amsa

2022-23 PRE-BUDGET SUBMISSION

AUSTRALIAN MEDICAL STUDENTS' ASSOCIATION

Australian Medical Students' Association
Level 1, 39 Brisbane Avenue
Barton, ACT 2600
January 24th 2022

The Hon Josh Frydenberg MP
PO Box 6022
House of Representatives
Parliament House
Canberra ACT 2600

Dear The Honourable Josh Frydenberg,

CC The Hon Greg Hunt MP, Minister for Health
The Hon Alan Tudge MP, Minister for Education
The Hon Ken Wyatt AM MP, Minister for Indigenous Australians

The Australian Medical Students' Association (AMSA) thanks the Government for the opportunity to present the following Pre-Budget Submission for consideration.

As the peak representative body for Australia's future medical workforce of over 17,000 medical students, AMSA has developed five health and education priorities for the 2022-2023 Federal Budget.

The recommendations are in the areas of:

1. Medical Workforce & Education
2. Indigenous Health
3. Mental Health
4. Gender Equity
5. Climate Change

Please get in touch if you or your colleagues would like to discuss any of the recommendations further.

Sincerely,

Jasmine Davis
President

Guy Jeffery
Vice President External

MEDICAL WORKFORCE AND EDUCATION SUMMARY OF RECOMMENDATIONS

1. National Medical Workforce Strategy

a. Fund the National Medical Workforce Strategy's Data Strategy.

b. Establish a Joint Medical Workforce Planning and Governance Body.

2. Medical Schools and Medical Student Numbers

a. Refuse to fund any scheme which directly or indirectly increases the number of Australian, especially international, medical students.

b. Refrain from supporting or funding any new medical school proposals unless guided by evidence-based modelling addressing workforce need and the National Medical Workforce Strategy.

3. Internships

a. Ensure all Australian medical graduates have access to an internship.

b. Align future Junior Doctor Training Program funding with medical student numbers.

4. Rural Specialist Training

a. Provide increased funding for vocational medical training options in rural and regional Australia via continuation and expansion of the Specialist Training Program.

5. Bonded Medical Program

a. Provide investment to conduct a tracer study investigating the retention rate and efficacy of the Bonded Medical Program in improving rural medical workforce distribution.

6. HECS Reimbursement Scheme

a. Increase investment to expand the HECS Reimbursement Scheme to include medical specialties outside of General Practice, as well as trainee doctors for whom the incentive will be realised most.

PUBLIC HEALTH
SUMMARY OF RECOMMENDATIONS

Indigenous Health

7. Culturally Safe Healthcare

a. Commit funding towards subsidising Cultural Safety Training for Australian medical students.

8. First Nations Medical Student Retention

a. Commit annual funding to support Indigenous medical students to complete their degrees.

Mental Health

9. Mental Health First Aid

a. Continue to provide funding for Mental Health First Aid Training for medical students.

10. Community Psychiatry Placements

b. Provide funding to facilitate medical student placement in community mental health settings.

Gender Equity

11. Gender-Affirming Care on Medicare

a. Fund the inclusion of gender-affirming healthcare, including surgical procedures, post-surgical care and other gender-affirming services, under Medicare and the Pharmaceutical Benefits Scheme (PBS).

12. Violence Against Women

a. Increase funding to frontline and crisis services to provide funding certainty for the increased demand and utilization in light of COVID-19.

Climate Change

13. Sustainable Development Unit

a. Commit funding to establish a National Sustainable Development Unit (SDU) to coordinate reform of Australian healthcare environmental sustainability.

1. NATIONAL MEDICAL WORKFORCE STRATEGY

Problem & Cost	Management of the medical training pipeline currently lacks top-down coordination and data-driven decision making, leading to workforce maldistribution that worsens healthcare burdens and economic inefficiencies.
Recommendations	**a. Fund the National Medical Workforce Strategy's Data Strategy.** **b. Establish a Joint Medical Workforce Planning and Governance Body.**
Expected Benefit	Improved healthcare coverage in a variety of underserved populations. Improved data collection to drive economically-efficient decision making. Improved efficiency in resource allocation in the health sector.

THE ISSUE

Australia's medical workforce suffers country-wide maldistribution, both geographically and with respect to the need for certain specialist doctors, bearing significant economic and health implications. This maldistribution is driven in large part by a lack of coordination between actors at various stages of the medical training pipeline, as well as the lack of data driving decisions made regarding workforce training models.

