



Australian Medical Association's

# Vision for Australia's Health



**General Practice**



**Public hospitals**



**Private health**



**A health system for all**



**A health system for the future**



**Independence**



**Sustainability**



**Quality**



**Patient empowerment**



**Fostering medical leadership**



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## President's Introduction



### **Health reform in this country is sorely needed, and long overdue.**

If the Australian health system is to evolve, then it needs to be reorganised to tackle the challenges of the future. We cannot expect an underfunded system to absorb the late-stage complications of an ageing, chronically ill and obese society. Already our hospitals, especially our emergency departments, are over-stretched. We cannot keep doing things the same way.

It is realistic for Australia to become the healthiest country in the world, and that should be our collective aim.

We cannot expect to manage the increasing chronic disease burden if we do not engage earlier in prevention and appropriately fund integrated general practitioner medical homes, as the foundation for improved care co-ordination across the entire health system. Seminal in this will be the effective adoption of innovative technologies and an emphasis on quality models of care where safety and clinical appropriateness protect patients.

The beginning point of all reform should be safe, high-quality, patient-centred care.

We must engage our patients in their own healthcare and improve health literacy. We must invest in our medical practitioners to ensure appropriately funded, efficient, evidence-based practice is at the heart of any new approach to healthcare.

Investment requires vision and ethical commitment. We must invest now to correct critical deficiencies within the Australian healthcare system. Failure to do so will translate into suboptimal outcomes and declining quality of life and access for Australians in the future.

Drawing upon the expertise of our broad member base, the Australian Medical Association (AMA) is uniquely positioned to identify and understand systemic issues in the healthcare system that cut across preventative health, General Practice, public and private healthcare. Members provide advice and make policy through committees, state AMAs, and Federal Council; our vision is a product of that significant effort and expertise.

The AMA's Vision for Australia's Health represents a clear blueprint for all Governments, and players in the system, built around five pillars of detailed policy reform.

For too long, health reform has been stagnant or piecemeal. The AMA believes now is the time for a comprehensive plan to be put forward, funded and implemented. The AMA stands ready to lead reforms in these areas and is eager to partner with other organisations, providers, and individuals. Our health system has responded to the immediate threat of COVID-19, while continuing to deliver care. Now is the time for Government to respond and future proof it for the challenges ahead.

A handwritten signature in black ink, appearing to read 'Omar Khorshid'. The signature is fluid and cursive, with a distinct loop at the end.

**Dr Omar Khorshid**  
Federal AMA President

A silver stethoscope is positioned vertically on the right side of the page. The earpieces are at the top, and the chest piece is at the bottom. The background is a solid light blue color.

“

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# Health Context

**Australia's response to COVID-19 has been rapid, and largely successful. Our success owes a lot to our dedicated doctors and nurses, but equally, the Australian community.**

There were already warning signs before COVID-19 that without reform, our health system was under strain and in danger of producing an inferior outcome for patients. A rapidly aging population<sup>1</sup> has put our health system under unprecedented demand. People aged 65 and over represent 16 per cent of the population but account for 50 per cent of total admitted bed days<sup>2</sup>. Chronic disease and injury dominate the Australian health landscape, contributing nearly two-thirds of the overall burden of disease<sup>3</sup>. Obesity data suggest that 67 per cent of Australian adults and 25 per cent of children are obese or overweight. For Aboriginal and Torres Strait Islander peoples, these figures are even higher, at 74 per cent of adults and 38 per cent of children<sup>4</sup>. Chronic respiratory disease affects seven million Australians, impacting 33 per cent of Aboriginal and Torres Strait Islander peoples and 30 per cent of non-Indigenous people<sup>5</sup>. This complexity burden is increasing<sup>6</sup>, which has implications for the workforce and necessitates protection of appropriate training opportunities for medical practitioners.

Mental health represents an increasingly large proportion of the health system; 8.7 million (45 per cent) of Australian adults will experience a mental disorder in their lifetime<sup>7</sup>. Data suggest the rate of having a common mental disorder is 4.2 times higher for Aboriginal and Torres Strait Islander peoples than for the general population<sup>8</sup>. Many health professionals, including GPs, psychiatrists, and emergency physicians, are witnessing significant growth in the number of patients seeking treatment and support for their mental health. Due to decades of under-resourcing and under-staffing, public mental healthcare services were struggling to deliver accessible and high-quality care before the pandemic crisis.

Australians are waiting longer for public hospital elective surgery, with the median wait time before COVID-19 (2018-19) of 41 days, eight days longer than in 2008-09. It is our worst performance on this measure since 2001-02<sup>9</sup>. Likewise, our public hospital emergency system access block continues to worsen, increasing emergency department overcrowding which is associated with increased mortality, morbidity and length of hospital

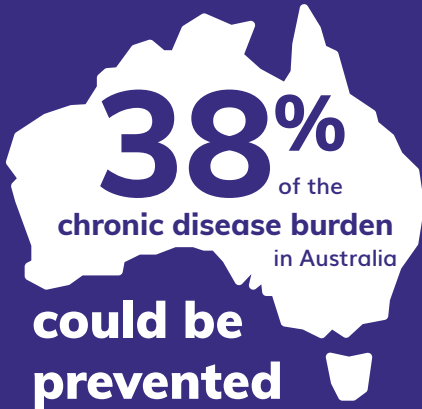
stay<sup>10</sup>. The number of available hospital beds per 1,000 residents aged 65 years or older – an important measure of public hospital capacity – has also been in persistent decline for decades<sup>11</sup>.

Australia's private health system is also facing challenges. Pre-COVID, from June 2015 to June 2020, private health insurance membership fell for 20 successive quarters. Like the broader population, the age of the insured population is increasing; while Australians aged 75 and older have increased their insurance membership by 3 per cent, 25-34 year olds have dropped a full 6 per cent, between 2015 and 2018. This creates a cycle of increasing insurance premiums as insurers seek to deal with the increased cost of care per policy holder. It creates a health system out of balance for everyone, with a dwindling funding pool<sup>12</sup>.

Australia has a maldistributed medical workforce. We have a chronic shortfall of doctors in rural and remote Australia, while more broadly some medical specialties have an oversupply, and some have an undersupply. We are training doctors at one of the highest rates in the world, but we have not identified the correct mechanisms or levers to direct the workforce where it is needed, particularly in rural and regional areas where the pressure on the public system is exacerbated by low rates of private health insurance and private practice.

General Practice is one specialty where training has been undersubscribed for three consecutive years. Australia's GPs are a central component of our health system but the extent of successive funding reductions in General Practice and loss of focus on this critical, unique function they fulfill, has diminished the coordination of care and endangered outcomes for patients. Primary healthcare professionals control or influence approximately 80 per cent of healthcare costs, with 83 per cent of patients seeing a General Practitioner (GP) each year. Yet spending on General Practice accounts for only 8 per cent of total government health spending.<sup>13</sup>

In 2017-18, 7 per cent of all hospitalisations were due to 22 preventable conditions that could be managed by General Practice. This accounted for almost 3 million bed days<sup>14</sup>. The increased prevalence of chronic health conditions has greatly increased the demand for and cost of treatments<sup>15</sup>. But with sufficiently funded longer consult item numbers GPs could have the time and resources to spend with patients with complex conditions, which would deliver major improvements for the health system.



through a reduction in modifiable risk factors such as overweight and obesity and insufficient physical activity.



