AMA VICTORIA

Advocacy Priorities 2023

REINFORCING A HEALTHCARE-LED RECOVERY FOR VICTORIA

Contents

Introduction

Throughout 2022, AMA Victoria relentlessly campaigned for a healthcare-led recovery for Victoria.

We argued that this recovery – encompassing investment, including relevant staff training education and recruitment, into public hospitals, general practice, and mental health – would lead not only to healthcare recovery for all Victorians, but also be the underlying driver of full Victorian economic recovery through investment in essential health infrastructure and services.

AMA Victoria was pleased, and acknowledges, that in both its 2022-23 State Budget and throughout the November 2022 election campaign, the Victorian Government relevantly placed health at the centre of its agenda. This was a sound result for our members, for all healthcare practitioners, but most especially for the community.

However, the very same issues for which we first argued that a healthcare-led recovery was necessary remain current in 2023. In some instances, the circumstances have deteriorated. This is most immediately evident in the state of Victoria's *healthcare workforce* – the focus of our 2023-24 State Budget Submission.

AMA Victoria remains acutely aware that whilst the Victorian Government has prioritised billions of dollars of new spending for health in the coming years, this does not improve the critical situation healthcare workers face on the ground right now. This crisis has built up over decades, across multiple administrations, due, in no small part, to a lack of sophisticated, coordinated and integrated long-term planning. In the past, there has been a failure to recognise increasing demand with population expansion and capacity constraints even as our systems stretched in an attempt to cope. Regrettably these factors are only poised to worsen with Victoria's increasingly complex patient base coupled with the administrative burden accompanying the post-COVID transformation to digital health.

This is occurring most visibly in Victoria's *public hospitals*, have faced a significant increase in demand over several decades which (until recently) has not been met by sufficient increased investment in staffing and infrastructure. This has manifested vividly in recent stark access block and ambulance ramping.

Compounding matters, the plight of *general practice* – indeed its very business viability – remains concurrently dire. General practice shoulders over 90 per cent of the healthcare burden in Victoria yet inappropriately receives the least attention from the Victorian Government. This must change. Most immediately, the Victorian Government must step up to address the parlous financial state of many general practices by exempting them from payroll tax on practitioner derived revenue to ensure that they can remain viable businesses dedicated to providing care to Victorians, particularly in rural and remote locations.

Additionally, AMA Victoria remains profoundly concerned at the present trajectory of mental health reform in Victoria. We note reform is required, but it must be balanced and sensible. We re-state that the recent Royal Commission occurred because many Victorians could not access timely and appropriate medical care. Reasserting the relevance and thus importance of the medical model, of the wisdom and insights of medical practitioners at the origin of the reform process, is a matter of the utmost urgency. There must also be a fundamental re-orientation of funding priorities towards acute, medically-required care so that those patients who are most in need can obtain the treatment and support they need, when they need it, and most usefully in the early stages of a mental health episode. There must also be a coordinated response with adequate referral and escalation pathways between general practice and public hospitals.

In addressing the interlinking components of *public hospitals, general practice, and mental health* which comprise this Submission, ensuring a healthy medical workforce into the future must be at the forefront of the Victorian Government's agenda. To this end, particular attention must be paid to *workforce burnout, workforce funding,* and *workforce planning*. We can no longer act in a "state of emergency". Instead, we must turn our focus to building a sustainable workforce for the post-pandemic world.

I am pleased to introduce AMA Victoria's State Budget Submission for 2023-24.

Dr Roderick McRae
President
AMA Victoria

1 Workforce

Victoria's healthcare workers have been consistently at the frontline long before the COVID-19 pandemic. Yet years of prolonged workforce shortages, heavy workloads and backups from the pandemic have placed intolerable stress on healthcare workers.

The Victorian Government needs to act now to ensure a healthy medical workforce into the future. We can no longer act in a "state of emergency". Instead, we must turn our focus to building a sustainable workforce for the post-pandemic world and adequately attracting, retaining and supporting the current workforce.

