

- Legislate for guaranteed long-term funding to progress the **strategies and actions identified in the National Aboriginal and Torres Strait Islander Health Plan (NATSIHP) Implementation Plan** commensurate with the burden of disease.
- Commit to secure, long-term funding for the **Rural Health Outreach Fund (RHOF) and Medical Outreach Indigenous Chronic Disease Program (MOICDP)** commensurate with the burden of disease.
- Commit to secure, long-term funding for comprehensive primary health care, community-led sexual health programs and specialised sexual health services to deliver Sexually Transmitted Infections (STIs) and Blood Borne Viruses (BBVs) services, and to ensure timely and culturally supported access to specialist care in all regions
 - Within this framework, explore with State and Territory governments reciprocal funding arrangements whereby Commonwealth contributions are matched by commitments by State and Territory governments to fund specialist services to complement, augment and support comprehensive primary health care in the provision of sexual health services.
- Fund the implementation plans of the National Blood Borne Virus and Sexually Transmissible Infection Strategies to ensure the implementation plan activities are delivered and targets achieved.

¹⁷ Kirby Institute. (2018). Bloodborne viral and sexually transmissible infections in Aboriginal and Torres Strait Islander people: annual surveillance report 2018. Sydney: Kirby Institute, UNSW Sydney.

Safer, effective care for older persons

The infrastructure of the aged care system is **not sufficiently resourced to safely and effectively meet present and future demand**. Sources of service pressure stem from:

- increasing numbers of people aged over 65;
- the increasing proportion of people with chronic conditions (older people and those becoming older);
- the negative impacts of divided funding responsibilities (between State and Federal governments); and
- the need to reduce avoidable and preventable hospital admissions which can have serious risks for older people.

Avoidable hospital admissions, which are a significant cost to government, especially avoidable hospital admissions for residents of residential aged care, **should be reduced**; this can be achieved, for example, **through integrated care approaches, more accessible physician and GP care**, care closer to home, including outreach services to residential care, rehabilitation and restorative care and ensuring there are sufficient support services.

The Australian Government needs to ensure that older people are not receiving delayed care or putting off obtaining health care due to poor service organisation, insufficient resourcing and fear of out of pocket cost. Not addressing these issues in a timely manner can lead to higher **demand for acute, secondary and tertiary care** when conditions have progressed, which also constitutes and even higher risk to an older person.

The RACP's recommendations, extracted here from our submission to the Royal Commission¹⁸, stress the need for comprehensive early assessment (including recognition of delirium), particularly in rural areas, improved culturally appropriate services for Aboriginal and Torres Strait Islander people, and adequate well-designed community support (including residential aged care facilities, home care packages and health service navigation supports).

The RACP recommends that the Australian Government:

- Guarantee continued funding for subsidised access to Comprehensive Geriatric Assessments (CGA) and specifically cover Aboriginal and Torres Strait Islander people over the age of 50, as they are eligible for aged care services.
- Provide accessible multidisciplinary comprehensive assessments for older patients in hospital and community care settings. The assessment services should have strong links with Geriatric Evaluation and Management (GEM) Units; existing geriatric services; and have a clear point of contact.
- Work jointly with State and Territory governments to train community based multidisciplinary teams which can undertake assessment services of dementia and delirium, accompanied by an appropriate management strategy for all hospitals and Residential Aged Care Facilities (RACFs). The number of community based, fully resourced dementia and delirium assessment and management services available in metropolitan and rural areas must be increased.
- Consider provision of My Aged Care support personnel to assist with navigating the system, allocation of funding, and selection of service providers.
- Enhance investments in the healthcare of older for Aboriginal and Torres Strait Islander older people by:
 - Establishing models of medical service provision and sustainable funding which ensure equitable and appropriate access for Aboriginal and Torres Strait Islander older people to consultant physician, palliative medicine and geriatric medicine services, across varying locations.
 - Reduce the barriers Aboriginal and Torres Strait Islander older people experience in relation to health services (including through investing in improving the cultural competency of healthcare professionals).
 - Provide additional funding for palliative care services for Aboriginal and Torres Strait Islander older people, especially in non-urban areas.
- Invest in additional research into dementia care.