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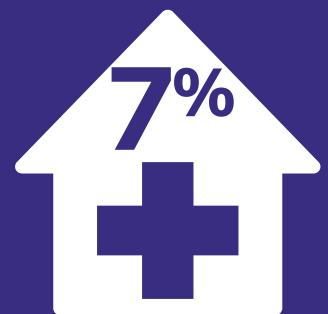
In 2018-19 more than **8.3 million patients** presented to a public hospital emergency department – an increase of **4.2 per cent** on the previous year.



We are training doctors at **one of the highest rates in the world**, but we have not identified the correct mechanisms or levers to direct the workforce where it is needed.



Primary healthcare professionals control or influence approximately **80 per cent** of healthcare costs, with **83 per cent** of patients seeing a GP each year.



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# Economic Context

**The COVID-19 pandemic remains a critical reminder of the importance of health investment as the best spend a government can make for its people, and its economy.**

With a significant increase in national deficits, it is reasonable to expect that the ability of the Government to fund significant new health expenditure will be constrained, and the dubious temptation may be to cease new spending, and instead search for savings by cutting services or delaying necessary innovation. But now is not the time to reduce spending on healthcare. A healthy society is a critical component of a healthier economy.

As Australia continues to suppress COVID-19, the health system will need to be ready to deal with dual challenges: low-level infections and outbreaks, as well as 'pent-up' demand for non-pandemic healthcare compounding routine activity. There are significant unrealised consequences of delayed care and worsening health conditions.

There are fundamental changes needed to accommodate ongoing disease identification, testing, infection control and suppression in our health system. The patient flow through health systems needs to be reconsidered, with appropriate resources, funding and infrastructure provided to accommodate the

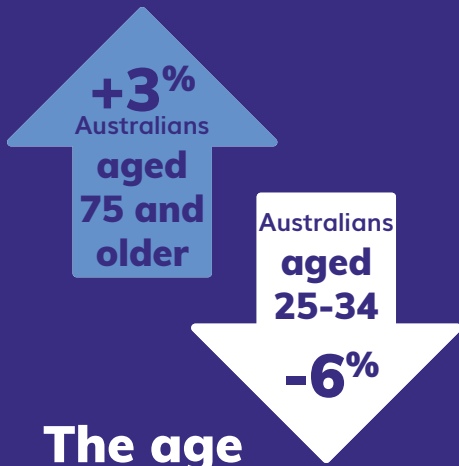
restrictions and demands required for a COVID-19 existence. This will require an expansion of our health system to respond to increased demand, recognising however that many Australians have been financially impacted by the pandemic.

Prior to the pandemic, Australia's health spending was 9.3 per cent of GDP — less than many similar countries, and close to half of the USA with its managed care model. It's clear our health funding provides a strong return on investment. The opportunity now exists to invest further into the reforms shown to be efficient and effective, such as integrated General Practice, telehealth and e-prescribing. It is important to recognise that the health sector is also a major employer, and therefore investment in health has an additional benefit in increasing economic activity and employment.

We also need to fix the historical underinvestment in health. Average Weekly Earnings increased by 4 per cent per year from 1995 to 2020, and practice costs for General Practice for example, rise by the same amount, with health inflation also 4 per cent<sup>16</sup>.

Medicare rebates only increased by 1.2 to 2.5 per cent between 1995 and 2012, before the recent Medicare freeze prevented indexation completely, furthering the erosion of rebate values into the future<sup>17</sup>. This impacts practice viability and affordability for patients and will only be more severe in harsh economic climates.

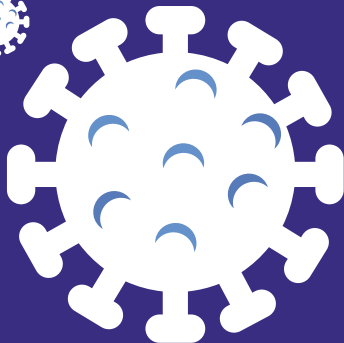
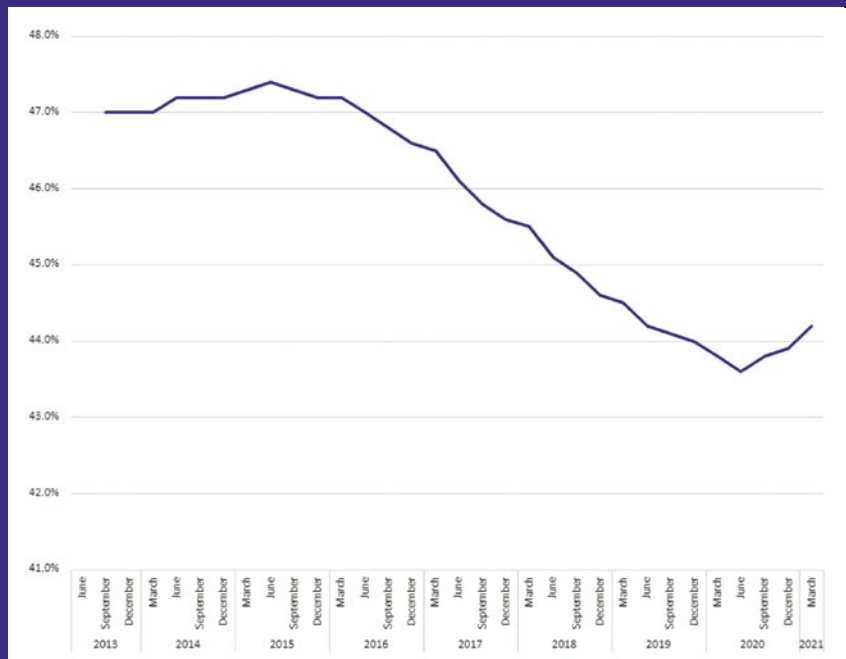




## The age of the insured population is increasing,

with Australians aged 75 and older increasing their insurance membership by 3 per cent, while 25-34 year olds have dropped a full 6 per cent, between 2015 and 2018.

Pre-COVID, from June 2015 to June 2020, **private health insurance membership** fell for 20 successive quarters.



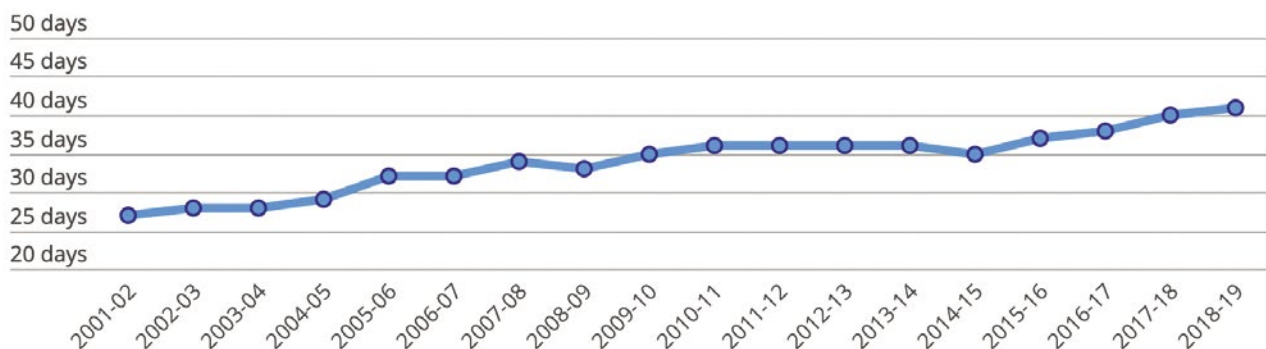
Organisation for Economic Co-operation and Development (OECD) data indicates that

**countries who were more successful at containing the COVID-19 virus are economically better off.**



Source: Smithson, M. (26 November 2020). "Data from 45 countries show containing COVID vs saving the economy is a false dichotomy." The Conversation. Retrieved 21/01/2021 from: <https://theconversation.com/data-from-45-countries-show-containing-covid-vs-saving-the-economy-is-a-false-dichotomy-150533>

## Median waiting time for elective surgery (days) - all States and Territories



**Australians are waiting longer for public hospital elective surgery, with the median wait time of 41 days - eight days longer than in 2008-09.**

Source: Australian Institute of Health and Welfare (AIHW). Elective surgery data cubes (2001-02 to 2006-07): Australian hospital statistics. Australian Institute of Health and Welfare (AIHW). Elective surgery waiting times (2007-08 to 2018-19): Australian hospital statistics.

