AUSTRALIAN
Medicine
The national news publication of the Australian Medical Association

Press Club hits the mark

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AMA

ISSUE 29.17 SEPTEMBER 18 2017

AUSTRALIAN
Medicine

Managing Editor: John Flannery

Editor: Chris Johnson

Contributors: Maria Hawthorne
Meredith Horne
Simon Tatz

Graphic Design: Streamline Creative, Canberra

Australian Medicine is the national news publication of the Australian Medical Association Limited. (ACN 008426793)

42 Macquarie St, Barton ACT 2600
Telephone: (02) 6270 5400
Facsimile: (02) 6270 5499
Web: www.ama.com.au
Email: ausmed@ama.com.au

AMA LEADERSHIP TEAM

President
Dr Michael Gannon

Vice President
Dr Tony Bartone

In this issue

Cover pic: AMA President Dr Michael Gannon addresses the National Press Club of Australia

Welfare drug testing is mean and unfair

BY AMA PRESIDENT DR MICHAEL GANNON

The Coalition Government delivered its best health budget for many years in May. Sadly, there was a major stain on what was an otherwise positive package of health-related initiatives – the proposal to introduce drug testing for welfare recipients.

This policy is mean, unfair, and totally unnecessary, especially when there are so many positive things the Government could be doing in the health and social policy sectors.

Drug testing is not an evidence-based measure. It is poor policy. It is divisive. It is a wedge. It is a distraction. It is most unlikely to work. The AMA strongly opposes it.

It is a widely held aspiration in the community for people on welfare to, wherever possible, return to a productive life in the workforce. If you discriminate against them, if you impair their return to full functioning by labelling them as a drug user, then you reduce the likelihood that they will be able to get their life back on track.

Even where the welfare system cannot get people back into the workforce, we want it to help them to contribute to our community in some other way.

The overwhelming majority of people do not end up on welfare by choice. Many arrive there through misfortune or tragic circumstance. They need a hand up, not measures that push them further into despair and lack of opportunity to turn their lives around.

We don't expect people in most industries to have drug testing before they turn up to work. Picking on welfare recipients is simply unfair. It is preying on an already disadvantaged and marginalised group in society.

It would be far better to put funding and resources into education, rehabilitation, and health care services to help turn things around. To invest in hope.

Services for drug and alcohol rehabilitation throughout the community are already stretched. Shaming people who are already struggling won't help.

The available evidence from overseas indicates that this type of drug testing is not effective.

In the USA, drug testing of welfare recipients has been largely ineffective.

According to *Time* magazine, in a trial in Tennessee in 2014, only one person in the 800 who applied for welfare assistance and was drug tested was found to be positive.

In Florida, during a four-month State-tested program for drug use, only 2.6 per cent of welfare applicants tested positive, although the illegal drug use rate in Florida is 8 per cent.

Time reported that "the drug testing cost taxpayers more money than it saved".

In Michigan, only 2.6 per cent of Michigan welfare recipients actually tested positive for drugs, which the court found did not demonstrate a substantial drug problem among welfare recipients.

Eventually, appeal courts found the laws in both States unconstitutional.

Both the UK and Canada abandoned policies to introduce drug testing for people on welfare.

An academic paper in *International Journal of Drug Policy*, "Thoroughfares, crossroads and cul-de-sacs: Drug testing of welfare recipients", by Emma Wincup, concluded that drug testing of welfare recipients would only identify "a minority of welfare recipients", and there was insufficient evidence to justify the financial and human costs [in the UK]. The policy was described as "a solution in search of a problem".

In the UK, the Trade Union Council noted that, even though drug testing accuracy has improved, there are still situations where a person has tested positive for taking legally prescribed medication.

As the AMA understands the Australian legislation, it is welfare recipients who have to pay an undisclosed amount for a second test should the first prove positive. This could leave a vulnerable person on welfare with a large out-of-pocket expense, even though they have been taking only prescription medication.

A further concern is that the proposed welfare recipient drug testing cannot indicate when a person took a substance, and if that renders them unfit for work.

Social Services Minister Christian Porter has said the Government's position on drug testing welfare recipients is "entirely focused on helping job seekers overcome drug problems" and not about "penalising or stigmatising" them.

The problem with this approach is that it equates a positive test for an illicit substance with a 'drug problem'.

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Let's have a thorough conversation about bulk billing

BY **AMA VICE PRESIDENT DR TONY BARTONE**

In recent days we have had the release of data showing the number of Australians using bulk billing has reached a record high, with visits to GPs rising by more than three million last year and bulk billing numbers increasing by 0.6 of a per cent to 85.7 per cent. Proof, one might say that Medicare is now more than ever well supported by the community, Government and doctors alike right? How can this be in the fourth year of an indexation freeze?

> "… it is clear that a lot of work is being done by doctors to address a growing trend that some patients are unable to meet all their healthcare costs."

The Government-released figures, which are published on a quarterly basis, point to a very slight but definitely increasing trend in terms of the number of consultations that are being bulk billed. They reveal that the cost of Medicare benefits has tipped the $22 billion mark, having risen four per cent.

The figures do not reveal the number of Australians being bulk billed and the proportion of patients who are bulk billed.

We know in fact that it remains somewhat difficult at times for some patients to find a bulk billing doctor.