¹⁸ [RACP 2019 Submission to the Royal Commission into Aged Care Quality and Safety](#).

- Increase the availability of Home Care Packages (HCPs) to eliminate delays in access which frequently lead to progressive impairment and loss of independence.
- Enhance funding to ensure adequate training in dementia care to all service providers.
- Establish and recurrently resource Primary Care Dementia Nurses positions in primary healthcare with the view towards also deploying these positions to purpose-built dementia units for those with significant Behavioural and Psychological Symptoms of Dementia (BPSD) who cannot be managed by non-pharmacological means and/or are aggressive and physically able.
- Review and improve the design of RACFs to more effectively customise their services to the population being served, for example, by delivering appropriate physical facilities where the majority of older persons have intellectual disabilities.
- Ensure there is sufficient funding to meet the needs in ambulatory and community settings (including RACFs) for appropriately qualified palliative medicine, geriatric medicine and other physicians and advanced trainees.
- Work with State and Territory governments to develop and fund better integrated and co-ordinated care between primary care and secondary care for older patients. For example, this could include integrated care models such as that described in the RACP Model of Chronic Care Management.

Good end-of-life care is not meeting demand

The demand for good end-of-life and palliative care is increasing in response to Australia's ageing population, including the rise in the prevalence of cancer and other chronic diseases associated with ageing. In 2019-20 approximately 160,000 Australians will have died; over 200,000 people will die in 2030 - a 25 % increase.¹⁹

End-of-life care, an essential part of health care, is not resourced sufficiently to meet the needs of Australian patients and their loved ones as demand increases. Well-designed and integrated end-of life care is not only a critical health and social service but is more cost-effective particularly when compared with an in-hospital stay.²⁰

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

The number of people wishing to die at home with the support of a community-based palliative care service far exceeds the availability of that care, especially for those with non-cancer conditions.²¹

For too many Australians, access to community-based end-of-life care is dictated by where they live rather than their wishes. **Resources must be allocated towards supporting patients wishing to access end-of-life care at a setting of their choice, be it at home, in a hospice or in a residential aged care facility.**

End-of-life and palliative care spans multiple sectors, including health, aged care, community care, disability care and mental health. To ensure that funding committed to end-of-life care leads to sustained improvement in patient outcomes and experiences, it is imperative that all state and territory governments endorse palliative care and end-of-life care as a key priority for the COAG Health Council.

The RACP recommends that the Australian Government:

- Prioritise end-of life-care as part of COAG's agenda and establish collaborative arrangements with the States and Territories to address the **urgent need for population-based integrated models of care** to ensure **access to appropriate end-of-life care for all Australians;**
- Address **the existing gaps in service delivery** by providing secure, long-term funding to:
 - increase the volume, and improve the coordination and delivery of community specialist palliative care services across the lifespan in ways that support integration with hospital services and primary care services and are delivered in conjunction with equitable, accessible, flexible and responsive social and community services; and
 - develop and implement models of care that improve the availability of palliative and supportive care services across all age groups, with a focus on non-cancer services in hospitals and in other settings such as residential aged care facilities, people's homes, in rural and remote communities (including via telehealth) and among other underserved populations
- Substantially expand the Comprehensive Palliative Care in Aged Care package to fund additional specialist doctors and nurses across Australia to meet the unmet needs of patients who would benefit from the delivery of high-quality palliative and end-of-life services **in residential aged care settings.**

¹⁹ Australian Bureau of Statistics, 3222.0 Population Projections, Australia, 2012 (base) to 2101.