WORKFORCE BURNOUT

In Victoria, our ageing medical workforce is burning out. A majority of Australian medical practitioners report that they are concerned about their own health, and similarly a majority report that they are concerned for a colleague.[1] Studies demonstrate that burnt-out medical practitioners are twice as likely to provide unsafe care,[2] and are more likely to experience low job satisfaction.[3]

Victorian medical practitioners are understandably burnt out from the increasingly complex patients that present to emergency departments and concomitant unmanageable workloads. These workloads are exacerbated by understaffing, inefficient work processes, and a high administrative burden.

The Victorian Government needs to urgently implement proactive measures to ensure patient care remains central to medical practitioners' work and to prevent an exodus of a highly trained workforce similar to that seen in America's medical workforce.[4]

Victoria's current measures against medical workforce burnout involve monitoring and public awareness campaigns. This is half-hearted and these programs have a misplaced blame on the individual medical practitioner rather than the larger hospital environment. Time and time again we see that individuals are a product of the environment in which they function, and burnout strategies targeted at organisations are shown to be far more effective than individual-level interventions.

Victoria's current burnout interventions need to be drastically bolstered by state-wide measures that target the organisational level and overhaul the design of medical jobs. These measures need to span workplace environment, structures, and processes in order to effect cultural change and structurally improve the demands on medical practitioners. Importantly, any government support for cultural change needs to set expectations and create accountability for action.

RECOMMENDATIONS

- Create a state-wide policy mandating the implementation of burnout mitigation strategies in hospital environments. These strategies could include: increasing the availability of supervisors, creating better communication channels from healthcare staff to hospital leadership, protecting time off, changing the designs of medical jobs, ensuring jobs have manageable workloads, and shared scheduling to avoid long stretches of uninterrupted shifts. Changes to job design and scheduling should be made in consultation with medical practitioners from the relevant job service, integrating their feedback in a co-design process.
- A dedicated section in these strategies should be given to the wellbeing of junior medical practitioners, who experience the worst of the pressures of the hospital environment.
- Settlement of the multiple class action proceedings related to junior doctors' wage theft.
- Implement a framework to measure hospital accountability to the new interventions. This could be integrated with the regular data collection and reporting that is already happening in Victoria.
- Reduce the administrative burden of digital health practices to enable clinicians to spend more time with patients. This could be facilitated by increasing automation, ensuring correct GP and GP clinic information is recorded, reducing duplication and fragmentation (such as increasing information sharing between services to reduce time spent chasing up results and moving to shared platforms between hospitals and community services), reducing red tape, and ensuring hospitals are equipped with faster, more up-to-date technology. Ultimately, digital health systems must work for doctors, not create work for doctors.
- Increase funding for the systemic determinants of health to reduce the downstream demands on our healthcare system. For example, funding for housing and food security.

WORKFORCE FUNDING

Victoria's healthcare workforce funding needs an overhaul. We need to refocus our spending on efficiency and efficacy. As a large driver of health workforce behaviours and the resultant level of care provided to patients, we need to ensure our healthcare funding shapes workforce behaviours and supply we want to see. Victoria's medical workforce, in both hospitals and in the community, needs more targeted investment in order to ensure staff retention and to ease the burden on our health system before it reaches a tipping point.

Primary care is our most efficient tier of healthcare. However, GP practices have experienced increasing pressures from inflation, energy supply, wages and superannuation costs, real lowered margins, and an complex patient load. Payroll tax worsens these pressures at a time when GP services are severely underprovided and when hospital access block is worsening (please see pages 5 to 6 of this Submission for additional information).

Furthermore, year-to-year funding for Victorian hospitals causes unnecessary workforce competition between our Victorian health services and uncertainty for medical practitioners.

RECOMMENDATIONS:

- Adequately fund hospitals to increase workforce satisfaction and to increase the number of employed medical practitioners to ease the hospital burden.
- Allow a payroll tax exemption for general practices on medical practitioner derived revenue.
- Reduce unrostered overtime for employed junior medical practitioners and increase the number of medical practitioners employed by hospitals.
- Change funding patterns for hospital medical practitioners — instead of year-to-year funding, consider contracts that span multiple years.