# Medical Profession Context and Impact on Patients

**The reforms in this document are designed to improve the operation of the health system for patient and practitioner alike.**

They respond to the experiences of our members, the insights offered by our patients, and the lessons learned from our rapid reform to respond to COVID-19. They embody the principles of building a sustainable, inter-connected, high-quality health system that provides access for all, with leadership and independence of the medical profession, while empowering our patients. It is not only possible, but absolutely necessary, to ensure that any reforms to the health system support our doctors – for otherwise we will fail to improve the health of Australia's patients.

Australia's medical practitioners have shown themselves to be adaptable, knowledgeable and resilient in times of need within the healthcare system. But Australia's doctors face some significant challenges resulting from COVID-19, which are compounded by our current policy and funding settings. Public hospitals are already operating at dangerously high capacity, and this could be made worse by people presenting with late-stage disease following a reluctance to attend hospital (e.g. to partake in cancer screening) at the height of the pandemic.

COVID-19 has also had significant impacts on trainee progression and therefore the workforce pipeline into the future. Beyond COVID-19, we have medical training shortfalls in key areas, and significant areas of workforce maldistribution. At the same time, we have a projected oversupply of medical students in some specialty disciplines, creating significant training pressures and negatively impacting our ability to train the right number of doctors in the right specialties who

want to work in the right areas to meet community healthcare needs.

GPs increasingly feel disconnected from the rest of the health system and curtailed in their ability to efficiently manage a patient's care through the life cycle. Despite being at the centre of the medical system, expansions in the scope of practice in allied health, an increasingly fractured model of health service delivery, and extreme financial pressures mean the next generation of GPs face significant challenges. Meanwhile the current generation feel beleaguered and under-appreciated, lamenting the lack of focus on prevention and innovation.

Our hospital doctors deal with the most complex life-saving treatments, 24 hours a day, seven days a week. Yet the AMA's research has shown many doctors are working dangerously unsafe hours, putting them at a higher risk of fatigue to the extent that it could impact on performance, and affect the health of the doctor and the safety of the patient. Patients continue to wait longer for treatment. Aboriginal and Torres Strait Islander doctors continually experience instances of racism and discrimination from patients and peers, which impacts the cultural safety of hospitals and clinics<sup>18</sup>. Funding agreements continue to drive quantity and haste, not quality and training.

The prolonged COVID-19 shutdown, financial pressures stemming from insurer changes, and reduced private health coverage threaten access to the critical private health pillar of the system. Complicated, variable insurance policies often leave patients confused and unknowingly underinsured, or significantly out of pocket. Practitioners often bear the brunt of a system in need of urgent further reform. In addition, the private system has not been funded to adapt to the ongoing changes needed to deal with COVID-19.



# Core Principles

**Core Principles for a Stronger Health System: The AMA's vision is underpinned by core principles that the AMA considers necessary for any success in health reform.**



## **Access to appropriate healthcare for all Australians by:**

- Accessible, integrated, navigable and convenient medical-led care, coordinated through nominated General Practice.
- Informed by the COVID-19 experience, a new approach to health coordination across jurisdictions, with doctors leading well-coordinated patient-centered care within and across health systems, (enhanced by technology).
- Patient-centered focus on prevention and wellness with engagement in care.
- Specific consideration of Indigenous Australians, and those impacted by economic downturn.
- Investment in models of care that improve geographic variation in healthcare opportunity.



## **Independence of the medical profession by:**

- Ensuring accessible, integrated, navigable and convenient medical-led care, coordinated through nominated General Practice.
- Protecting the health system from any form of funder-led, managed care.
- Ensuring the future of private practice — promote a system supported with fair Medicare and private health insurance patient rebates.
- Building a system that is efficient, transparent and accountable with a focus on evidence-based care.



## **Sustainability of the medical workforce and healthcare system by:**

- Acknowledging the diversity of the medical workforce and assuring doctor satisfaction with work conditions. Providing conditions that are safe and free of bullying and discrimination, ensuring an environment that is free from racism, and promoting greater representation of women.
- Promoting efficient use of resources and cultivating systems/targets that use healthcare resources efficiently with reduction in waste.
- Acting on health determinants beyond the control of the healthcare system, particularly climate impacts and social determinants of health.
- Providing a vision of Australia's future medical workforce, with clear training pathways and solutions to rural medical workforce needs and distribution.



### **Quality of the medical system by:**

- Embracing data and international evidence to improve quality, rather than taking a punitive approach based on existing policy or funding constraints of new technology.
- An ongoing profession-wide commitment to excellence and patient-centred care.
- Introducing new technologies that deliver doctors' and patients' health information seamlessly across different parts of the health system.
- Committing to appropriately resourced and accessible teaching and research.



### **Patient empowerment to ensure that people can take charge of their health by:**

- Ensuring choice within the private system by making it affordable for more Australians.
- Striving to introduce technology that promotes engagement, interaction and access as well as literacy.
- A concerted push for public health and prevention activities aimed at preventing illness from occurring.
- Recognising environmental and social determinants of health in policy development.



### **Fostering medical leadership by:**

- Recognising enhanced safety and efficiency in healthcare systems resulting from investment in empowering diverse medical leadership.
- Enhancing training opportunities for medical practitioners to develop management and leadership skills to complement clinical expertise.
- Building a positive work culture through system design, leading by example to promote equity, diversity, reward for effort, expertise in training/research/administration, and actively managing bullying and harassment.
- Supporting the appointment of professionally trained and qualified specialist medical administrators in medical leadership roles.
- Ensuring doctors are trained in and appointed to positions in clinical governance, workforce planning and wellness.

# Policy Pillars

**The AMA's Vision for Australia's Health represents a clear blueprint for all Governments, and players in the system, built around five pillars of detailed policy reform.**



## **Pillar 1: General Practice**

Integrated, multi-disciplinary GP led patient-centred medical homes represent the foundation of an evidence-based healthcare system. This is underpinned by increased funding rewarding quality, as well as industry and expertise to achieve the most cost-effective optimisation of health outcomes for patients and families, regardless of geography. This focuses on management of chronic and/or complex diseases, reduction in preventable hospital admissions and improved stewardship of resources, including in the aged care sector. Equally, it is important to recognise that General Practice is critical to aged care services and mental health services – two significant and growing health areas.



## **Pillar 2: Public hospitals**

An evolved and adequately funded public hospital sector, providing for timelier elective and emergency treatment, greater linkages to primary care and more transparent and simplified Commonwealth-State funding arrangements. Key to this will be striking the right balance, so our focus is patient care and improving outcomes, and reforming burdensome audit and accreditation requirements which can, if poorly designed, detract from limited resources. A new funding approach to supplement the current focus on activity-based funding – one that includes funding for positive improvement, increased capacity, and reduced demand, and puts an end to the blame game.