Furthermore, it is clear that a lot of work is being done by doctors to address a growing trend that some patients are unable to meet all their healthcare costs. Doctors are recognising that pressure on their patients and are often trying to accommodate their needs. Doctors sense that pressure and feel the unease that patients are under. At the same time doctors are working harder and longer to try and accommodate pressure to bulk bill patients who need that support.

On the flip side, we know that for the portion of the population that isn't being bulk billed, their out-of-pocket expenses, especially in light of the current freeze, have been growing significantly over the past years. They are finding that they're dipping into their pockets even more than they have in the past.

So it's a two-edged sword.

GP clinics are all small businesses with increasing costs that have had to be met in the face of a frozen rebate for many years now. So it is no surprise that at the end of the day, the pressures are building and will continue to build.

Something's got to give and, unfortunately, what we'll probably find is that spring will keep being wound tighter and tighter until the ability to fund those increasing expenses comes to a head. GPs and clinics need to ensure their viability long term and avoid the dilemma of potentially deciding between the number of consultations and what can be done within a given consultation.

We know from recent data that consultation lengths have been increasing. The average consultation is approximately 15 minutes according to the last set of BEACH data. That has been a steadily increasing trend and it's not surprising given the increase in chronic disease and ageing demographics of our patients.

Unfortunately, doctors are being put in a situation where they need to increase their efficiencies even beyond what can be normally done, while also trying to accommodate the patient need for a bulk billing consultation item as opposed to charging a fully private consultation item.

The increasing spend on Medicare will no doubt be used as evidence by Government that spending needs to be controlled and justifying the freeze and that the level of MBS rebates is adequate. Advocacy for increases in MBS rebates is of course very difficult in such an environment.

Most of us will acknowledge that there is a need to ensure that Medicare remains robust enough to ensure it is equitably accessed by those in community most in need. While it might be politically a taboo topic, unless the Government is prepared to lift its investment in General Practice, we must have an honest conversation about the case to support Medicare by ensuring that those who have the means to contribute to their GP care do so at the appropriate time. As such, record rates of bulk billing need to be thoroughly examined in the current climate.

President's speech highlights AMA's influential voice

BY AMA SECRETARY GENERAL ANNE TRIMMER

You might not have caught the speech given by the AMA President Dr Michael Gannon to the National Press Club in Canberra in August. It was a good speech, well-delivered, and touched on many of the major policy and advocacy debates currently being prosecuted by the AMA.

The President's comments on the strength of the AMA brought to mind the frequently-stated truism that the AMA represents all doctors but that not all choose to pay the membership subscription. In his speech, Dr Gannon reflected on the AMA's positioning on major community health and social issues.

"The significance of challenging social issues like Indigenous health, marriage equality, and euthanasia is that they highlight the unique position and strengths of the AMA.

We are completely independent of governments.

We rely near totally on member subscription income to survive. I can promise you, as a Board member, it is often a concern.

But unlike many other lobby groups, inside and outside the health industry, this gives us a total legitimacy to speak honestly, robustly, and without fear or favour in line with our mission – to lead Australia's doctors, to promote the health of all Australians.

We have strong public support and respect as the peak medical organisation.

The AMA was recently ranked the most ethical organisation in the country in the Ethics Index produced by the Governance Institute of Australia.

People want and expect us to have a view, an opinion. Sometimes a second opinion.

The media demand that we have an opinion. And not just on bread and butter health issues. But also on social issues that have an impact on health.

Our view is never knee-jerk.

We consult our members and the broader medical profession. Often we encourage feedback from other health professionals – the ones who provide quality health care with us in teams.

We attract public feedback whether we like it or not. I can promise you that social media has taken this to a whole new level."

These reflections accurately represent the contribution of the AMA to public debate on health issues, and on broader social issues that impact on the health of the community. The AMA's Constitution spells out that the role of the AMA is to represent the interests of its members, and also to promote the well-being of patients, taking an active part in the promotion of programs for the benefit of the community and to participate in the resolution of major social and community interests.

The AMA draws its legitimacy as a powerful voice in public debate through its representation of medical practitioners across the broad sweep of the profession from medical students to retired doctors, and across all specialties and places of work. The development of medico-political policy within the AMA is robust, through the specialist councils and committees of Federal Council and then to debate within Federal Council itself. The President and Vice President are the public faces of the AMA but behind them is a substantial process that ensures a representative voice for the medical profession.

Welfare drug testing is mean and unfair ... from p3

Testing of alcohol, such as random breath tests, are instantaneous and indicate the level of intoxication and impairment to drive. With some illicit substances, testing cannot determine when a substance was consumed, whether the user has a 'dependency' or 'drug problem', or if it was one-off or recreational use.

Other factors – such as mental health, alcohol consumption, and fitness to work – are critical. Drug testing alone is not a reliable indicator of a person's ability to work.

This policy is wrong. The Government should turn its attention to other social policy priorities.

Alcohol is Australia's biggest drug problem. It accounts for the majority of workplace accidents and injuries. It kills productivity. It destroys families. It ruins lives. How about we start there?

This article was first published in The Huffington Post Australia on 29 August 2017.

Press Club address covers wide range of topics

National Press Club of Australia President Chris Uhlmann and AMA President Dr Michael Gannon

AMA President Dr Michael Gannon's Address to the National Press Club of Australia was both well delivered and well received – covering a wide range of topics of importance to health practitioners and their patients.