WORKFORCE PLANNING

Victoria's health workforce is maldistributed, geographically and by specialty. These workforce issues prevent patients from accessing appropriate care and health services from providing comprehensive and high-quality care.

Workforce shortages exist because of misaligned incentives for Victoria's medical students and junior medical practitioners. Not only are current specialty training positions not planned according to patient or community need, different specialties also have differing pay incentives that are uncorrelated to patient need. There is also a significant current level of stigma against general practice and psychiatry in the medical profession that compounds the pay disincentives to discourage our medical students and junior medical practitioners from pursuing these specialties of known shortage.

Workforce shortages have serious implications for our health system. Any imbalance puts undue pressure on the other parts of our system that pick up the slack. In the immediate aftermath of the COVID-19 pandemic we saw an example of this: a relative, but predicted, shortage of GPs that has been long in the making caused our emergency departments to overflow with patients who couldn't access a GP appointment within a reasonable timeframe. Overbooked GPs were more likely to refer patients they would previously have managed in the community, to hospital emergency departments due to inadequate funding and time available per patient, and insufficient resources to safely manage and follow-up such patients. As patient complexity increases, this problem exacerbates. Concurrently, exacerbating our GP shortage, time-poor hospital outpatient systems were more likely to refer patients for community GP management. These factors jointly created — and are still creating — a downwards spiral.

Addressing imbalances in workforce skill-mix ultimately addresses multiple workforce problems as it also improves workforce wellbeing. For example, one study shows that enabling clinicians to acquire appropriate skills to meet their job demands likely leads to greater job satisfaction.[5]

However, AMA Victoria cautions that any expansion of the scope of allied health practitioners, with their necessarily reduced exposure to all parts of medical training, should be in consultation with and collaboratively supervised by the relevant medical expertise to ensure patient safety is put first and foremost, and to reduce the potential for fragmentation of healthcare delivery in Victoria.

RECOMMENDATIONS:

- Invest in effective workforce retention strategies, particularly in rural areas, to reduce the cost burden of constant recruitment, particularly on rural hospitals.
- Create more positive drivers for general practice and reduce drivers into non-GP specialities. For example, better non-GP specialty support for GPs in rural and regional areas.
- Support a single employer model for general practice registrars to remove immediate economic barriers to preventing pursuing a desirable career in general practice.
- Provide job security and state government support (and thus reduction in general practitioners leaving the industry) by eliminating the threat of payroll tax and subsequent clinic collapse.
- Create data-driven workforce training, distribution and planning programs.
- Upskill the medical workforce. For example, by supporting medical practitioners to obtain relevant training to ensure they have the right skill mix to meet new job demands, particularly in rural and remote regions.
- Support Victoria's mental health workforce by improving terms and conditions for public mental health medical practitioners' employment.
- Proactively build workforce models that address future needs. For example: allowing increased flexibility in training and service provision, increasing the number of consultant (full time and sessional) positions available at hospitals, and increasing the number of medical generalists through training and work incentives to prevent continued city-centric subspecialisation and fragmentation of care.
- Reduce the fragmentation of healthcare by ensuring GPs and hospitals can continue to engage in shared care, supported by relevant, timely digital communication technology, particularly related to medical imaging.
- Proactively create a framework around any expanded scope of the allied health workforce to ensure collaborative, safe, supervised practice.
- Continue increasing workforce diversity to ensure more Aboriginal and Torres Strait Islander medical practitioners and rural and regional origin medical practitioners participate in the medical workforce.