²⁰ The Economic Value of Palliative Care and End-of-Life Care Palliative Care Australia 2017

²¹ The Economic Value of Palliative Care

Invest in children’s health – build integrated, accessible, multidisciplinary care

There is substantial evidence that investment in the early years of children’s health, development and wellbeing is the most cost-effective means of tackling long-term health conditions and health inequity. Investing in the early years offers the possibility of shifting the trajectory of a person’s health over the course of their life and disrupting intergenerational cycles of disadvantage. By tackling health inequities, societies can not only achieve better health overall but also reap “spill over” benefits on non-health outcomes such as social, educational and workforce inclusion and crime reduction. Significant economic benefits flow from providing strong and truly universal child health and education services that are proportionate to a population group’s needs, especially when those children most at need have the greatest access to quality services.

The RACP’s Position Statements in [Inequities in Child Health](#) and [Early Childhood: The Importance of the Early Years](#) outline key actions that governments can take to achieve fairer access to healthcare and more equitable health outcomes for all Australian children.

The RACP recommends that the Australian Government:

- Fund the provision of a minimum schedule of universal preventative health care interventions, to be delivered at point of vaccination to both babies and mothers.
- Invest in paediatric child health services that are universally available and with a scale and intensity that is proportionate to the level of disadvantage.
- Fund expanded home visit programs, particularly in rural and remote areas, and for families who experiencing high levels of stress or disadvantage. The programs should include implementing a universal, sustained postnatal home visiting programme and providing support to all parents for the first 10 days after birth, with the possibility to extend the programme for families experiencing high levels of stress or disadvantage to the infant health check at 6 weeks. These must be combined with wrap-around or “child team” multiagency integrated service delivery approaches.
- Commit funding to establish and maintain an Inequities in Child Health Alliance, in conjunction with several leading Australian universities, policy groups and health services.
- Develop, implement and appropriately fund better coordination between primary/secondary and specialist mental health services or infants and children, including funding for promotion, prevention, early intervention and treatment if required.
- Fund antenatal and postnatal parental education about foods, micronutrients and other items which carry risks to the foetus.
- Fund the development, implementation, evaluation and scaling up of integrated early childhood programmes designed to improve access to child and allied health, as well as social care services
- Commit to long-term, sustainable funding of the National Partnership on Universal Access to Early Childhood Education beyond 2020–21 for all Australian children and expand it to starting at three years old.
- Immediately reinstate the Australian Health Ministers' Advisory Council (AHMAC) principal committee on child and youth health to provide strategic guidance on the prioritisation and delivery of child and youth health programs.
- Extend paid parental leave policy to provide up to 6 months (26 weeks) of paid parental leave (taken by either parent) and continue to fund the childcare support system to assist families with the cost of child care and to ensure that lower income families will not be disadvantaged.

Adolescent and Young People’s health – gaps in prevention and chronic care management across sectors

Adolescence presents an opportunity for health interventions to positively influence young people’s health for the rest of their life. The onset of puberty begins a period of profound physical growth and neurological development. Establishing healthy habits in adolescence, when health behaviours related to non-communicable diseases are adopted, contributes to significantly improved health outcomes and is likely to lead to reduced health costs throughout adulthood²².

Optimal care is culturally, age and developmentally appropriate and delivered from a youth-friendly perspective. Young people experience a range of barriers to good health and in being able to access appropriate health services that are different to adults and children. These barriers include: a lack of aged-based health assessments available for young people, fragmented health services across paediatric, adult and community health services, challenges navigating the health system and a lack of services targeted to the specific health needs of young people.

Funding and support for prevention services are particularly important for young people, as is investing in their capacity to self-manage chronic disease. The RACP recognises the significant improvements to youth mental health funding in the 2019-2020 budget, but they need to be complemented by commensurately increased access to appropriately designed physical health prevention services. Effective mental health care, alongside quality physical health care, provided early, reduces avoidable hospital and emergency department admissions and takes pressure off the health system²³.

Young people have the right to information, education and clinical care that supports healthy sexual development and informed choices, and minimises the risk of coercion, unplanned pregnancy, sexually transmitted infection and other unwanted or unintended consequences, including emotional, psychological, social and cultural consequences.