It was the second time Dr Gannon had addressed the Press Club, a Canberra-based national institution and forum for policy debate, and will likely be the last as President of the AMA.

During the nationally televised event on August 23, Dr Gannon laid out the AMA's priorities for the future and highlighted its recent achievements in influencing policy outcomes.

He also fielded a range of questions from the Canberra Press Gallery.

Titled *Beyond the Freeze – Time for Heavy Lifting in Health*, Dr Gannon noted there had been numerous changes in the realm of health policy since he last spoke at the Press Club 12 months ago.

"There is no more talk of co-payments," he said.

"The cuts to pathology and diagnostic imaging bulk billing incentives have been reversed.

"The general practice pathology rents issue has, for the most part, been resolved.

"The Medicare freeze has a 'use by date'. It can't come soon enough."

Dr Gannon said while the AMA wanted an immediate end to the freeze right across the Medicare Benefits Schedule, it didn't quite get it.

The hour-long address, which involved both a speech and a question and answer session, was moderated by National Press Club President Chris Uhlmann.

Mr Uhlmann at the time was also the *ABC News* Political Editor, but has since resigned to join the Nine Network as Laurie Oakes's replacement as Political Editor.

Not one to be passive while in the moderator's chair, Mr Uhlmann joined in with his Press Gallery colleagues to grill Dr Gannon on a few policy areas.

One insightful exchange was over the emotive issue of euthanasia and the role doctors have in end-of-life care.

"Could you speak just a little bit more on the principle of double effect?" Mr Uhlmann asked.

"I don't think that most people actually understand that it's available and actually exists in Catholic canon law, that if someone dies as effect of their pain management being turned up to a point where that's the secondary effect, that's something you can even request in a Catholic hospital."

Dr Gannon's response was both revealing and informative.

"One of the things you have to be very careful doing when you're talking on ethical matters is to invoke Catholic canon law, because there are some people who would have great concerns about that," he said.

"But, Chris, who I know is a scholar in this area, will be able to tell you that this all goes back to St Thomas Aquinas. This is well established in Catholic ethics. And it's a well-established ethical principle which is very much secular as well.

"But in very simple terms it means that if your primary intention is to relieve suffering, and by secondary effect it has the effect of hastening someone's life, that is ethically, completely distinct from the intention of ending someone's life.

"So, if we look at proposed assisted dying laws, the intention is to end the patient's life. If you look at palliative care, the intention is to relieve pain and suffering. The intention is important.

"I can promise you that palliative care physicians, the nurses who work with them, the teams they work in, they're a great example of multidisciplinary care for all of us, but they work very carefully and compassionately to provide a level of care which is seven levels above the morphine drip that you've all heard of."

The following pages contain a detailed account of Dr Gannon's National Press Club appearance.

CHRIS JOHNSON

Political message in National Press Club speech

AMA President Dr Michael Gannon has called on all sides of politics to take some of the politicking out of health, for the good of the nation.

Addressing the National Press Club of Australia, Dr Gannon said some health issues needed bipartisan support and all politicians should acknowledge that.

“Some of the structural pillars of our health system – public hospitals, private health, the balance between the two systems, primary care, the need to invest in health prevention – let’s make these bipartisan,” he said.

“Let’s take the point scoring out of them. Both sides should publicly commit to supporting and funding these foundations. The public – our patients – expect no less.”

During the nationally televised address, broadcast live as he delivered it on August 23, Dr Gannon warned political leaders that the next election was anyone’s to win and so they should pay close attention to health policy.

“Last year we had a very close election, and health policy was a major factor in the closeness of the result,” he said.

“The Coalition very nearly ended up in Opposition because of its poor health policies. Labor ran a very effective Mediscare campaign.

“As I have noted, the Government appears to have learnt its lesson on health, and is now more engaged and consultative – with the AMA and other health groups.

“The next election is due in two years. There could possibly be one earlier. A lot earlier.

“As we head to the next election, I ask that we try to take some of the ideology and hard-nosed politicking out of health.”

In a wide-ranging speech, the AMA President outlined the organisation’s priorities, while also explaining the ground it has covered in helping to deliver good outcomes for both patients and doctors.

The AMA’s priorities extend to Indigenous health, medical training and workforce, the Pharmaceutical Benefits Scheme, and the many public health issues facing the Australian community – most notably tobacco, immunisation, obesity, and alcohol abuse.

“I have called for the establishment of a no-fault compensation scheme for the very small number of individuals injured by vaccines,” Dr Gannon said.

“I have called on the other States and Territories to mirror the Western Australian law, which exempts treating doctors from mandatory reporting and stops them getting help.

AMA President Dr Michael Gannon at the National Press Club of Australia

“We also need to deal with ongoing problems in aged care, palliative care, mental health, euthanasia, and the scope of practice of other health professions.

“In the past 12 months, the AMA has released statements on infant nutrition, female genital mutilation, and addiction.

“In coming months, we will have more to say on cost of living, homelessness, elder abuse, and road safety, to name but a few.

“Then there are the prominent highly political and social issues that have a health dimension, and require an AMA position and AMA comment.

“All these things have health impacts. As the peak health and medical advocacy group in the country, the community expects us to have a view and to make public comment. And we do.