2 Public Hospitals

Victoria's public hospitals have faced a significant increase in demand over several decades which (until recently) has not been met by sufficient increased investment in staffing and infrastructure capacity across physical and mental health. AMA Victoria recognises the recent increased medical staff employment in public hospitals, and this must continue to expand. Factors including an ageing population, an increase in chronic and complex health conditions, and escalating presentations to Emergency Departments (EDs) for physical and mental health conditions, have all contributed to a health system under immense pressure. A shortage of inpatient beds means EDs are unable to admit patients in a reasonably acceptable timeframe. This 'access block' leads to overcrowding and longer wait times for increasingly frustrated and angry emergency patients, as well as ambulance ramping, creating a vicious cycle on staff morale.

AMA Victoria acknowledges that most damning statistics predate the COVID-19 pandemic, which has nonetheless severely aggravated the circumstances, and that remedial action is now under way. However, this must be buttressed and continued.

Headlines of increasing ED waiting times in the 'emergency' triage category (the second most urgent classification) reflect real experience related to whole-of-hospital patient flows. Regarding workforce, Victoria's public hospitals have fewer staff per 1000 people than the national average in the latest statistics, with 14.8 staff per 1000 people in 2019-20 compared to 15.7 nationally. We need to continue to attract and retain required numbers of medical practitioners into our public hospital system, related to their terms and conditions of employment. Regarding hospital beds, Victoria, as it contemplates increased migration, has 2.3 per 1000 people, compared with the national average of 2.5. Per capita funding is perhaps the most troubling statistic, with Victoria being the lowest in the nation. Whilst per capita funding for Victoria's hospitals increased to $2,687 in 2019-2020 (a 28.4 per cent increase) this is lower than the national average increase of $2,971/42.9 per cent over the same period.[6] AMA Victoria calls for an ongoing increase in per capita funding to above the national average. The ambition is to lead the nation. Elective surgery statistics are equally disquieting, and, recognising what the Victorian Government has already put in motion, the planning to address this must continue to be rationally observed, soundly and permanently funded, and regularly assessed for fitness for purpose.

Recent reports of rising inflation impacting hospital funding during a period of record-breaking demand are concerning. AMA Victoria does, however, in this context recognise the changing manner of healthcare delivery, including changes based on learnings related to the COVID-19 pandemic, in particular hospital-in-the-home pathways. We urge the Victorian Government to both commit to public hospital funding that exceeds inflation, demonstrating a real-time investment for the next four years, and to seek to address funding complications around hospital-in-the-home pathways. We are interested in driving best healthcare outcomes for Victorians.

Concurrently, Victoria's existing public hospital infrastructure is ageing, being functionally and structurally at end-of-life and are severely constrained in their ability to meet the standards expected in the delivery of health care in 2023 and beyond. AMA Victoria calls for a well-planned, sophisticated, clearly articulated program for regular, routine upgrading, improvement and renewal. Buildings need to be flexible and need to be built to evolve as technology develops, delivery of care models change, and community expectations shift. This includes requirements for climate-change-based energy (electricity) requirements to meet the government's own guidelines, as well as support in the regions as we approach the 2026 Commonwealth Games. We support expansion with relevant robotic surgical capacity to increase patient care efficiency.

Beyond the buildings themselves, the management of public hospital assets and equipment requires huge investment to ensure end-of-life infrastructure does not fail. When such critical public hospital infrastructure does fail, as we have seen in several major tertiary hospitals in Melbourne in recent years, quality and safety of patient care is compromised and public confidence in the system is undermined.

Whilst the problems are profound, the solutions are not complicated. Victoria's public hospital system requires urgent investment in infrastructure coupled with workforce. This is not only to allow the system to return to a sustainable footing related to predicted population growth, but also to ensure that Victoria's hospitals are able to rapidly scale up for any future, predicted to be likely, surges from viruses or other pathogens in the medium-term future.

AMA Victoria has consistently advocated for a 50:50 split of public hospital funding between state and federal governments. However, given the current and unique ravages of the COVID-19 pandemic on our state, coupled with the longstanding underfunding of our public hospitals as compared to other jurisdictions, the Victorian Government has a special responsibility to adequately fund the public hospital system.