## **Pillar 3: Private health**

A reinvigorated and resilient private health system, which complements the public hospital system by providing high-quality, timely and affordable care in a sustainable way. Demographics, chronic disease, technology, and healthcare are all changing rapidly, and our policies must change accordingly. Having cleared the first hurdles for telehealth and home-based hospital care, we need to develop them further as part of a deliberate design of a better system. A system that provides the right programs which are cost effective, clinically advantageous, medical practitioner led and insurer funded. One that focuses on continual improvement – including, but not limited to prostheses reform, addressing the issue of private patients in public hospitals, new and improved clinician led models of care and the adoption of new technology.



#### **Pillar 4: A health system for all**

A sustainable health system achieved via policy and sustainable funding reform to ensure:

- prevention becomes a foundation of healthcare planning and design;
- access for all Australians remains a key feature of our system, including identifying and filling service gaps for: Aboriginal and Torres Strait Islander peoples, people living in aged care settings, and other vulnerable groups, in conjunction with the National Disability Insurance Scheme;
- emphasis is placed on key environmental, social and moral determinants of health; and
- efficiencies in care are identified, with reduction in waste and savings reinvested.



#### **Pillar 5: A health system for the future**

Embracing new technology and innovation, consolidating the gains from COVID-19 reforms, and building upon them to facilitate better access for all patients and greater understanding and engagement between patients and practitioners. It will also require better use of data and technology to aid diagnosis, clinical audit and patient engagement, and to provide solutions to deliver care in circumstances currently not possible. Key to consideration of a future health system is the opportunities offered by new innovative models of care, integrated care at a lower cost and value-based healthcare – that is, sustainable system redesign.

## Pillar 1.

# General Practice



Integrated, multi-disciplinary GP led patient-centred medical homes represent the foundation of an evidence-based healthcare system. This is underpinned by increased funding rewarding quality, as well as industry and expertise to achieve the most cost-effective optimisation of health outcomes for patients and families, regardless of geography. This focuses on management of chronic and/or complex diseases, reduction in preventable hospital admissions and improved stewardship of resources, including in the aged care sector. Equally, it is important to recognise that General Practice is critical to aged care services and mental health services – two significant and growing health areas.







# Pillar 1: General Practice

GOALS	ENABLERS	OUTCOME MEASURES
1.1 Implement voluntary GP nomination, allowing all patients to nominate their preferred or regular GP/General Practice.	<ul style="list-style-type: none"> <li>• Embed the concept of the patient-centred medical home in Australia.</li> <li>• Improve the coordination of long-term care for patients, leading to improved healthcare outcomes for patients.</li> </ul>	<ul style="list-style-type: none"> <li>• 80 per cent of all patients have a nominated General Practice by end of 2022.</li> </ul>
1.2 Medicare Benefits Schedule (MBS) rebates for GP telehealth via a patient's nominated General Practice are available for all clinically appropriate circumstances where a face-to-face visit is not required/possible.	<ul style="list-style-type: none"> <li>• More flexible access to care for patients.</li> <li>• Cost and mobility barriers for patients are improved, including the need to take time off work, travel and pay for travel – thus helping the most vulnerable in our society.</li> <li>• Improved productivity in both General Practice as well as the broader workforce, where telehealth is appropriate and infrastructure provided.</li> </ul>	<ul style="list-style-type: none"> <li>• Number of new telehealth MBS items and their uptake by General Practice.</li> </ul>
1.3 Improve access to GP coordinated community care for patients.	<ul style="list-style-type: none"> <li>• Link Medicare Chronic Disease Management and health assessment items to voluntary patient nomination from 2021.</li> <li>• Introduce an extended 'Level B' consultation to allow greater routine care of more complex patients without disrupting current routine care.</li> <li>• Restructure MBS consultation items to remove the current remuneration bias so that longer, more complex consultations are better valued.</li> <li>• Support patients with hard to heal wounds by funding the costs of dressings for targeted patient groups.</li> <li>• Improve Medicare funding arrangements for after-hours GP services provided by a patient's usual/nominated General Practice.</li> </ul>	<ul style="list-style-type: none"> <li>• Improved management of chronic disease in General Practice.</li> <li>• Reduction in avoidable hospital admissions.</li> <li>• Reduction in some preventable presentations at emergency departments.</li> <li>• Measurable increase in average GP consultation times via an established and agreed methodology and mechanism, noting the loss of the Bettering the Evaluation and Care of Health (BEACH) reporting.</li> <li>• Increased access to after-hours care by patients.</li> </ul>
1.4 Lift caps on subsidies available through the Commonwealth Department of Health's Workforce Incentive Program.	<ul style="list-style-type: none"> <li>• Enhanced access to GP-led team-based care for patients.</li> </ul>	<ul style="list-style-type: none"> <li>• Increased employment of nurses, pharmacists and allied health professionals in General Practices.</li> </ul>

GOALS	ENABLERS	OUTCOME MEASURES
1.5 Improved access to GP care for elderly patients through their usual GP, ensuring continuity of care.	<ul style="list-style-type: none"> <li>• Greater access to GPs in nursing homes, improved management of health conditions, falls reporting, polypharmacy.</li> </ul>	<ul style="list-style-type: none"> <li>• Significant investment in funding models that better support the delivery of GP services in nursing homes.</li> </ul>
1.6 Introduction of the Single Employer Model for GP trainees, offering competitive remuneration and working conditions for GP trainees.	<ul style="list-style-type: none"> <li>• General Practice perceived as a more attractive career option for graduating medical students and doctors in training.</li> <li>• Reverse the decline in recruitment to the GP training program and ensure that Australia has a strong GP-led primary care system.</li> </ul>	<ul style="list-style-type: none"> <li>• GP trainees have equivalent working conditions to their hospital-based colleagues.</li> <li>• GP training meeting its annual recruitment targets.</li> <li>• Sustainable growth in GP numbers, matched to community need.</li> <li>• Increased desire of medical students to choose a General Practice career upon leaving medical school.</li> <li>• Introduction of the Single Employer Model for GPs in Training by start of 2022 or 2023.</li> <li>• All Australian General Practice Training (AGPT) spots filled nationally, with surety to prioritise and incentivise rural placements and areas of workforce shortage to meet community needs.</li> </ul>
1.7 General Practice funded and resourced to transform and innovate.	<ul style="list-style-type: none"> <li>• Targeted annual rounds of infrastructure grant funding to support training and multi-disciplinary care in General Practice.</li> <li>• Funding support through the Practice Incentive Program and the MBS that enables the adoption of innovative models of care including telehealth, point of care testing and remote monitoring of patients.</li> <li>• Funding for ACCHOs infrastructure and practice beyond COVID-19 prevention.</li> </ul>	<ul style="list-style-type: none"> <li>• Number and take-up of grant opportunities.</li> <li>• Adoption of new technology in General Practice including point of care testing, video consultations and remote monitoring.</li> <li>• Conversion to 50 per cent e-prescriptions by end of 2022.</li> <li>• Enhanced My Health Record upload rate.</li> <li>• Increased facilities and infrastructure at ACCHOs.</li> <li>• Improved access for rural and regional areas and disadvantaged communities.</li> </ul>

## Pillar 2.

# Public Hospitals



An evolved and adequately funded public hospital sector, providing for more timely elective and emergency treatment, greater linkages to primary care and more transparent and simplified Commonwealth-State funding arrangements. Key to this will be striking the right balance, so our focus is patient care and improving outcomes, and reforming burdensome audit and accreditation requirements which can, if poorly designed, detract from limited resources. A new funding approach to supplement the current focus on activity-based funding – one that includes funding for positive improvement, increased capacity, and reduced demand, and puts an end to the blame game.