Speciality maldistribution has manifested as projected over-supply of disciplines such as Emergency Medicine and Anaesthetics, and undersupply in areas such as Psychiatry and Ophthalmology. This represents an inefficient use of resources, but also increases disease burden in the Australian community as undersupplied medical specialties struggle to cope with healthcare demand. For Australians, this can include increased disease morbidity and mortality, reduced quality of life, preventable hospitalisations, and social and economic disengagement.

THE SOLUTION

The funding and establishment of a Joint Medical Workforce Planning and Governance body with the authority to advise, direct, or make decisions on the size and structure of the entirety of the medical workforce & training pipeline, will allow medium to long-term planning and resource allocation to align our workforce with population demand. Concurrently, the funding of a National Medical Workforce Data Strategy will facilitate data-driven decision making and modelling of workforce planning, enabling more efficient designing processes, as well as the capacity to monitor and evaluate ongoing training models.

2. MEDICAL SCHOOLS AND STUDENT NUMBERS

Problem & Cost	The rapid increase of medical schools is estimated to cause an oversupply of doctors. Training medical students is a costly exercise, and without providing ample opportunities for graduates to complete internship, is an inefficient use of federal funds.
Recommendations	**a. Refuse to fund any scheme which directly or indirectly increases the number of Australian, especially international, medical students.** **b. Refrain from supporting or funding any new medical school proposals unless guided by evidence-based modelling addressing workforce need and the National Medical Workforce Strategy.**
Expected Benefit	Improved medical workforce planning. Avoidance of flooding the medical pipeline with graduates unable to access specialty training programs.

THE ISSUE

The rapid increase of medical schools in Australia from 15 in 2006 to 23 in 2022 is estimated to cause an oversupply of doctors of at least 4,494 by 2030. Given that Australian medical graduates cannot register as doctors without the completion of an internship, training medical students who will be unable to become fully qualified doctors represents both an inefficient use of federal funds and a waste of personal investment; as much as $58,318 per student per year, according to Medical Deans.

New medical schools, regardless of whether they are placed rurally or in a metropolitan location, have not been proven to yield an increased rural medical workforce. Due to the lack of available specialty training opportunities in rural areas, the vast majority of doctors return to metropolitan regions even after undertaking a rural medical education, and efforts to increase the interest of medical students in rural practice remain fruitless as long as medical training pathways are unable to retain training doctors in rural areas.

Further, the investment required to establish new medical training programs in rural areas duplicates the already-successful Rural Clinical School scheme and represents a poorly-targeted use of federal funding that may otherwise be directed at rural health services. A far more targeted use of funding is to invest in strategies that increase the number of rural speciality training opportunities, such as the Specialty Training Program (STP), such that qualified doctors may be brought into rural communities now, rather than hoping medical students will return to the region in 10-20 years.

THE SOLUTION

In line with AMA and AMSA policy, we request that the government refuse to fund any scheme which directly or indirectly increases the number of Australian, especially international, medical students. Further, to ensure the efficient use of health and education spending, we request that the government refrain from supporting or funding any new medical school proposals unless guided by evidence-based modelling to address workforce need.

3. INTERNSHIPS

Problem & Cost	The training of medical students, without a corresponding internship and progression through post-graduate medical training, represents poor workforce planning and inefficient use of Government funding.
Recommendations	**a. Ensure all Australian medical graduates have access to an internship.** **b. Align future Junior Doctor Training Program funding with medical student numbers.**
Expected Benefit	All medical graduates will be able to practice as doctors in Australia. Maintenance of the international reputation of Australia's medical programs. Improved distribution of doctors across Australia who have had their medical education in the Australian context.

THE ISSUE

The Australian internship, or postgraduate year 1, is a requisite for full registration to practice medicine with the Medical Board of Australia. Medical student numbers have been steadily increasing, with numbers nearly doubling between 2007 and 2022. This has not always been matched by a proportionate rise in internship positions. International students form the majority of those who miss out on internships due to being considered for internships below their domestic student counterparts, despite completing the same course.

The presence of medical graduates who are prevented from accessing the right to practice in Australia is a failure of workforce planning, and may result in the loss of competent students who would have otherwise contributed holistically to the workforce and possibly alleviated workforce shortages in rural Australia.

THE SOLUTION

AMSA commends the Federal Government's support of the Junior Doctor Training Program (JDTP) in recent years. We request that this program continue to be funded beyond 2022 to ensure that all Australian-trained medical students may access an internship position. Future JDTP funding should be aligned with medical student numbers.