The RACP recommends that the Australian Government:

- Strengthen health service accessibility and reach for adolescents, through funding and supporting appropriate prevention and treatment services. Achieve this through expanded telehealth GP, specialist and counselling services and building education and health promotion strategies that target risky behaviours.
- Invest in developing physical and sexual health services for adolescents which complement the Government’s funding of the Headspace network and build the capacity of adolescents to self-manage chronic disease in a holistic, patient-centred way.
- Support relationships and good sexual health by providing sustained funding for accessible adolescent sexual and reproductive health services, including updating and harmonising delivery of sex education information, resources and tools implemented in schools, community and health settings across Australia.
- Fund greater access to bulk-billed STI screening for children and young people through:
 - Ensuring children and young people can receive a full rebate for short GP consultations, regardless of their location; and
 - Funding full-service sexual health clinics in underserved areas.
- Harmonise support for children and young people with chronic conditions by expanding the eligibility of the Medicare Benefits Schedule health assessment items 701, 703, 705 and 707 to include adolescents and young adults aged 10-24 year to facilitate early identification of risks and needs.

²² Patton, G.C., Sawyer, S.M., Santelli, J.S., Ross, D.A., Afifi, R., Allen, N.B., Arora, M., Azzopardi, P., Baldwin, W., Bonell, C. and Kakuma, R., 2016. Our future: a Lancet commission on adolescent health and wellbeing. *The Lancet*, 387(10036), pp.2423-2478.

²³ National Mental Health Commission., 2016. Equally Well Consensus Statement: Improving the physical health and wellbeing of people living with mental illness in Australia.

Specialist Training Positions

The RACP acknowledges the importance of developing specialist training arrangements beyond traditional metropolitan teaching settings in public hospitals. A prime objective of the Specialist Training Program (STP) is to enhance the capacity of the health care sector to provide high quality, appropriate training opportunities by increasing training in health care settings beyond traditional metropolitan public teaching hospitals. The College is concerned the new private and rural training target for STP positions, set by the Department of Health, will adversely impact some specialties who are already meeting the STP objectives and who will be unable to replace these positions through other channels.

The RACP administers a substantial number of STP positions in both rural and private settings and provides the opportunity for expanding the emerging and changing areas of medical specialty. However, there will be significant difficulties for some specialties to meet the new requirement for at least 50 percent of the training to be in private or rural settings. The reasons are:

- There are thirty-three different specialty training areas within the RACP. Training requirements vary due to the nature of the specialty areas and not all training areas have appropriate supervision in non-metropolitan areas.
- Training may have to take place in metropolitan locations for a medical trainee to complete the specialty training.

For example, in specialties such as Community Child Health (a relatively new speciality) the curriculum requires that the trainees attend at units and other specialist metropolitan clinics to enable family access. While some of these positions can be classified as private settings, quite a number would be classified as public metropolitan training settings.

Therefore, the RACP requests reconsideration of this new requirement. This is to mitigate the risk of potential adverse impact and variation, and to continue to meet safe, high quality and comprehensive training standards.

The RACP recommends that the Australian Government:

- Allow for some case by case medical specialty variations to the rural training requirement of Specialist Training Program (STP) positions.

National Disability Insurance Scheme (NDIS) – improved access and processes needed

The RACP strongly supports the NDIS, its underlying values and principles. Good health is fundamental to wellbeing for all people, including those living with disability. It helps them to participate in their community, to cope with life's adversities, and to set and achieve their goals. Further investment in improving NDIS access and processes will significantly improve the lives of children, young people and adults living with disability, spanning a range of areas like choice and control, daily activities, relationships, health and wellbeing, lifelong learning, work and community participation.

However, the NDIS is complex, hard to navigate and access is highly variable, particularly for vulnerable groups of people. There are gaps and complications that arise for NDIS participants throughout the NDIS access, planning, reviews and appeals processes. The level and quality of support for participants also varies greatly.

While we acknowledge the power of a client/carer driven application process, it is apparent that vulnerable families who need NDIS support most often struggle to gain an understanding of the system or simply cannot find the time to fill out the forms. It is therefore strongly recommended that the Government provide a Health Care Provider initiated entry into the NDIS.