## Pillar 2: Public Hospitals

GOALS	ENABLERS	OUTCOME MEASURES
<p>2.1 Simplified funding arrangements, which see the Commonwealth increasing their contribution to 50 per cent for activity (as per current COVID-19 partnership agreement), as well as providing funding for improvement and capacity. The States and Territories could use the 5 per cent of 'freed-up' funds on improvement, as determined by the needs of the region/ network.</p>	<ul style="list-style-type: none"> <li>• Greater responsibility for all Governments with equal funding commitment to activity.</li> <li>• State and Territory Governments benefit from a 5 per cent increase in funding, but are required to invest these additional funds into improved capacity and quality of care.</li> </ul>	<ul style="list-style-type: none"> <li>• Patients do not remain in emergency departments after decision to admit.</li> <li>• Reduced waiting times for elective surgery and emergency admissions.</li> <li>• No overcrowding of emergency departments and improved hospital flow, with elimination of access block in emergency departments.</li> <li>• Elimination of ambulance ramping.</li> <li>• Hospitals are funded to resolve the cause of complications and adapt future workflow, resulting in fewer patient complications, re-admissions and shorter length of stay – rather than a penalty approach.</li> <li>• Improved efficiencies and patient throughput.</li> <li>• Compliance with industrial conditions that facilitate doctors' health and safety, education and training and quality of patient care delivery.</li> </ul>
<p>2.2 Commonwealth and State and Territory funding at a sufficient scale to allow increased capacity and growth, beds where needed, and improved performance. This means funding that is appropriately indexed and incentivises positive outcomes.</p>	<ul style="list-style-type: none"> <li>• Commonwealth funding is fully indexed, and additional funding is made available, so that hospitals are resourced to increase capacity as needed and invest in improving their performance. A shift in focus from penalising struggling hospitals operating at breaking point, to resourcing hospitals for scalable, efficient and improved care.</li> <li>• Hospitals are funded so that staff are not working unsafe hours and overtime is recognised and rewarded.</li> <li>• Funding to support investment and wellness of hospital staff, including fostering medical leadership in hospital administration and management.</li> <li>• Funding to adapt to post-COVID-19 healthcare, allowing implementation of:             <ul style="list-style-type: none"> <li>• Methods of managing patient flow in light of social distancing and infection control;</li> <li>• Additional infrastructure and modifications to ensure safety for healthcare staff, patients and visitors; and</li> <li>• Surge facilities and Personal Protective Equipment (PPE) in case of winter spike, and to deal with increased testing requirements during winter months.</li> </ul> </li> </ul>	<ul style="list-style-type: none"> <li>• Residual and surge capacity in our health system. This is essential both to maximise efficiency in the setting of entirely predictable normal surges, but also to accommodate for predictable future pandemics and disasters. Residual capacity that is not used every day can be invested back into improving quality, culture, teaching, training and research.</li> </ul>

GOALS	ENABLERS	OUTCOME MEASURES
2.3 Transition of Medicare public hospital outpatient clinic funding to an appropriately indexed funding system.	<ul style="list-style-type: none"> <li>Scalable, simplified and transparent funding that significantly reduces the administration workload within public hospitals to capture Medicare income.</li> </ul>	<ul style="list-style-type: none"> <li>Measurable reduction in administration costs, with savings reinvested into clinical care.</li> </ul>
2.4 Deeper connections between General Practice and public hospitals, with appropriate funding provided.	<ul style="list-style-type: none"> <li>Hospitals provide best practice, full discharge summaries and seamless integration of clinical systems between hospital and community to facilitate information sharing.</li> <li>Governments fund improved delivery of integrated care post-discharge to prevent avoidable admissions, co-designed with the profession.</li> <li>Improved integration of medical care to nursing homes, hospital in the home, and GP integration pre-discharge.</li> </ul>	<ul style="list-style-type: none"> <li>Lower emergency presentations and re-admissions, post-discharge.</li> <li>Greater management of chronic patients in the community.</li> <li>GP download rate of hospital discharge summaries</li> </ul>
2.5 Alternative delivery options for outpatient care.	<ul style="list-style-type: none"> <li>Adopt digital health technologies to maintain clinical connections with vulnerable patients post-discharge.</li> <li>Expand hospital in the home services for simple treatments that otherwise require hospital admission.</li> <li>Invest in communications channels to facilitate quality and efficiency across health spheres – GPs, hospital, aged care.</li> </ul>	<ul style="list-style-type: none"> <li>Reduced re-admission rates post-discharge for vulnerable patients.</li> <li>Reduced cost and improved quality of patient care.</li> <li>Increased GP satisfaction with hospital communication.</li> </ul>
2.6 Expanded uptake of telehealth across hospital networks.	<ul style="list-style-type: none"> <li>Telehealth is an integral part of care delivery across hospital networks.</li> <li>Deeper connections between public hospital clinicians and primary care services across hospital networks.</li> </ul>	<ul style="list-style-type: none"> <li>Reduced patient acuity for chronic disease patients and reduced complications if admission is required.</li> </ul>

GOALS	ENABLERS	OUTCOME MEASURES
<p>2.7 Regulation change to ensure patient is offered choice when presenting for care, and availability of private sector options are investigated and discussed with patients holding credible private hospital insurance cover. This to be documented before public hospital admission.</p>	<ul style="list-style-type: none"> <li>Enhanced fully informed financial consent provided to patients before proceeding with care.</li> <li>Increase in genuine attempts to allow patients holding private hospital insurance to transfer care to a private facility where spare capacity exists in order to unburden the public hospital system for patients without insurance.</li> <li>Regulation change to prevent public hospitals from advertising to patients in order to pressure them to use their private health insurance in public hospitals to enhance system capability or resourcing.</li> </ul>	<ul style="list-style-type: none"> <li>Increased transfer of patients from public hospital emergency departments to private hospitals for ongoing inpatient care.</li> <li>Greater coordination and streamlining of the system, including timely patient transfers to private emergency department facilities.</li> </ul>
<p>2.8.1 Ensure adequate representation and diversity of practicing medical practitioners from the full range of public and private services, on government working groups and committees.</p> <p>2.8.2 Hospital accreditation requirements for a fully empowered executive director of medical services (or equivalent) who is a registered medical practitioner with a Fellowship of the Royal Australasian College of Medical Administrators (RACMA), to have responsibility for clinical service delivery, safety/quality and credentialing within each hospital.</p>	<ul style="list-style-type: none"> <li>Ensure appropriate training via the RACMA or equivalent as a basis for all medical leadership roles.</li> <li>Medical responsibility for health and workplace culture within organisations recognised at executive level.</li> <li>Recognition that diversity is essential for quality of leadership and organisational performance.</li> <li>Hospital accreditation to require further training for current medical leaders in management and healthcare policy, and identification of new medical leaders.</li> </ul>	<ul style="list-style-type: none"> <li>More appropriate policy, and importantly implementation, that does not impact negatively on patients or practitioners, while reflecting the specific requirements of differing medical environments.</li> <li>Hospital accreditation process amended or introduced.</li> <li>Increase in appointments of Executive Director of Medical Services in line with these criteria.</li> </ul>



GOALS	ENABLERS	OUTCOME MEASURES
<p>2.9 Accreditation of all pre vocational training years for junior doctors.</p>	<ul style="list-style-type: none"> <li>• Postgraduate Medical Council (PMC) accreditation of pre vocational training prior to vocational training would provide a structured, safe, high-quality training experience for all doctors.</li> </ul>	<ul style="list-style-type: none"> <li>• Accreditation by PMC of all postgraduate year 2+ training places by end of 2023.</li> </ul>

## Pillar 3.

# Private Health



A reinvigorated and resilient private health system, which complements the public hospital system by providing high-quality, timely and affordable care in a sustainable way. Demographics, chronic disease, technology, and healthcare are all changing rapidly, and our policies must change accordingly. Having cleared the first hurdles for telehealth and home-based hospital care, we need to develop them further as part of a deliberate design of a better system. A system that provides the right programs which are cost effective, clinically advantageous, medical practitioner led and insurer funded. One that focuses on continual improvement – including, but not limited to prostheses reform, addressing the issue of private patients in public hospitals, new and improved clinician led models of care and the adoption of new technology.