4. RURAL SPECIALIST TRAINING

Problem & Cost	A paucity of specialist doctors in rural areas means that rural Australians experience a higher disease burden and more difficulty accessing healthcare, leading to higher preventable hospitalisations, higher death rates, and lower productivity rates.
Recommendations	**Provide increased funding for vocational medical training options in rural and regional Australia via the continuation and expansion of the Specialist Training Program.**
Expected Benefit	Reduction in the health gap faced by rural Australians. Greater retention of doctors in rural areas. Greater flexibility for doctors wishing to undertake a career in rural medicine.

THE ISSUE

Australia's remote and rural population continues to face inequity in accessing health services, in particular, access to specialist medical doctors. Consequently, rural Australians face significantly poorer health outcomes in comparison to their metropolitan counterparts. Avoidable death rates are approximately 20% to 65% higher than in metropolitan areas, while there were 60.9 potentially-preventable hospitalisations per 1,000 people in very remote areas of Australia compared with only 25 in major cities, each of which costs Australia an average of $3100-6100. These represent an area of economic inefficiency that stem directly from reduced accessibility to healthcare,

Vocational opportunities in rural areas are critical to retaining rural doctors and addressing workforce maldistribution, and while AMSA commends the government's investment into the National Rural Generalist Pathway, training pathways in other specialties are also required to successfully address the wide health gap that rural Australians face.

THE SOLUTION

The Specialist Training Program (STP) has been central to supporting the provision of rural vocational training opportunities via the specialist medical colleges. Continuing to fund and expand the STP into the future, providing more opportunities to train specialists across a wider variety of rural sites, will facilitate rural workforce retention and capacity in areas of need.

5. BONDED MEDICAL PROGRAM

Problem & Cost	Retention rates in the Bonded Medical Program appear to be exceptionally low, with many medical graduates buying out of completing their Return of Service Period, leading to a questionable benefit to the rural communities of Australia, despite the substantial financial investment put into the program.
Recommendations	**Provide investment to conduct a tracer study investigating the retention rate and efficacy of the Bonded Medical Program in improving rural medical workforce distribution.**
Expected Benefit	Insight into the efficacy and cost-efficiency of the Bonded Medical Program. Opportunities to identify weaknesses in the current system, and provide more effective ways to retain medical graduates in the rural workforce.

THE ISSUE

The Bonded Medical Program (BMP), contracts approximately 28.5% of prospective medical students to complete a number of years of professional medical work in a rural or regional area in return for Commonwealth support to complete their degree. In its various forms, this scheme has been running for over 20 years.

Data from 2017 demonstrated that, of the medical students who were contracted to the scheme since 2001, approximately as many students had withdrawn, breached or terminated their contract, as had completed or undertaken their return of service obligations, meaning the attrition rate of the scheme at that time was above 50%. Additionally, there is currently no information available regarding whether those individuals who had completed their return of service obligation continue to work in rural or remote areas, which is the ultimate intention of the program. Data on students and graduates in the BMP has also not been collected since this time, leaving the efficacy of the scheme, and consequently the viability of its investment, questionable.

THE SOLUTION

A tracer study to collect data from BMP students and graduates will allow the scheme to be objectively analysed and its efficacy determined. This would include the publication of the absolute numbers of BMP participants in the various stages of their career pathway; whether they have completed, are in the process of completing, intend to complete, or have withdrawn from their return of service obligation; and whether the return of service obligation has had a tangible impact on a health professional's retention in the rural workforce, and thus whether the BMP is demonstrably beneficial to the rural communities of Australia.

6. HECS REIMBURSEMENT SCHEME

Problem & Cost	Rural Australia continues to have a shortage of doctors across all specialities. The new HECS Reimbursement scheme, while a positive development, is narrow in its scope due to its focus on fully-trained General Practitioners.
Recommendations	**Increase investment to expand the HECS Reimbursement Scheme to include medical specialties outside of General Practice, as well as trainee doctors for whom the incentive will be realised most.**
Expected Benefit	A positive incentive for junior doctors to train in rural Australia will increase the retention of these doctors in these areas throughout their medical training and career.

THE ISSUE

AMSA welcomes the Government's recently-announced HECS Reimbursement Scheme for General Practitioners willing to practice rurally. We especially commend the government for creating a positive incentive-based model, rather than more punitive and less flexible solutions like the Bonded Medical Program. However, this new incentive remains narrow in its scope due to its focus on GPs, and its success depends on rural Australians also being able to access specialty care when required.