“Not everybody agrees with us. But our positions are based on evidence, in medical science, and our unique knowledge and experience of medicine and human health.

“Health policy is ever-evolving. Health reform never sleeps.”

The address covered, among other things, health economics: “Health should never be considered just an expensive line item in a budget – it is an investment in the welfare, wellbeing, and productivity of the Australian people.”

Political message in National Press Club speech

Public hospital funding: "The idea that a financial disincentive, applied against the hospital, will somehow 'encourage' doctors to take better care of patients than they already do is ludicrous."

Private health: "If we do not get reforms to private health insurance right – and soon – we may see essential parts of health care disappear from the private sector."

The medical workforce: "We do not need more medical school places. The focus needs to be further downstream.

"Unfortunately, we are seeing universities continuing to ignore community need and lobbying for new medical schools or extra places.

"This is a totally arrogant and irresponsible approach, fuelled by a desire for the prestige of a medical school and their bottom line.

"Macquarie University is just the latest case in point."

And general practice: "General practice is under pressure, yet it continues to deliver great outcomes for patients.

"GPs are delivering high quality care, and remain the most cost effective part of our health system. But they still work long and hard, often under enormous pressure.

"The decision to progressively lift the Medicare freeze on GP services is a step in the right direction."

On even more controversial topics, Dr Gannon stressed that the AMA is completely independent of governments.

While sometimes it gets accused of being too conservative, he said, it was not surprising to see the reaction to the AMA's position on some issues – like marriage equality.

"Our Position Statement outlines the health implications of excluding LGBTIQ individuals from the institution of marriage," he said.

"Things like bullying, harassment, victimisation, depression, fear, exclusion, and discrimination, all impact on physical and mental health.

"I received correspondence from AMA members and the general public. The overwhelming majority applauded the AMA position.

"Those who opposed the AMA stance said that we were being too progressive, and wading into areas of social policy.

"The AMA will from time to time weigh in on social issues. We should call out discrimination and inequity in all forms, especially when their consequences affect people's health and wellbeing."

Last year, the AMA released an updated Position Statement on Euthanasia and Physician Assisted Suicide.

It came at a time when a number of States, most notably South Australia and Victoria, were considering voluntary euthanasia legislation.

There was an expectation in some quarters that the AMA would come out with a radical new direction. But it didn't.

"The AMA maintains its position that doctors should not be involved in interventions that have as their primary intention the ending of a person's life," Dr Gannon said.

"This does not include the discontinuation of treatments that are of no medical benefit to a dying patient. This is not euthanasia.

"Doctors have an ethical duty to care for dying patients so that they can die in comfort and with dignity."

The AMA also takes Indigenous health very seriously.

Dr Gannon travelled to Darwin last year to launch the AMA's annual Indigenous Health Report Card, which focused on Rheumatic Heart Disease.

"In simple terms, RHD is a bacterial infection from the throat or the skin that damages heart valves and ultimately causes heart failure," he said.

"It is a disease that has virtually been expunged from the non-Indigenous community. It is a disease of poverty.

"RHD is perhaps the classic example of a Social Determinant of Health. It proves why investment in clean water, adequate housing, and sanitation is just as important as echocardiography and open heart surgery.

"The significance of challenging social issues like Indigenous health, marriage equality, and euthanasia is that they highlight the unique position and strengths of the AMA.

"The AMA was recently ranked the most ethical organisation in the country in the Ethics Index produced by the Governance Institute of Australia.

"People want and expect us to have a view – an opinion. Sometimes a second opinion."

CHRIS JOHNSON

A transcript of the full address can be found here: https://ama.com.au/media/dr-gannon-national-press-club-address-0

Questions asked and answered during Press Club appearance

AMA President Dr Michael Gannon takes questions at the Press Club

In addition to delivering a wide-ranging 30-minute speech at the National Press Club, AMA President Dr Michael Gannon spent another half hour at the podium fielding questions from the Canberra Press Gallery.

The issues raised by the inquiring reporters ranged from doctors' fees, to refugee health, to codeine prescriptions, to marriage equality – and a whole lot in between.

On the subject of cost-shifting by the States to patients covered by private insurance who are attending public hospitals, Dr Gannon said he had made the point directly to Health Minister Greg Hunt, that flexibility must be maintained.

"We don't want a situation where insured patients are prohibited from care in public hospitals," Dr Gannon said.

"They might live in a rural area where there's no alternative; no fancy, shiny, private hospital there in the region. It might be the case that a doctor with sub-specialist expertise only works in a public hospital. It may be that they need the intensive care unit that only exists in a public hospital. It may simply be the patient's choice. So, wherever we land, we must end up with flexibility.

"One of the things that's led to this problem is the fact that the States and the Territories and the Commonwealth have underinvested in public hospitals. So, the public hospitals are looking for new revenue streams, and sometimes they're a bit too tricky and clever trying to get hold of insured patients when they're not actually providing any greater level of care.

"But I also think this is an area where the private health insurers need to step up to their part of the responsibility."

In his speech, Dr Gannon described the push by insurers for doctors to publish their fees and customer referrals as "dangerous territory".

In response to questioning about that, he said informed financial consent was very important.

"But I don't trust a website owned by the insurers to produce un-vetted information about the quality of the magazines in the waiting room, whether or not the receptionist was rude, and I have great concerns about people not being able to obviously interpret quality data," he said.