## Pillar 3: Private Health

GOALS	ENABLERS	OUTCOME MEASURES
<p>3.1 Recalibrate the private health insurance policy levers around rebates, Lifetime Health Cover (LHC) loading, and Youth Discounts to account for the ageing demographic and changing insurance pool.</p>	<ul style="list-style-type: none"> <li>• A private health insurance system that offers affordable and appropriate cover within reach of all Australians.</li> <li>• Enhanced levels of membership for younger Australians.</li> <li>• Greater incentives to hold private health insurance among older Australians and existing policy holders.</li> <li>• Measures to assist people, especially through the COVID-19 period by extending the age allowed under family policies, and pausing LHC loadings for those impacted by COVID-19 related losses.</li> </ul>	<ul style="list-style-type: none"> <li>• Increasing numbers of younger people taking up private health insurance hospital cover.</li> <li>• Greater retention of existing policy holders.</li> <li>• Reduced premium inflation due to a rebalanced and sustainable insurance pool.</li> </ul>
<p>3.2 Engage in further policy reform to put greater value and protections into private health insurance in the eyes of consumers.</p>	<ul style="list-style-type: none"> <li>• A minimum threshold level of premiums returned to the health consumer as health benefits, i.e. payout ratio minimum of 90 per cent.</li> <li>• A higher standard of transparency for private health insurance policies to clarify what benefit rates are, so patients can determine their out-of-pocket costs.</li> <li>• Lower levels of variation between private health insurance rebates.</li> <li>• An independent regulator to regulate the legal conduct of the private health insurance industry.</li> <li>• Consider and adapt for the additional costs of responding to COVID-19 in the long term.</li> <li>• Add private health insurance rebates on to the Commonwealth Government's doctors' fees (Medical Costs Finder) website.</li> </ul>	<ul style="list-style-type: none"> <li>• Reduced number of complaints to Ombudsman about benefits, membership and service.</li> <li>• A greater proportion of premiums being paid towards benefits, not management expenses or profit taking, instilling greater consumer confidence in for-profit insurers.</li> <li>• Protection against managed care, which has been shown to lead to increased costs.</li> <li>• A higher standard of transparency for private health insurance policies to clarify benefits and reduced number of patients experiencing "bill shock".</li> </ul>

GOALS	ENABLERS	OUTCOME MEASURES
<p>3.3 Ensure patient choice and medical-led care remains central, while also developing new models of more efficient care and reducing low-value care.</p>	<ul style="list-style-type: none"> <li>• Invest in developing new medical-led, innovative models that will ultimately create new best-practice care. This should include adoption of new technology to support care provision, including community-level care where clinically appropriate.</li> <li>• An independent regulator to oversee the legal conduct of the private health insurance industry and guard against insurer-directed care.</li> <li>• Consider potential cost savings and efficiencies in other areas of outlays such as devices/prostheses.</li> </ul>	<ul style="list-style-type: none"> <li>• Increased number of medical services being carried out in the most clinically appropriate and efficient settings, including home-based care, community-based care and other non-admitted day programs.</li> <li>• Ongoing efficiency and cost savings related to acute treatment.</li> </ul>
<p>3.4 Hospital accreditation requirements for a fully empowered executive director of medical services (or equivalent) who is a registered medical practitioner with a Fellowship of RACMA, to have responsibility for clinical service delivery, safety/quality and credentialing within each hospital.</p>	<ul style="list-style-type: none"> <li>• Ensure appropriate training via RACMA or equivalent as a basis for all medical leadership roles.</li> <li>• Medical responsibility for wellness and workplace culture within organisations recognised at executive level.</li> <li>• Hospital accreditation to require further training for current medical leaders in management and healthcare policy, and identification of new medical leaders.</li> </ul>	<ul style="list-style-type: none"> <li>• Hospital accreditation process amended or introduced.</li> <li>• Increase in appointments of Executive Director of Medical Services in line with these criteria.</li> </ul>

## Pillar 4.

# Health for All



A sustainable health system achieved via policy and sustainable funding reform to ensure:

- prevention becomes a foundation of healthcare planning and design;
- access for all Australians remains a key feature of our system, including identifying and filling service gaps for: Aboriginal and Torres Strait Islander peoples, people living in aged care settings, and other vulnerable groups, in conjunction with the National Disability Insurance Scheme;
- emphasis is placed on key environmental, social and moral determinants of health; and
- efficiencies in care are identified, with reduction in waste and savings reinvested.



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## Pillar 4: Health for All

GOALS	ENABLERS	OUTCOME MEASURES
<p>4.1 Prevention of illness becomes a foundation of Australia's health system policy and funding response in the immediate future.</p>	<ul style="list-style-type: none"> <li>• Increased funding directed towards preventative health.</li> <li>• A tax on sugar sweetened beverages.</li> <li>• GPs at the centre of preventative health system design.</li> <li>• Increased Medicare rebates and improved indexation to lessen patient out-of-pocket costs and encourage greater access to medical services.</li> <li>• An Australian Centre for Disease Control (CDC) is established with a focus on current and emerging communicable disease threats, and to engage in global health surveillance, health security, epidemiology, and research.</li> <li>• Maintain the funding and support needed for each sector of the health system to remain vigilant in response to COVID-19, while allowing treatment and prevention services to run.</li> </ul>	<ul style="list-style-type: none"> <li>• Five per cent of total health expenditure dedicated to illness prevention.</li> <li>• Number of GP MBS items dedicated to preventative health.</li> <li>• Funding to establish a CDC.</li> <li>• Application of best-practice principles of infection prevention, control and treatment of COVID-19, which reflect continuously evaluated emerging evidence.</li> <li>• Increased prevention and identification of disease at earlier stages.</li> <li>• Reduced acute demand on hospital facilities.</li> <li>• Evidence of improved patient experience and flow through the health system.</li> </ul>



GOALS	ENABLERS	OUTCOME MEASURES
<p>4.2.1 Ensure that health policy addresses the needs of Aboriginal and Torres Strait Islander Australians.</p>	<ul style="list-style-type: none"> <li>• Specific needs-based Aboriginal and Torres Strait Islander health funding allocated to address health needs of Aboriginal and Torres Strait Islander communities, including unimplemented parts of the National Aboriginal and Torres Strait Islander Health Plan 2013-2023, as well as greater investment in primary care.</li> <li>• Build on the fine examples of Aboriginal and Torres Strait Islander healthcare service delivery already operating in Australia – such as the Institute for Urban Indigenous Health – and replicate this or equivalent models as appropriate throughout Australia.</li> <li>• Mandate regular cultural safety training for all medical practitioners.</li> </ul>	<ul style="list-style-type: none"> <li>• Health outcomes of Aboriginal and Torres Strait Islander communities improved against the new National Agreement on Closing the Gap targets and health policy benchmarks – including at least 90 per cent population access to fluoridated water.</li> <li>• Significant performance uplift against the age-standardised rate of potentially preventable hospitalisations, as outlined in the National Health Reform Agreement and State and Territory Aboriginal and Torres Strait Islander health plans.</li> <li>• The level of funding for healthcare for Aboriginal and Torres Strait Islander people is based on the level of need indicated by the Burden of Disease studies.</li> <li>• Increase in Aboriginal and Torres Strait Islander people having a health assessment with a GP, as measured by an increase in MBS item 715 - Indigenous Health Assessment.</li> </ul>
<p>4.2.2 Ensure that health policy addresses the needs of those who are marginalised and those who suffer socioeconomic disadvantage, as well as those in aged care who have limited access to health services.</p>	<ul style="list-style-type: none"> <li>• Adequate nursing staff in nursing homes and enhanced integration between the aged care and health systems.</li> <li>• Universal healthcare and affordability achieved for all, particularly people in socioeconomic disadvantage.</li> <li>• Options for telehealth between the GP and a carer or nursing home nurse on behalf of a patient, where patients are non-communicative.</li> <li>• Adequate healthcare for those in other institutional care settings, and those within the disability sector.</li> </ul>	<ul style="list-style-type: none"> <li>• Disadvantaged communities accessing healthcare more regularly and achieving improved health outcomes.</li> </ul>