A strong rural training pathway requires incentives and available opportunities throughout the medical training pipeline in order to be effective in retaining doctors, including: medical student selection with a focus on rural origin; early and continuing exposure to rural practice; vocational training based in rural areas; and professional and family support after take-up of rural practice (including appropriate remuneration, professional development, locum relief, and social support). The HECS Reimbursement scheme helps provide a remuneration incentive but does not address the other aspects of the rural medical workforce necessary to retain doctors in the long-term.

THE SOLUTION

Expanding the HECS Reimbursement Scheme incentive, to make it available for all trainees and doctors in any specialty who are able to fulfil the requirements, has the potential to drive alleviating rural workforce shortages in many different ways. This should be completed alongside extending and increasing funding of the Specialist Training Program to ensure training opportunities for specialists are also available in rural areas. Long-term studies should be completed on the efficacy of the scheme, and if found to be effective, this scheme has the potential to phase out the punitive approach taken by the Bonded Medical Program.

7. CULTURALLY SAFE HEALTHCARE

Problem & Cost	Disparities in Indigenous health outcomes, fuelled by a lack of cultural safety in the Australian health sector, costs the Northern Territory $3.34 billion annually. The healthcare cost of preventable hospital admissions alone for Indigenous peoples totals $136-268 million annually.
Recommendations	**Commit funding towards subsidising Cultural Safety Training for Australian medical students.**
Expected Benefit	Improvements to the health equity gap experienced by Indigenous Australians. Reduced expenses incurred through preventable hospitalisation and disparities in health outcomes amongst Indigenous peoples.

THE ISSUE

Aboriginal and Torres Strait Islander peoples almost universally experience poorer health outcomes than the non-Indigenous population, largely due to a lack of accessible and culturally safe healthcare. Amongst medical practitioners, a lack of understanding of First Nations values, principles and cultures hinders their capacity to deliver culturally safe and sensitive healthcare. This further ostracises First Nations peoples from healthcare settings, reduces help-seeking behaviours and results in poorer outcomes from health service engagement.

Research from the Northern Territory has calculated disparities in Indigenous health outcomes to cost the Northern Territory $3.34 billion annually. Further, during 2017-18 Indigenous Australians were three times as likely to have a potentially preventable hospitalisation as non-Indigenous Australians. This represents 44,040 annual potentially preventable admissions. Considering the average cost to the health sector of a hospital admission lies between $3100 and $6100, this totals $136,524,000 to $268,644,000 in annual government expenditure for preventable hospitalisations of Indigenous Australians.

THE SOLUTION

Several studies have suggested that the key to reducing Indigenous health disparities is health care workers developing partnerships, eliminating bias through self-reflection, and building relationships with Indigenous people. We ask that government commit $1,346,000 annually to the provision of Cultural Safety Training for one cohort – 3,845 Australian medical students. Through an annual commitment from government, we may ensure that all medical students graduating in Australia will enter the workforce trained to provide culturally sensitive, informed and safe care. We request that this training be administered by National Aboriginal Community Controlled Health Organisations in collaboration with the Australian Indigenous Doctors' Association.

8. FIRST NATIONS MEDICAL STUDENT RETENTION

Problem & Cost	$2.16 to $2.54 million of government investment is lost annually to Indigenous medical student attrition.
Recommendations	**Commit annual funding to support Indigenous medical students to complete their degrees.**
Expected Benefit	Improved Indigenous representation in the Australian medical workforce. Reduction in lost return on investment to student attrition.

THE ISSUE

In 2020, about 600 doctors in Australia's medical workforce identified as being Aboriginal and/or Torres Strait Islander peoples – about 0.5% of the workforce. To reach population parity, that number should be closer to 3,600. One key barrier to this is Indigenous medical student attrition. Indigenous medical student retention can be calculated as less than 70% by tracking medical student enrolment and graduation data over time. Further, growth in recruitment is currently outpacing growth in retention by a factor of 1.175, emphasising that a shift in resources towards increasing retention is necessary.

Consequently, of the 121 Indigenous medical students who commenced their studies in 2020, at least 36 will not complete their degree. With medical school Commonwealth Supported Places (CSPs) equating to a $40,000-$47,000 government investment per student per year, we estimate Indigenous medical student attrition to cost the government $2.16 to $2.54 million annually. This loss is projected to be higher due to the funds invested in Indigenous medical education scholarships, bursaries, and ABSTUDY. Course non-completion also places considerable financial burden on Indigenous medical students and their communities.