RECOMMENDATIONS:

- Provide urgent funding to ensure Victorian public hospitals are adequately staffed to meet demand, with future funding based on projected patient (population) numbers, for both physical and mental health support requirements.
- As a minimum match, and optimally exceed, national per capita funding for public hospitals.
- Commit to real public hospital funding that exceeds inflation for the next four years.
- Fund more inpatient beds and increase overall hospital capacity to meet demand and reduce access block.
- Establish strategies to facilitate effective workforce planning and rapid identification of areas of shortage, with data analysis of quarterly reporting by health services of the numbers of employed hospital medical officers in positions and the number of specialists in each specialty.
- Increase investment in the maintenance budgets of all public hospitals.
- Implement a maintenance and renewal strategy to address the future infrastructure needs of Victoria's public hospital system, factoring in an ageing population, an anticipated decrease in private health insurance coverage, impact of deferred care during the global COVID-19 pandemic, and the elective surgery backlog.
- Ensure new hospital developments are built with consideration given to Enterprise Bargaining Agreement clauses and entitlements, including climate emissions, infection control and digital technology requirements.

ALTERNATIVES TO INPATIENT CARE

These measures are unlikely to replace the need for more hospital bed capacity, but will help ease the current overwhelming demand for inpatient beds currently faced by our public hospitals.

RECOMMENDATIONS:

- Commit significant funding towards Victoria's public hospital specialist outpatient services.
- Resource options to prevent and respond to urgent health care needs outside the acute system such as extended hours and after-hours primary acute care clinics (continuing to ensure such facilities do not undermine the financial viability of existing private practice), support for primary care practitioners to undertake wound management, psychiatry outpatient clinics, 'hospital-in-the-home' services, community care, and mobile diagnostic services, all to decrease the need for hospital presentation, aiming to reduce avoidable ED presentations.[7]
- Increase funding for diagnostic and rehabilitation services for inpatients — such as extended hours radiology, allied health, and pathology — to decrease delays and allow earlier discharge of patients where clinically appropriate.
- Continue to fund telehealth and virtual care options to decrease the strain on hospitals and presentations to emergency departments - for example, Northern Health's Victorian Virtual Emergency Department.
- Adequately fund support and safe accommodation for patients who are medically fit for discharge but must remain in hospital as 'long stay' patients as they do not have access to the support they need in the community (for example NDIS patients).

3 General Practice

Most medical care in Victoria occurs in general practice, the most efficient part of our healthcare system. Moreover, most complex illnesses need comprehensive health care planning and provision across both hospitals and primary care. This notwithstanding, there has until recently been a lamentable longstanding neglect of general practice by successive Victorian governments (in this context, we do acknowledge the Government's announcement of a 'Chief GP Adviser' position within the Department of Health, and look forward to working with the State Government to select the right candidate to be positioned at the right level within the department, reporting to the Departmental Secretary). The continuing impacts of COVID-19 and the subsequent consequences of delayed and deferred care are presently placing a profound stress on all parts of the healthcare system (and will continue for years to come), but general practice, as always, is shouldering most of the burden.

There are three areas most in need of substantial reform:
- Financial sustainability of general practice.
- General practice and public hospital interaction.
- Rural and regional health.

ONGOING FINANCIAL SUSTAINABILITY OF GENERAL PRACTICE

The significant financial pressures currently faced by general practice are well known to the Victorian Government. In this context, AMA Victoria acknowledges recent revolutionary steps taken by the Victorian Government that resulted in direct state engagement and investment into general practice to address COVID-19 vaccination, including direct Victorian funding of Victorian general practices. This as a watershed moment for the provision of essential healthcare. Afterall, viable practices equate to better healthcare.

However, there is much more work to be undertaken to ensure sustained small business viability for general practice. A profound concern that we have consistently brought to the attention of the Victorian Government, and which requires urgent attention, is the impact of payroll tax on general practices.

The potential imposition of unanticipated payroll tax is a further, and potential lethal, blow for medical practices. It has the potential to place general practitioner and even other non-general practice medical specialist practices in danger of being forced to close due to financial unviability. In addition, it is making general practice an increasingly unattractive career option due to the constant threat and lack or support, thus exacerbating the already critical workforce shortage.