GOALS	ENABLERS	OUTCOME MEASURES
4.3.1 Establishing a Community Resident Program (CRP).	<ul style="list-style-type: none"> <li>• Stronger recruitment into General Practice, by providing doctors in training with more opportunities to undertake pre vocational training in General Practice.</li> <li>• Ensuring more doctors have a fundamental understanding of the functioning of General Practice and primary care.</li> </ul>	<ul style="list-style-type: none"> <li>• All CRP places filled each year.</li> </ul>
4.3.2 Expand the Commonwealth Government's Specialist Training Program (STP) to 1700 places by 2022, giving priority to rural areas, generalist training and specialties that are under-supplied.	<ul style="list-style-type: none"> <li>• An increased focus on generalism within the specialist workforce.</li> <li>• Improved access to specialist services in rural Australia.</li> </ul>	<ul style="list-style-type: none"> <li>• All STP places filled each year.</li> <li>• Evidence of improved recruitment into under-supplied medical specialties.</li> </ul>
4.3.3 Increase the focus of medical schools on rural training opportunities by supporting end-to-end rural medical school programs.	<ul style="list-style-type: none"> <li>• Improve workforce distribution by encouraging the development of a rural training pipeline which takes students all the way through to the completion of specialist fellowship training.</li> <li>• Dedicating at least one-third of all domestic first-year medical school places to students with a rural background and requiring one-third of all medical students to undertake at least one year of clinical training in rural areas.</li> </ul>	<ul style="list-style-type: none"> <li>• Increased numbers of Australian-trained specialists working in rural Australia.</li> <li>• Evaluation of end-to-end rural medical training to ensure it is providing positive rural exposure, leading to retention of rural medical practitioners.</li> </ul>
4.3.4 Rollout of the National Rural Generalist Pathway (NRGP) nationally by 2021.	<ul style="list-style-type: none"> <li>• Improved access to GPs in rural areas.</li> </ul>	<ul style="list-style-type: none"> <li>• NRGPs fully subscribed by end of 2021.</li> </ul>

GOALS	ENABLERS	OUTCOME MEASURES
<p>4.3.5 Regulate all medical school places, including domestic and overseas full fee-paying places to match medical school intakes with community need.</p>	<ul style="list-style-type: none"> <li>• Avoiding the boom-bust cycle that has characterised medical workforce planning.</li> <li>• Ensuring that medical school intakes are matched to the available number of training places in the pre vocational and vocational training pipeline.</li> <li>• Ensuring medical school intakes are linked to workforce planning and community need.</li> <li>• Regulation to limit the number of full-fee paying overseas medical student in Australian universities to no more than 15 per cent of the total number of students.</li> <li>• Ensuring the 10-year moratorium rules for overseas trained doctors (OTDs) are enacted simply, fairly and uniformly.</li> </ul>	<ul style="list-style-type: none"> <li>• Medical school intakes reflect the advice of the Medical Workforce Reform Advisory Committee (MWRAC).</li> <li>• Annual reporting of medical school places through the Medical Education and Training data reporting.</li> <li>• Greater proportion of OTDs serving full 10-year moratorium and current loopholes closed, while working towards dismantling the 10-year moratorium over time. More robust incentives and support mechanisms should be introduced to encourage increasing numbers of locally-trained doctors and appropriately skilled international medical graduates alike to consider a career in rural and remote practice.</li> </ul>
<p>4.3.6 Promotion of regional training and research teaching hospital hubs to grow non-GP specialist capacity outside metropolitan areas.</p>	<ul style="list-style-type: none"> <li>• Quarantined National Health and Medical Research Council research grant funding for regional teaching hospitals.</li> <li>• Commonwealth Medical Workforce Strategy to recognise importance of development and investment in regional teaching hospitals with sufficient capacity to host STP-funded non-GP specialist registrars.</li> </ul>	<ul style="list-style-type: none"> <li>• Greater coverage and access to non-GP specialist capacity in regional training centres, aiming for a 20 per cent increase by end of 2023.</li> </ul>
<p>4.4.1 Mental health-specific investment in developing capacity in mental health support services in GP practices in a coordinated manner, rather than siloed funding to non-government organisations.</p>	<ul style="list-style-type: none"> <li>• Accredited mental health nurses/ social workers embedded in General Practice, with appropriate training and support.</li> </ul>	<ul style="list-style-type: none"> <li>• Greater continuity of care, shorter follow-up times, increased compliance with mental health plans.</li> </ul>

GOALS	ENABLERS	OUTCOME MEASURES
<p>4.4.2 Mental Health - Investment in evidence-based nursing programs, integrated in General Practice, and funded increased support by psychiatrists, and mental health nurses.</p>	<ul style="list-style-type: none"> <li>• Greater GP rebates for longer consultations and management of complex medical conditions.</li> <li>• Improved rebates and continuation of telehealth for psychiatrists.</li> </ul>	<ul style="list-style-type: none"> <li>• Greater linkage between mental health concerns and physical health and wellbeing through GP integration.</li> <li>• Improved access to psychiatrists.</li> </ul>
<p>4.5 Mental Health - Invest in alternatives to emergency department and acute presentations for mental health patients, including active deployment of hospital in the home options and improved Medicare rebates.</p>	<ul style="list-style-type: none"> <li>• Community mental health services expanded and commensurately staffed to provide comprehensive care, including an immediate focus on the impact of COVID-19.</li> <li>• Rapid development of metropolitan and rural outreach telehealth resources (videoconferencing) and administrative support specifically for mental health consultations.</li> </ul>	<ul style="list-style-type: none"> <li>• Decrease in emergency department and acute presentations for mental health patients.</li> </ul>
<p>4.6 Place renewed emphasis on healthcare services operating in an environmentally sustainable manner; and plan for climate change's impact on population health.</p>	<ul style="list-style-type: none"> <li>• A national sustainable development unit is established to reduce carbon emissions in the healthcare sector.</li> <li>• Health benefits of addressing climate change are promoted.</li> <li>• A national strategy for health and climate change is developed.</li> <li>• Waste-reduction strategies incorporated as a requirement in hospital accreditation.</li> </ul>	<ul style="list-style-type: none"> <li>• Carbon emissions attributable to the health sector are reduced.</li> <li>• A reduction in deaths and adverse health outcomes attributable to climate change.</li> </ul>
<p>4.7 Develop new partnerships between colleges and professional associations, encourage diversity in leadership, and necessary reforms to achieve cultural change.</p>	<ul style="list-style-type: none"> <li>• Medical leadership training curriculums developed, standardised and recognised as part of continuous education programs.</li> </ul>	<ul style="list-style-type: none"> <li>• Number of leadership training programs available.</li> <li>• Increased diversity in training program leadership.</li> <li>• Number of doctors taking part.</li> <li>• Number of partnerships.</li> </ul>