"It's a lot more complicated than a cheesy website might appear."

Questions asked and answered during Press Club appearance

Drug testing welfare recipients

The AMA President was highly critical, when he was asked about it, of the Government's plan to drug test welfare recipients.

"If I had to put a nasty star on the Government's last Budget, it was this mean and non-evidence-based measure. It simply won't work," Dr Gannon said.

"This is not an evidence-based measure (and) will not help. We don't expect people in most industries to have drug testing before they turn up to work.

"It's simply unfair and it already picks on an impaired and marginalised group. It's not evidence-based. It's not fair. And we stand against it."

NDIS

On the question of the NDIS eligibility of people with mental health conditions, Dr Gannon said the scheme needed certainty of funding to ensure proper access and eligibility.

"This is going to be a very difficult and vexed issue for Governments now going forward," he said.

"Talk to the experts. Talk to the GPs, the psychiatrists, the psychologists, the carers who are there providing that care every day. Look at the evidence. Look at what works, and fund it according to what might be expected to work from international evidence, or from talking to home-grown experts here in Australia."

Same-sex marriage

On marriage equality, the President said he wouldn't lecture parliamentarians on legislative approaches, but a risk existed that the wider discussion on the issue will have mental health impacts on people directly affected.

"Equally, we live in a democracy where people are entitled to have their say. I faced criticism of our Position Statement from within the membership, and I have made it very clear that we, as an organisation, are a broad enough church that we can accommodate different views on this topic," he said.

"And I am not uncomfortable with the Australian people being given their say. We believe that this is an area of discrimination and therefore does have health impacts. We would like to see it resolved. We would like to see the Government, the Parliament getting on in other crucial areas of public policy, but we are silent on the exact details about how we get there."

Codeine prescriptions

On codeine, and the AMA's agreement with the decision to make it available only by prescription, Dr Gannon said the AMA's position was not a unilateral statement.

"This is very much the AMA supporting the Therapeutic Goods Administration, the TGA, in their independent science-based analysis of the issues," he said.

"Now, many people might not know that there's already 25 countries where codeine requires a prescription. Many people might not know that the science tells us that we all metabolise codeine very differently. So for a significant minority of us, we metabolise it in a way that is extremely potent, every bit as powerful as morphine, and is a common cause of death from opioid overdose.

"Not only have we told the Minister we support the TGA's decision, we are also telling the State and Territory Health Ministers that we do not want to see exemptions from this. That's wading into very, very dangerous territory, when the independent regulator looking at scientific evidence is overrun by an industry that has a different view."

Euthanasia

On palliative care and support of doctors who may wish to assist patients to die, he was very clear.

"We have inadequate legislation in most parts of Australia to protect doctors acting ethically and lawfully with inadequate doctrine of double effect legislation," Dr Gannon said.

"Ninety-nine per cent of end-of-life decisions do not involve requests to die. That is a very, very, very small part of the system.

"And surely the aspiration of all people, whether they favour voluntary euthanasia or not, is to improve palliative care services.

"The AMA Position Statement makes it extremely clear that we understand this is a decision for society: it's Parliament's, it's legislators'. The AMA's position is that doctors should not participate in these arrangements."

Refugee health care

Regarding the level of health care provided to asylum seekers in offshore detention, Dr Gannon said the ethical principles were very clear.

People seeking the protection of the Australian Government are entitled to healthcare standards the same as Australian citizens.

Questions asked and answered during Press Club appearance

"So, that's a matter of ethics and that's a matter of law. What we've developed over the past 12 months or so is a relationship with the Chief Medical Officer of the Department of Immigration and Border Protection, so that when we receive discussions on individual healthcare episodes we are able to talk about them," he said.

"... a difficult and vexed issue where a form of medical care, namely termination of pregnancy – which could relatively easily be provided on Nauru – can't legally be provided because it's illegal on the island.

"That means that if that cannot be provided, that those patients must be transferred to the mainland. This is a hotly contested political issue. I am not an immigration expert. But I like to think I'm an expert in medical ethics, and I've stated our position very clearly as to the health standards that we would expect."

Private health insurance

On private health insurance, Dr Gannon said agreement must be reached on basic level of cover, or at least better transparency, so people know what they're covered for.

"The policies that are nothing more than to dodge the tax penalty, they're junk," he said.

"The policies that limit you to care in a public hospital, I need to be convinced why they're any better than being a public patient in our excellent public hospitals.

"Now I don't want to spend my entire life arguing with the insurers. They have a right to make a profit. In fact they've got a corporate responsibility to deliver a profit. But they cannot deliver that profit on the back of diminished services to private patients. And if they don't get it and they don't get it soon, they will drive their industry off the cliff."

CHRIS JOHNSON

The full transcript of Dr Gannon's Q&A session at the National Press Club can be found here:

https://ama.com.au/media/dr-michael-gannon-national-press-club-q-and

AMA being heard over the medical indemnity concerns

AMA President Dr Michael Gannon used his National Press Club address to assure doctors and patients alike that he was keeping the issue of medical indemnity at the forefront of his discussions with political leaders.

He said medical indemnity was an area of great concern to the medical profession that has recently re-emerged.

"Some of you may remember the indemnity crisis more than a decade ago. The reforms and protections put in place by then Health Minister Tony Abbott are showing signs of stress," Dr Gannon said.