AMA Victoria's concerns commenced following the *Optical Superstore* decision of the Court of Appeal in Victoria.[8]

If this decision is brought to bear on medical practices' business models, it will threaten the viability of many practices due to the increased tax burden it will place on them. A significant number of clinics will become insolvent overnight, and those that survive will pass the cost on to the patients, forcing a vicious cycle of higher patient cost, causing patients to divert to already crowded ED waiting rooms.

Medical practitioners, like the rest of the population, are struggling with their own mental health and physical health concerns. Any additional burden of an unanticipated [payroll] tax liability that until now has not been levied is unfair and unreasonable in any circumstances. Imposing unplanned, unannounced [payroll] tax would necessitate many Victorian practices to close altogether (as seen interstate already), reduce or abandon the level of bulk billing they currently undertake, and to charge non-rebatable fees to Victorian patients to remain a sustainable and viable business. Any adjustment will cause higher pressure on already distressed public hospital EDs (and its concomitant resultant excess unbudgeted expenditure through increased hospital attendances and morbidity through chronic disease progression and associated delayed interventions).

AMA Victoria urges the Victorian Government to openly declare that any retrospectivity being applied to payroll tax assessments on any medical practices in Victoria will not be pursued. We further call for a legislative exemption on medical practices from certain payroll tax obligations. This would allow for medical practices to remain viable businesses able to reliably treat Victorians into the future.

In the short term, AMA Victoria requests clarity regarding State Revenue Office (SRO) payroll tax obligations:
- Advice regarding what Medical Practice business structure is considered compliant.
- Formal confirmation of the position of the Victorian SRO regarding rosters and websites and whether the Victorian SRO position has changed.
- Confirmation that the Government and its agency – the SRO – is cognisant of the implications of the implementation and interpretation of payroll parameters that are deleterious to medical practices and patients.
- Confirmation that the Government and SRO are not specifically accelerating targeting of medical practices for audit activity.

AMA Victoria requests information on what mitigations government is proposing to obviate the predicted negative consequences to the health of Victorians and the Victorian budget should interstate revenue office's new interpretation be adopted in Victoria.

AMA Victoria further requests funding for the provision of historical audit data of medical practices in Victoria, and how the interpretation has changed over the years.

RECOMMENDATIONS:

» Provide a clear statement that no retrospectively will be applied to medical payments to medical practitioners related to payroll tax assessments on medical practices.

» Exempt Victorian medical practices from payroll tax obligations being applied to medical payments to medical practitioners, distinguishing the circumstances from the reasoning in Optical Superstore and like cases.

GENERAL PRACTICE AND HOSPITAL INTERFACE

Over decades there has evolved what is now a substandard communication interaction between general practice and hospitals, to the detriment of Victorians' healthcare. This chronically poor interaction results in significant problems in many areas including safety, equity and access, and gaps and expensive duplication of investigations. With respect to referrals, in 2023, it is scarcely believable that many public hospitals continue to rely on facsimile as a mode of communication. This results in both clinical governance problems (lost referrals, lack of accountability and audit trails) and efficiency issues (hundreds of pages printed, faxed and refaxed). Funding must also be prioritised for GPs providing care in the community and in hospitals.

RECOMMENDATIONS:

» Mandate that all public hospitals must develop a single point of contact to receive electronic referrals sent by general practitioners.

» Ensure that electronic referrals are able to be received directly from GP software and have sufficient processing speed that they do not cause delays to general practitioner workflow

» Discharge and outpatient communication from public hospitals to GPs to be measured (measure and report on the timeliness, quantity and quality of discharge planning and clinical handover to general practitioners under hospital accreditation standards).[9]

» Mandate that rejection of a referral to a public hospital for clinical reasons must be undertaken by an identifiable senior medical practitioner, and communication to the referring general practitioner must include why the referral was rejected in all cases, and two-way communication is available to discuss.