THE SOLUTION

AMSA asks for a further $2 million to be invested into services to support Indigenous medical students to complete their degrees. Opportunities to direct this funding include investments in Indigenous Engagement and Support Units, and Indigenous medical student sponsorships and bursaries, with 86% of Indigenous medical graduates reporting financial hardship during their studies in AIDA's Healthy Futures report. Indigenous medical students are best positioned to guide the provision of services to better support their needs and we advocate for their consultation in this process.

9. MENTAL HEALTH FIRST AID

Problem & Cost	Medical students are an at-risk population for poor mental health and the economic investment in training a medical student is significant (~$58,318 per year). The opportunity cost of poor mental health on the health workforce due to attrition of medical students or loss of productivity is therefore immense.
Recommendations	**Continue to provide funding for Mental Health First Aid Training for medical students.**
Expected Benefit	Improved retention rates of Australian medical students in their degree. Improved clinical competency of the medical workforce in situations of mental health crisis. Reduced rates of mental ill-health and suicide amongst the Australian medical student population.

THE ISSUE

Medical students and doctors are an at-risk population for poorer mental health outcomes, experiencing higher rates of psychological distress, mental health diagnoses and suicide than other professionals. Furthermore, medical students are more likely to be approached by colleagues, friends, or family in distressed or pre-distress states. Mental Health First Aid training is invaluable in facilitating early intervention by training students to identify and respond to crisis scenarios in themselves and others.

THE SOLUTION

AMSA commends the government for the $690,000 Mental Health First Aid (MHFA) funding for medical students in 2020-21 to complete the online component of MHFA training. We request the Federal Government provide further funding over 2022-23 and beyond, to ensure this invaluable training is to remain freely available to Australian-based medical students. This is especially important as MHFA training certificates last 3-years, while medical school is between 4 and 6 years, and continual access will ensure MHFA training, and the associated skills, cover the entirety of medical school.

10. COMMUNITY PSYCHIATRY PLACEMENTS

Problem & Cost	The shortage of psychiatrists in Australia's mental health workforce continues to place an economic and healthcare burden on Australia's population, as unaddressed mental illness implies substantial productivity impairment.
Recommendations	**Provide funding to facilitate medical student placement in community mental health settings.**
Expected Benefit	Increased medical student interest in pursuing a career in psychiatry, helping to address gaps in the mental health workforce. Decreasing the stigma associated with the psychiatry discipline. Improving the representation of valuable community health service experiences in medical education.

THE ISSUE

The National Mental Health Commission has acknowledged gaps in Australia's mental health workforce. While AMSA commends the Government's recent investment into expanding Headspace centres across the country, the Productivity Commission found that the workforce shortage pertained to psychiatrists, much more so than psychologists. The Final Report delivered by the Select Committee on Mental Health and Suicide Prevention noted the urgent need to address the perception of psychiatry as a career amongst medical students, in order to create a more sustainable mental health workforce. In particular, barriers to student interest in psychiatry included the quality and breadth of exposures on placement, the lack of support infrastructure following difficult patient interactions, and the stigma attached to psychiatry as lacking treatment efficacy.

THE SOLUTION

In an effort to address all of the aforementioned barriers to student interest in psychiatry, AMSA recommends funding be allocated towards facilitating medical student placement in community mental health settings, as these provide a substantially more optimistic and treatment-oriented experience than hospital and psychiatric emergency settings. Doing so will help address much of the stigma associated with the profession, as well as provide more robust student support in often challenging clinical environments.

11. GENDER-AFFIRMING CARE ON MEDICARE

Problem & Cost	Many aspects of gender-affirming healthcare are not currently accessible within Australia's public health system due to significant financial barriers. Inability to access adequate gender-affirming care significantly increases trans and gender diverse people's risk of psychological distress, mental ill-health, and suicidal ideation or attempts.
Recommendations	**Fund the inclusion of gender-affirming healthcare, including surgical procedures, post-surgical care and other gender-affirming services, under Medicare and the Pharmaceutical Benefits Scheme (PBS).**
Expected Benefit	Access to gender-affirming care promotes positive health outcomes for trans and gender diverse people, including reduced risk of mental ill-health and psychological distress. This will also promote positive downstream effects in both social and economic domains, including, but not limited to, employment, housing, and engagement with the public health system.