"While back in the UK recently, I saw what could happen here again without intelligent policy.

"Medical indemnity in the UK is becoming unstable. The two major providers have pulled out of private obstetrics. There is talk of pulling out of coverage in other high risk areas."

Dr Gannon noted that more than a decade ago, the AMA advocated tirelessly and brought together the profession to work with the Government in designing a series of schemes that have been a resounding policy success.

Those schemes have promoted stability. They provide affordable insurance, which flows through to affordable care.

That has been the AMA's strong message heading into the current review of indemnity insurance.

"Thankfully, the Government has been receptive to our advice, and I am grateful to Health Minister Greg Hunt for listening," he said.

"He was surprised to hear that annual premiums got as high as $126,000 a few years ago. And that's after the support schemes' contributions are taken into account.

"We now have a review that is focussed on improving and building on the current policy success. It is not a savings exercise.

"It removes a threat to a stable medical workforce."

CHRIS JOHNSON

COAG move on mandatory reporting welcomed

The Council of Australian Governments (COAG) Health Council has resolved to develop a nationally consistent approach to mandatory reporting provisions for health practitioners.

The move has been warmly welcomed by the AMA.

Federal and State and Territory Health Ministers have agreed to consult with practitioner and consumer groups, and develop a nationally consistent proposal for consideration at the next COAG Health Council meeting in November 2017.

The agreement follows months of lobbying and advocacy from the Federal and State AMAs, highlighted by discussions in face-to-face meetings between Health Minister Greg Hunt and AMA President Dr Michael Gannon in recent weeks.

Dr Gannon said that the AMA had always advocated for treating practitioners to be exempted from mandatory reporting requirements.

"Mandatory reporting laws deter health practitioners from seeking early treatment for health conditions that could impair their performance," Dr Gannon said.

"We have advocated long and hard at both the federal and State level for changes the mandatory reporting provisions.

"It is an issue that the AMA and the whole medical profession feel passionately about. It affects every doctor, their families, their loved ones, and their colleagues."

Delegates to the AMA National Conference in May were unanimous in seeking amendments to the mandatory reporting requirements under the National Law, so as to not dissuade medical practitioners from seeking necessary medical treatment or assistance.

The intention of the legislation was to ensure the protection of the public by requiring doctors and other health practitioners to report colleagues whose health was impaired.

But this created a barrier for health professionals to access health care, particularly in relation to mental illness. The lived experience of doctors' health advisory services across the country confirms these fears.

"Mandatory reporting undermines the health and wellbeing of doctors," Dr Gannon said.

"It is a tragic reality that doctors are at greater risk of suicidal ideation and death by suicide. This year we have lost several colleagues to suicide.

"While there are many factors involved in suicide, we know that early intervention is critical to avoiding these tragic losses.

"The AMA has identified that mandatory reporting is a major barrier to doctors accessing the care they need.

"The real work begins now. We need action from all our governments.

"The medical profession and the public need a sensible system that supports health practitioners who seek treatment for health conditions, while at the same time protecting patients.

"We urge all Health Ministers to work cooperatively to come up with an achievable agreed proposal at their next meeting."

CHRIS JOHNSON

INFORMATION FOR MEMBERS

Essential GP tools at the click of a button

The AMA Council of General Practice has developed a resource that brings together in one place all the forms, guidelines, practice tools, information and resources used by general practitioners in their daily work.

The GP Desktop Practice Support Toolkit, which is free to members, has links to around 300 commonly used administrative and diagnostic tools, saving GPs time spent fishing around trying to locate them.

The Toolkit can be downloaded from the AMA website (http://ama.com.au/node/7733) to a GP's desktop computer as a separate file, and is not linked to vendor-specific practice management software.

The Toolkit is divided into five categories, presented as easy to use tabs, including:

- online practice tools that can be accessed and/or completed online;
- checklists and questionnaires in PDF format, available for printing;
- commonly used forms in printable PDF format;
- clinical and administrative guidelines; and
- information and other resources.

In addition, there is a State/Territory tab, with information and forms specific to each jurisdiction, such as WorkCover and S8 prescribing.

The information and links in the Toolkit will be regularly updated, and its scope will be expanded as new information and resources become available.

Members are invited to suggest additional information, tools and resources to be added to the Toolkit. Please send suggestions, including any links, to generalpractice@ama.com.au

New medical school places undermined by bad policy

The AMA has welcomed the Federal Government's commitment to 50 medical school places at the Sunshine Coast University Hospital, but AMA President Dr Michael Gannon said the policy surrounding the move needed rethinking.

Dr Gannon said he was pleased the impasse over medical school places on the Sunshine Coast had been resolved, with a commitment to 50 Commonwealth Supported Places (CSP) announced at the end of August, but good intention had been undermined by bad policy.

He said the AMA has supported the establishment of the new medical school, provided total national medical student numbers do not increase.

"We welcome the fact that the Government has partly listened to our arguments, with the overall number of CSP medical school places across the country remaining unchanged," Dr Gannon said.

"The 50 CSP places on the Sunshine Coast have been reallocated from other medical schools.

"However, the AMA understands that, as part of the negotiations with other medical schools, the Commonwealth has been forced to agree to support the recruitment of additional international full fee paying medical students at those universities that have given up places."