GOALS	ENABLERS	OUTCOME MEASURES
<p>4.8 Achieve positive cultural change that eliminates harassment, bullying and racism through improved reporting structures available and ongoing training.</p>	<ul style="list-style-type: none"> <li>• Improved and safe rostering of doctors and registrars.</li> <li>• Progress toward implementation of the Every Doctor, Every Setting: A National Framework to improve the mental health of doctors and medical students.</li> <li>• Greater availability and uptake of training programs on bullying, racism and harassment.</li> <li>• Funding support for hospital investment in staff wellness and positive cultural change.</li> <li>• Avenues for reporting and addressing racism in the workplace, including promoting the Australian Health Practitioner Regulation Agency reporting mechanism.</li> <li>• Encouraging greater participation of women in the medical workforce (including leadership and management) and the health workforce more broadly.</li> <li>• Fostering diversity in leadership.</li> <li>• Providing equal access to parental leave for both parents.</li> </ul>	<ul style="list-style-type: none"> <li>• Improved work satisfaction by doctors and registrars.</li> <li>• Lower reports in AMA State and Territory hospital health checks of junior doctors, both in measures of fatigue and workplace culture.</li> <li>• Lower number of complaints.</li> <li>• Increased participation of women in the medical workforce, particularly in leadership positions.</li> <li>• Increased percentage of male doctors taking parental leave and being able to access flexible work arrangements.</li> </ul>

## Pillar 5.

# A Health System for the Future



Embracing new technology and innovation, consolidating the gains from COVID-19 reforms, and building upon them to facilitate better access for all patients and greater understanding and engagement between patients and practitioners. It will also require better use of data and technology to aid diagnosis, clinical audit and patient engagement, and to provide solutions to deliver care in circumstances currently not possible. Key to consideration of a future health system is the opportunities offered by new innovative models of care, integrated care at a lower cost and value-based healthcare – that is, sustainable system redesign.





## Pillar 5: A Health System for the Future

GOALS	ENABLERS	OUTCOME MEASURES
<p>5.1 Adapt private medical practice to incorporate telehealth and e-prescribing in “business as usual” without detracting from face-to-face medicine.</p>	<ul style="list-style-type: none"> <li>• Telehealth Medicare items that fairly compensate doctors for patient and non-patient contact time, while ensuring appropriate oversight and governance to ensure continuous evaluation and evidence-based quality of care.</li> <li>• Doctors are more accessible to patients while reducing the risk of COVID-19 transmission – with access to non-GP specialists particularly important for rural and regional patients.</li> <li>• Options for telehealth between a GP and a carer or nursing home nurse on behalf of patient, where patients are non-communicative.</li> <li>• Ensure appropriate tools are available to assist practitioners in adoption of telehealth and e-prescribing, designed in a way that improves workflow.</li> <li>• Remote monitoring technology will facilitate equitable healthcare, in particular for private medical practices in rural and remote areas.</li> </ul>	<ul style="list-style-type: none"> <li>• Number of telehealth Medicare items for GP and non-GP specialists.</li> <li>• Number of patients choosing telehealth as an option for care.</li> <li>• Conversion to 50 per cent e-prescriptions by end of 2022.</li> <li>• Government funding for innovations in rural health and technological infrastructure.</li> </ul>
<p>5.2 Patients empowered to track their health data and access follow-up care.</p>	<ul style="list-style-type: none"> <li>• Secure, private health information access for doctors and their patients.</li> <li>• Seamless access to medicines through e-prescribing.</li> <li>• Widespread use and adoption of the My Health Record, with a specific focus on supporting non-GP specialists.</li> </ul>	<ul style="list-style-type: none"> <li>• Increased uptake of the My Health Record by specialists.</li> <li>• Increased patient satisfaction in practice-based questionnaires.</li> <li>• Expanded upload into My Health Record.</li> </ul>



GOALS	ENABLERS	OUTCOME MEASURES
<p>5.3 Implement ehealth solutions to deliver doctors and patients health information seamlessly across different parts of the health system.</p>	<ul style="list-style-type: none"> <li>• Each person involved in care has current information about the patient that they need for the best possible quality care.</li> <li>• Development of a standard of interoperability across the health system.</li> <li>• Patients are supported with education for, and access to, digital health and assistive technologies to receive high-quality care at home and maintain independence.</li> <li>• Decision-making and health literacy are improved.</li> <li>• A national focussed attempt to improve digital maturity through workforce training initiatives, eliminating fax use, promoting secure messaging uptake, etc. via directed improvement payments or grants.</li> </ul>	<ul style="list-style-type: none"> <li>• Communication and coordination improved.</li> <li>• Improved access by hospitals to GP notes.</li> <li>• Increase in patients receiving high-quality, appropriate care at home instead of in acute care settings.</li> <li>• Health literacy indicators improved.</li> <li>• Measurable improvement in use of secure messaging and reduction in use of fax.</li> </ul>
<p>5.4 Liaison with colleges and universities to incorporate management and leadership training as well as ehealth training as a routine part of their education requirements for students and registrars.</p>	<ul style="list-style-type: none"> <li>• Incorporation of leadership and ehealth units of study with assessment in training programs.</li> <li>• Expanded capacity for remote learning (training and educational opportunities, especially for trainees in regional/rural sites, and potential remote supervision).</li> </ul>	<ul style="list-style-type: none"> <li>• Australian Medical Council accreditation guidelines adjusted to reflect this need, with 100 per cent conversion within 3 years.</li> </ul>

## Endnotes

<sup>1</sup> Australian Bureau of Statistics. Australian Demographic Statistics June 2018, Publication 3101, Table 7.

<sup>2</sup> Australian Institute of Health and Welfare (2020) *Admitted Patient Care 2018-19*. Retrieved 22/01/2021 from: <https://www.aihw.gov.au/reports-data/myhospitals/sectors/admitted-patients>

<sup>3</sup> Australian Institute of Health and Welfare (2019). *Australian Burden of Disease Study: Impact and causes of illness and death in Australia 2015 - Summary report*. Australian Burden of Disease Study series no. 18. Cat. no. BOD 21. Canberra: AIHW. Retrieved 21/01/2021 from: <https://www.aihw.gov.au/reports/burden-of-disease/burden-disease-study-illness-death-2015/summary>

<sup>4</sup> Australian Institute of Health and Welfare (2019). *Overweight and obesity: An interactive insight*. Cat. no: PHE 251. Retrieved 19/11/2020 from: <https://www.aihw.gov.au/reports/overweight-obesity/overweight-and-obesity-an-interactive-insight/data>

<sup>5</sup> Australian Institute of Health and Welfare (2020). *Aboriginal and Torres Strait Islander Health Performance Framework Report 2020. Tier 1 - Health Status and Outcomes: 1.04 Respiratory Disease*. Retrieved 12/01/2021 from: <https://www.indigenoushpf.gov.au/measures/1-04-respiratory-disease/data#DataVisualisation>

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<sup>7</sup> Australian Institute of Health and Welfare (2020). *Mental Health Services in Australia*. Retrieved 22/01/2021 from: <https://www.aihw.gov.au/reports/mental-health-services/mental-health-services-in-australia/report-contents/summary>

<sup>8</sup> Nasir, B.F. et al (2018). Common mental disorders among Indigenous people living in regional, remote and metropolitan Australia: a cross-sectional study. *BMJ Open* 8(6), e020196. Doi: 10.1136/bmjopen-2017-020196

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