The Access Request Form is itself unclear about whether it needs to be completed by a participant or treating health professional, and if it is not completed by a professional, what supporting information is needed. It has been reported that the Access Request Form does not currently appropriately reflect and explain NDIS eligibility requirements to participants and because of this, key details are not included by them. As a result, people miss out on the NDIS because of a 'poor' application, not because they are ineligible.

Investment in more streamlined access and planning processes that include direct communication (telephone or face to face) with participants and their families would expedite decision making, shortening waiting periods for access and plan development, and improving the suitability of plans for participants.

As a longer-term reform to further improve access to disability services we recommend that the Federal Government support the development of multidisciplinary services that focus on providing high quality clinical care for adults with complex needs relating to disability and associated medical and mental health conditions. Such services should focus on patients living with disability and their carers as they both transition from paediatric to adult care and for ongoing care of adults. Current medical-based multidisciplinary care arrangements (incorporating specialist doctors (mostly Fellows and Members of the RACP) and allied health care providers are extremely limited given the lack of a viable funding modes to support these. This can often lead to preventable complications, reduced quality of life and hospital admissions with attendant disruptions and distress for existing community-based care arrangements.

The RACP recommends that the Australian Government:

- Provide a health care provider-initiated entry pathway into the NDIS to improve the timeliness of the application process and ensure that participants and their families, who are often under time and financial pressure dealing with the disability, have support in navigating a complex system.
- Invest in the development of integrated, interagency models of care that will ensure that NDIS participants and their families don't need to retell their stories over again; effectively coordinate intervention, especially for those people with complex needs or vulnerabilities.
- Fully implement the National Framework for Quality and Safeguards in order to protect NDIS participants from potential abuse by service providers.
- Commit to ensure that planners and service providers are supported to develop sufficient expertise so that they may provide adequate support for participants with high or complex needs.
- Fund more tailored supports to those with difficulties accessing the NDIS, including people with limited English and communication difficulties, and intellectual disability.
- Introduce "immediate response" policies and procedures to ensure support for children with significant changes or deterioration in skills or behaviour.

- Ensure that vulnerable groups, for example children in out-of-home care, who were given priority access under previous schemes, do not experience undue delays in accessing NDIS funded services.
- Support the development of multidisciplinary services that focus on providing high quality clinical care for adults with complex needs relating to disability and associated medical and mental health conditions by:
 - Developing specific MBS item numbers for the assessment and management of adult patients living with a disability and with complex medical care needs. This would be in line with, but an expansion of, the existing MBS 132/133 Consultant Physician Attendances for patients with chronic co-morbidities and would reflect the increased time and complexity associated with assessing and managing such patients.
 - Developing a block funding arrangement (in line with those used for rural hospitals and defined programs such as readmission prevention programs/HealthLinks) to encourage jurisdictions and public hospitals to develop dedicated clinical multidisciplinary services to support such patients both in the community and when in hospital
 - Developing mechanisms for cost recovery/transfer of non-medical care expenses associated with the admission of NDIS clients in public hospitals. At present admissions of NDIS clients to public hospitals can often relate, at least in part, to a failure of NDIS-funded community-based care. Such hospital admissions, particularly in clients with significant behavioural issues, can result in a need for substantial non-medical expenses required to employ non-clinical staff required to provide safety for both patients and staff. Such services would be provided by NDIS in the community and should be similarly funded when NDIS clients are admitted to hospital.

Climate Change and Health

The contribution of climate change to mortality and morbidity is leading to a serious health emergency that requires urgent and decisive government action.²⁴ Australia's slow policy response to the impacts of climate change on human health puts pressure on healthcare services and personnel. Promoting and protecting human health is the core business of healthcare, necessitating a call for the urgent transition to zero emission renewable energy.