The move comes on top of the decision by Macquarie University to establish a new $250,000 medical degree course – a decision that prices a medical degree out of reach for many of Australia's best and brightest students.

The AMA insists the policy focus must be on the mal-distribution of doctors and shortages in particular specialty areas, not supporting universities to boost their bottom line.

"We are graduating record numbers of medical students, putting us well above the OECD average," Dr Gannon said.

"But we are not providing enough prevocational and specialist training places for our medical graduates. Next year, we face a shortage of 569 first year advanced specialist training places.

"We must address community need by supporting extra prevocational and vocational training places, otherwise access to medical care will continue to be a problem in many parts of the country."

Dr Gannon said the downside of the Sunshine Coast Medical School announcement was that it was unfortunately another example of where horse trading has replaced good medical workforce planning and policy.

"The Government needs to take a much tougher approach to full fee paying medical school places, both for domestic and international students," he said.

"Working with the AMA and other groups will ensure that policy settings genuinely tackle the medical workforce problems we now face."

CHRIS JOHNSON

Health Department boss leaves

Martin Bowles has retired from the Australian Public Service and stepped down as the Secretary of the Federal Health Department.

Mr Bowles was a high-profile senior career public servant who had led the Health Department since October 2014. He had previously served as the Secretary of the Immigration Department, Deputy Secretary in the Department of Climate Change and Deputy Secretary of Defence.

He was awarded the Public Service Medal in 2012.

Mr Bowles has also worked in senior roles in the public health systems of Queensland and NSW.

Prime Minister Malcolm Turnbull announced the Health Department boss's resignation on August 22, effective from September 1 this year.

"I thank Mr Bowles for his professionalism, dedication and significant contribution to the public service and wish him all the very best for the future," Mr Turnbull said.

Deputy Secretary Mark Cormack is currently the Department's Acting Secretary.

Mr Bowles has taken up a new position leading Calvary Health Care's national operations network in Canberra.

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Across Australia

AMA calls for urgent Government action on junk policies

The community is losing faith in private health insurance, with health funds offering too many "junk" policies that provide no cover when people need it, AMA President Dr Michael Gannon says.

The AMA has called on the Government to legislate to ensure that all policies have a minimum level of cover, appropriate to the age of the person taking out the policy.

"Private medicine is under siege and, in many ways, that's because, very quickly, the community is losing faith with their private health insurance, which underpins most visits to private hospitals," Dr Gannon told *ABC AM*.

"We seem to be seeing an orchestrated campaign by the insurers – an industry which is increasingly a for-profit industry – to deflect the blame from the real problems, and the real problems are that patients are getting sick and tired of finding out when they're sick that their insurance isn't good enough."

Almost 35,000 people dropped their hospital cover between March and June this year, latest figures show. More than half (17,685) were in the 20 to 24 age group.

The slide coincided with an average 4.84 per cent premium rise in April – three times the inflation rate – and a 15.5 per cent rise in health funds' net profits in the 2016-17 financial year.

While the AMA is part of the Private Health Ministerial Advisory Council (PHMAC), which is due to report by the end of the year, Dr Gannon says enough is known about junk policies for the Government to act now.

"There are people who have carefully, dutifully, responsibly put aside money for private health insurance, over many years in many cases, and then when they get sick they find they're not covered," he said.

"Policies for people over the age of 60 that exclude them from having their hips or knees fixed, or having their eyes fixed, are silly.

"We've a proliferation of junk policies which are worth nothing more than the paper they're written on, and are purely designed so people avoid the tax penalty.

"The Government has the power to legislate — to make sure that [the policies] are worthwhile for people who take them out."

Dr Gannon rejected a call by former Health Department head, Professor Stephen Duckett, for doctors to be forced to publish their fees.

He conceded that doctors could do better when it comes to providing information, but said patients should make better use of their general practitioner.

"If you've got time to spend with your GP, if you've got your own trusted GP, they're pretty clever," Dr Gannon told *ABC Radio Adelaide.*

"They get to know you, they get to know which specialists might fit with your personality, which specialists bulk bill, which specialists work in which hospitals, which operations can be done where.

"They know this information, and if you really want to talk about value in the health system, it's having a good relationship with your GP.

"A lot of the time, a good GP will save you a visit to the specialist to start with, and a lot of the time they'll work out who the right specialist for you is."

The AMA's submission to the Senate *Value and Affordability of Private Health Insurance and Out-of-Pocket Medical Costs in Australian Health Care* inquiry points out that medical fees make up just 16 per cent of total benefit outlays for private health insurers, so it would take a substantial decrease in fees to have an effect on premiums.

But it argued that if doctors' fees should be published in the interests of transparency, so should all components of private health insurance costs.

"Private health insurers, hospitals, and other key stakeholders should all provide details of costs to the system," the submission said.

"This could include senior management remuneration and/or fully itemised hospital list of charges post-surgery, so the patient can see exactly how their insurance has supported them."

The AMA is prepared to consider a proposal where specialists publicly reported on a Government website the fees they charge for the five most common procedures they carry out.

MARIA HAWTHORNE

The AMA's submission to the Senate inquiry can be found here:

https://ama.com.au/submission/ama-submission-inquiry-value-private-health-insurance

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If you are interested in making a contribution, you can do so by downloading the donation form at: https://ama.com.au/donate-indigenous-medical-scholarship. Further information about the Scholarship go to: https://ama.com.au/advocacy/indigenous-peoples-medical-scholarship.