» Support GPs to provide care in the community (including via secondary referral to decrease unnecessary referral to hospital in the first instance and direct funding to GPs to support models diverting patients away from hospital).[10]

» Employment contracts for GPs providing care in hospitals or outside of hospitals whilst a patient is 'admitted' in a hospital-in-the-home style program.

RURAL AND REGIONAL HEALTH

The provision of accessible and high-quality health care for people living in Victoria's rural and regional areas must be a high priority for the Victorian Government, particularly as we prepare for the forthcoming Commonwealth Games. Key initiatives are required to address health workforce shortages in rural and remote regions, including allocation of funding to support teaching, training, and recruitment and retention of medical practitioners comprising general practitioners and non-general practitioner specialists in a sensible, planned service and training concept in a reduced numbers of healthcare networks. For many general practitioners and GP registrars working in rural and regional areas, access to education, research opportunities and support and mentorship from specialists is currently scarce. AMA Victoria advocates that local and referral hospitals should be appropriately resourced and tasked with supporting general practitioners in their regions to develop and maintain their clinical skills.

RECOMMENDATIONS:

- Fund and develop strategies to assist general practitioners to provide care in their community and in small rural and regional hospitals, including training and skills maintenance, support for secondary referral to hospital specialists, and facilitating the development of referral pathways.
- Provide general practitioners working in rural hospitals with priority support from regional hospital hubs and streamlined pathways of care for emergency advice and patient transfer when indicated.
- Expanding initiatives such as Northern Health's medical community virtual consult service to regional and rural areas of Victoria.[11]
- Provide support to hospitals to upskill and maintain the clinical skills of general practitioners in maternity care (including intrapartum care), anaesthetic care, dealing with trauma, palliative care, minor surgical procedures and reproductive health (including insertion of long-acting reversible contraception, and medical termination of pregnancy). This may include provision of locums to cover practitioners to attend training days to allow them to leave their community.
- Fund transparent models of employment, conditions and standards for rural general practitioners providing clinical services at rural health services.
- Support non-GP specialists to provide care in regional and rural areas, including accommodation support for those who live in urban areas, but who work in rural areas.
- Fund relevant training for consideration of end-of-life issues for regionally and remotely located Victorians.

4 Mental Health

In 2021, AMA Victoria welcomed the Final Report of the Royal Commission into Victoria's Mental Health System, and congratulated the Victorian Government for its pledge to fully implement all 65 of the Report's recommendations. We noted at the time that the Royal Commission did not go into detail regarding how the recommendations were to be implemented. We stated that the required transformation of the Victorian mental health system would depend upon successful implementation of its recommendations, and that medical expertise would be absolutely essential for any successful implementation.

In 2023, whilst still acknowledging the State Government's dedication to transformative mental health reform in Victoria, we now have profoundly serious reservations about the trajectory being undertaken. It is our objective to ensure that the promise from the Royal Commission is realised, and that yet another opportunity for generational reform is not squandered.

REASSERTING THE IMPORTANCE OF THE MEDICAL MODEL IN MENTAL HEALTH REFORM

For AMA Victoria, the marginalisation of the medical model in mental health reform, and of the views of frontline experienced mental health clinicians, is profoundly problematic and unwise.

AMA Victoria is extremely concerned that, to date, the involvement of medical specialists, particularly psychiatrists, in the mental health reform process has been suboptimal, most recently as manifested in the lack of meaningful consultation into the development of the *Mental Health and Wellbeing Act 2022*.

Moreover, AMA Victoria considers that current structural and governance arrangements within the Department of Health's Mental Health Division are not fit for purpose. Noting that 'Lived Experience' has its own Executive Director, AMA Victoria believes that clinical involvement within the Department should similarly be executive and operational, as opposed to advisory.