Anthropogenic climate change is real and urgent action is warranted to stop warming at 1.5°C, as evidenced in the 2018 Intergovernmental Panel on Climate Change (IPCC) Special Report on Global Warming of 1.5°C.²⁵

The reality of climate change can be seen in these health impacts:

- Australians are already suffering higher rates of respiratory illness, diarrhoea and morbidity requiring hospital admission during hot days, and experiencing higher rates of suicide in rural areas during drought years.
- Extreme heat events in Australia have been more fatal than all other natural hazards combined and will increase without climate action and adaptation.²⁶ We note 2018 was Australia's third-warmest year on record, with extreme temperatures and an extended period of heatwaves.²⁷

Coal extraction and combustion causes cardiovascular and respiratory health issues.²⁸

The Australian health sector is a significant industry that must reduce its own carbon emissions. The carbon footprint of the health sector has been estimated at 7% of Australia's total. With close to 700 public hospitals alone, more effective measures are required to lower the impact of health-care services on the environment^{29, 30}. An environmentally sustainable healthcare system would have no cumulative harmful impacts on the natural environment or society, while providing high-quality healthcare. 'Green' initiatives such as improving energy efficiency and promoting recycling are important, but healthcare organisations need to act more broadly to reduce carbon and resource use by developing integrated models of care, strengthening primary care, and optimising the use of new technologies.

The RACP calls on the Government to develop and implement a national climate and health strategy to reduce the risks to health and realise the health benefits of climate adaptation and risk mitigation. The strategy should be closely aligned with other prevention strategies such as obesity-prevention and chronic disease-reduction efforts, such as incentivising increasing physical activity through active transport and fresh vegetable intake and supporting improvements to the energy efficiency of homes and buildings. The College supports strategies that will result in improved population-wide health and environmental outcomes and urges more proactive actions on climate change health-related responses.

We also call on the Australian Government to provide support to better enable Pacific Island countries and territories to develop their medical workforce and support development and implementation of climate change mitigation and adaptation measures. The impact of severe weather events in the Pacific Islands including health impacts due to rising sea levels and biosecurity concerns will be of growing importance in the years to come.

²⁴ Solomon CG and RC LaRocque 2019. Climate Change — A Health Emergency. *N Engl J Med* 2019; 380:209-211

²⁵ Intergovernmental Panel on Climate Change Special Report on Global Warming of 1.5°C. <https://www.ipcc.ch/sr15/>

²⁶ Coates L., Haynes K., O'Brien J., McAnaney J., De Oliveira F.D. Exploring 167 years of vulnerability: An examination of extreme heat events in Australia 1844-2010. *Environmental Science and Policy* 2014; 42:33-44.

²⁷ Australian Government Bureau of Meteorology. Annual climate statement 2018 and Special Climate Statement 68.

²⁸ Castleden WM, Shearman D, Crisp G, Finch P. The mining and burning of coal: effects on health and the environment. *The Medical Journal of Australia* 2011; 195(6): 333-335. doi: 10.5694/mja11.10169

²⁹ Productivity Commission 2019 Report on Government Services

³⁰ Malik, A, Lenzen, M, et al, The carbon footprint of Australian health care, *Lancet*, 2018.

[https://www.thelancet.com/journals/lanph/article/PIIS2542-5196\(17\)30180-8/fulltext](https://www.thelancet.com/journals/lanph/article/PIIS2542-5196(17)30180-8/fulltext)

The RACP recommends that the Australian Government:

- Escalate efforts to cut carbon emissions as Australia agreed to in the Paris Agreement,³¹ including expediting a transition from fossil fuels to zero emission renewable energy, with support to affected communities.
- Establish a national healthcare environmental sustainability unit to reduce the carbon footprint of the healthcare sector.
- Develop a national climate change and health strategy for Australia, including:
 - policies to address the adverse health effects of climate change
 - policies that harness health co-benefits of action
 - strategies for heat hazard reduction
 - meaningful mitigation and adaptation targets
 - effective governance arrangements
 - professional and community education
 - effective intergovernmental collaboration
 - a strong research capacity.
- Provide funding and resources to support Pacific Island countries to mitigate and adapt for climate change and to develop their medical workforce.

³¹ Paris Agreement of the United Nations Framework Convention on Climate Change, opened for signature 22 April 2016 (entered into force 4 November 2016) https://unfccc.int/sites/default/files/english_paris_agreement.pdf