THE ISSUE

Gender-affirming care refers to the medical and surgical affirmation of a person's gender identity. For many trans and gender diverse (TGD) people, gender-affirming care is instrumental in improving their wellbeing, yet 76% of TGD youth feel they are not supported in their gender-affirmation. Key financial barriers to accessing gender-affirming care in Australia include inadequate subsidisation of surgeries (under Medicare) and difficulty accessing publicly-funded medications (under the Pharmaceutical Benefits Scheme). Research has demonstrated that inability to access gender affirming healthcare increases the risk of psychological distress. In Australia, over 53% of TGD adults have self-harmed, and transgender people aged 14-25 are over 15 times more likely to attempt suicide than the general population. Inadequate access to gender-affirming care creates significant, and preventable, downstream economic costs to the government through high levels of unemployment, homelessness and mental health care costs in the TGD community.

THE SOLUTION

AMSA recommends that the Australian government funds the inclusion of gender-affirming healthcare under Medicare and the Pharmaceutical Benefits Scheme (PBS). One estimate places the cost at $15 million. Specifically, it is recommended that gender-affirming surgical procedures and post-surgical care are included the Medicare Benefits Schedule (MBS), and that access to funding of hormone therapy via the PBS is improved.

12. VIOLENCE AGAINST WOMEN

Problem & Cost	The rates of domestic violence and use of frontline and crisis services have risen due to the COVID-19 pandemic and associated restrictions. The annual cost of violence against women in Australia is estimated at $26 billion, with $1.4 billion of that cost being attributed to the healthcare burden of treating the effects of violence against women.
Recommendations	**Increase funding to frontline and crisis services to provide funding certainty for the increased demand and utilization in light of COVID-19.**
Expected Benefit	Reduce strain on the healthcare system, frontline and crisis services. Ameliorate the social, psychological and health effects of violence to women. Increased remote and rural service delivery through improved access to technology for service delivery.

THE ISSUE

Violence against women and children takes multiple forms including physical, psychological, emotional, sexual and financial. Violence against women is highly prevalent in Australia - one in six women have experienced physical or sexual violence by a current or previous partner since the age of 15 and one woman is killed every nine days by a partner in Australia. After years of relatively stable rates of violence, the COVID-19 pandemic has caused an increased frequency and/or severity of domestic violence, leading to an increased demand for services.

This demand is reflected in the increased number of clients seeking assistance from domestic or family violence services during the pandemic, as reported by 62% of providers in a national survey. The financial cost of violence against women in Australia is estimated to be $26 billion annually. Violence against women causes significant physical and mental health problems, the resultant costs to the healthcare system to treat the effects of violence are an estimated $1.4 billion.

THE SOLUTION

AMSA commends the Australian Government on its commitment to funding services for women's safety thus far. We hope for this funding to continue with renewed focus on the COVID-19 pandemic and the increased strain it has placed on crisis services. In addition to the $17.1m package, increased funding should be delivered to domestic and family violence service providers to ensure forward planning and funding certainty. Increased funding is crucial to aid the increased utilization of domestic violence services, finance infrastructure development of remote service delivery, and enhance data collection and evaluation of services.

13. SUSTAINABLE DEVELOPMENT UNIT

Problem & Cost	Climate change poses population-wide health impacts that place substantial workforce and economic burden on Australia's healthcare system. Additionally, hospitals are frequently highly inefficient in waste and resource management, contributing both to emissions and cost.
Recommendations	**Commit funding to establish a National Sustainable Development Unit (SDU) to coordinate reform of Australian healthcare environmental sustainability.**
Expected Benefit	Reduced environmental impact of the Australian health sector. Improved efficiency in hospital waste and resource management. Reduced climate change-related health impacts on the Australian population.

THE ISSUE

When considering the issue of hospital waste management, the economic benefits of a sustainability strategy are clear. Victoria's public hospital sector alone produces 52,000 tonnes of waste annually and spends an estimated $21 million disposing of it. In Australia, hospital infectious waste costs approximately $1/kg, which is tenfold that of non infectious/general waste. This provides a strong financial argument for policy mandating the separation of wastes, yet there is currently no national oversight or body to guide and monitor these efforts. In hospitals around the world, efforts to reduce disposable plastic use alone have resulted in annual savings of upwards of $760,000 per institution.

THE SOLUTION

The United Kingdom's Sustainable Development Unit (SDU) provides a successful example of the benefits of national coordination, commitment to targets, regular monitoring, and the provision of guidance to health providers on environmental sustainability. Since its foundation, the SDU has enabled cost reductions of £190 million (over AUD$340 million) annually across energy, waste, water and fuel spending. The SDU has also successfully reduced healthcare emissions by 18.5% and water use by 21% in 10 years.