AMA Victoria further considers it is profoundly detrimental to sideline the perspective of medical professionals in the development of policy and important aspects of the reform process (for example, on the future of restrictive interventions such as seclusion and restraint). Recently, engagement with the medical profession occurs well after the primary principles have already been determined. Such principles have tended to focus on issues such as power imbalances and human rights which are important, but cannot be considered alone. There needs to be a balance achieved between a patient's rights, their health, and the need to keep a patient and their carers physically safe. The narrow and limited communications that have taken place at times have not given appropriate weight to the genuine realities of caring for people who have very real and severe, advanced, psychiatric illness.

RECOMMENDATIONS:

- Invest in meaningful, early consultation with the medical profession in developing a co-designed policy to reform Victoria's mental health system.
- Establish and appropriately staff and fund a medical clinician executive unit within the Victorian Department of Health to co-design reforms from their conception.
- Budget for appropriate remuneration to enable experienced clinicians to participate in such consultations.

REORIENTING FUNDING PRIORITIES

While AMA Victoria appreciates that significant funding has been allocated by the State Government towards mental health, to meaningfully transform mental health care in Victoria, substantially more funding must be prioritised for acute care for urgent, complex and high-risk mental health cases so that treatment and support is available for those most in need in a nearby facility.

AMA Victoria notes and supports the $1.6 billion investment in capital infrastructure to provide 82 new forensic care beds at the Thomas Embling Centre, and 120 beds in the north-west of Melbourne and in Geelong, in addition to augmented inpatient facilities at Western and Frankston hospitals. There is, however, still a great need for enhanced inpatient beds in other parts of Melbourne and the rest of Victoria.

AMA Victoria considers there was a lamentable lack of focus on the role of primary care related to mental health in the Royal Commission's Final Report. AMA Victoria advocates that primary care systems should be strengthened to address multiple health priorities more broadly, as physical, social, economic, and mental health conditions are often inexorably linked.

A key strategy for improving access to quality health care while keeping costs down is to prevent mental health crises in the first instance, which often result in expensive emergency care, delayed appropriate admission, and consequent impact on staff morale. This is best achieved by targeted funding that supports general practice to meet the early mental health needs of patients, by investing in the ability of patients to access timely and appropriate care by psychiatrists and other specialist services, and by ensuring the state health system is integrated and easily navigated by patients, carers, and health professionals.

Even after all the beds recommended by the Royal Commission have been 'added to the system', Victoria will still have substantially fewer beds per head of population than the current OECD average. For too long Victorians

have had their mental health disease unnecessarily progress to advanced illness before they are deemed to warrant under resourced inpatient care, when evidence indicates earlier treatment would benefit the patient (perhaps obviating inpatient care), their carers, and the community at large through cost savings.

AMA Victoria considers there is a clear need to substantially increase the number of acute general mental health beds in Victoria, particularly including beds related to eating disorders (an issue that has consistently been brought to our attention by members).

To support patients to receive timely and high-quality health care, AMA Victoria also urges that the public psychiatry inpatient and outpatient sector be substantially better resourced to provide at least an equivalent care opportunity to that currently provided in the private system. This is because the unique assessment and complex treatment required by some patients can only be provided by the public system.

RECOMMENDATIONS:

- Substantially increase the psychiatric bed capacity in public hospitals (or within their networks) beyond the Royal Commission's recommendations.
- Invest in ongoing specialist support for general practitioners to treat and manage patients with mental illness early in the illness trajectory, with a recognition of the longer-term chronic nature of many mental illnesses.
- Provide adequate resourcing for community care services to address the 'missing middle' (those patients who are too sick for primary care, yet not sick enough for public hospital care) through investment in state-wide psychiatric outpatient clinics.
- Invest in specialised mental health areas that have never been adequately resourced: EDs and crisis presentations; dual diagnosis services; dual disability services, and psychotherapy training for psychiatric registrars and general medical practitioners.
- Provide trauma informed training to all hospital staff, to better manage patients who require hospitalisation, but avoid seeking such care due to past experiences.
- Appropriate and adequate resourcing of an array of related health services- including effective funding of drug and alcohol services, housing for persons with a mental illness, and forensic services.

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