For enquiries please contact the AMA via email at indigenousscholarship@ama.com.au or phone (02) 6270 5400.

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Health Star Rating – five years on

BY PROFESSOR GEOFF DOBB, AMA BOARD MEMBER

Five years ago I authored a column in *Australian Medicine* advising members that after concerted advocacy on the need for easy to improve food labelling, the AMA had been recognised as a key stakeholder and invited to join the Front of Pack Labelling Stakeholder Working Group.

The Group, chaired by Jane Halton AO PSM, then Secretary of the Federal Department of Health and Ageing, was tasked with developing a new approach to front-of-pack labelling that would help consumers identify healthier packaged food options.

We recognised that the Nutrition Information Panel was too complex, and often too small to help consumers. The move also recognised that there was some level of dissatisfaction with the two most popular front-of-pack labelling approaches at the time. I welcomed the invitation to participate but am sure there was a level of scepticism about whether this diverse group of stakeholders could work together to create and implement a system that would support Australians to make healthier choices.

Five years on and the AMA has just lodged its submission to the Five Year Evaluation of the Health Star Rating system. Health Star Ratings (HSR) are now found on over 7,000 products, produced by 122 manufacturers, in major supermarkets Coles, Woolworths and Aldi. It appears that the HSR system is largely working as intended. A representative survey conducted with 1000 participants recently found that:

- 59 per cent were aware of the Health Star Rating system;
- 50 per cent were likely to use HSR on a regular basis; and
- Of those using HSR, 33 per cent recalled buying a different product because it had a higher HSR.

Some food producers are reformulating their products in order to achieve a higher HSR. Regardless of the motive, removing unnecessary salt, sugar and fats from processed foods is beneficial. The AMA's submission has recommended monitoring the number of reformulations to provide important insights into the effectiveness of the HSR system in driving change.

Consumers report that they would like to see HSR on more products. If uptake in a particular food category is low it can make comparisons difficult. The HSR system is currently voluntary, but it is essential that the food industry recognises the benefit to consumers and displays the HSR on as many products as possible. On this point, the AMA's submission argued that any slowing of uptake should result in active consideration of the HSR becoming mandatory.

There have been some vocal critics of the HSR, but the reality is that most are not responsible for the weekly grocery shopping, the target audience for HSR. The criticisms typically focus on three issues. Firstly, that the system can't be used to compare a can of baked beans with a tub of yogurt. This was never the intention of the HSR, rather instead it helps consumers compare similar products in order to identify the healthiest option.

Further criticism highlights that certain foods receive an inappropriately high HSR. The HSR Advisory Committee takes these concerns seriously. For example, the rules around products that display HSR based on how they are prepared (cake mixes, powdered soup, sauce mixes or drink flavourings) are currently under review.

Finally, some advocate that HSR apply to fresh foods. This was never the intention, with the HSR applying only to manufactured and processed products. A general principle that "fresh is best" is recognised by the AMA and we continue to advocate for more public education on nutrition. The HSR isn't perfect, but it is certainly much better than nothing.

The AMA submission also advocates that HSR play a role in helping consumers to reduce consumption of 'added sugars' through penalisation of these additions. A recent report by the George Institute found that 70 per cent of packaged foods contain added sugars. Current labelling doesn't provide any distinction between naturally occurring and added sugars, making it extremely difficult for consumers to identify products that contain unnecessary added sugars. Food labelling alone will not address obesity, but supporting consumers to identify healthier food products will play a part.

The AMA's submission is available from: *https://ama.com.au/submission/ama-submission-five-year-review-health-star-rating-system*

Communiqué from Federal Council meeting 17-18 August 2017

BY DR BEVERLEY ROWBOTHAM, CHAIR OF FEDERAL COUNCIL

Welcome to the inaugural communiqué from Federal Council highlighting the debates had, and decisions taken, at its meeting in Canberra in the depths of winter on 17-18 August.

In giving his report, AMA President Dr Michael Gannon made mention of the many recent advocacy wins of the AMA. He reported that the working relationship with the Federal Government has evolved following the compact agreed at the time of the Federal Budget in March, enabling frank and effective engagement with Health Minister Greg Hunt.

Dr Gannon reported that benefits of this engagement can be seen in recent successes with the Minister moving to scrap the draft national maternity services framework which was opposed by the AMA for lack of obstetrician and GP involvement; and support by Minister Hunt to work with State and Territory colleagues to remove mandatory reporting from the National Law. Advocacy on this latter issue has been strongly supported by Federal, State and Territory AMAs, which uniformly endorse the WA approach to mandatory reporting.

The Secretary General's report provided a comprehensive overview of the AMA's medico-political advocacy. The Secretary General Anne Trimmer noted that the Governance Institute's 2016 Ethics Index, with research undertaken by IPSOS, ranked the AMA as the most ethical of the national membership and industry associations.

She reported that the secretariat is working with the Minister's advisers and the Department of Health to shape appropriately targeted after hours GP services, arising from the draft MBS Review report into these services. The secretariat is working with the NBN to finalise criteria for improved access to broadband in rural areas with a proposal to grant Public Interest Premises status to medical practices under the satellite footprint.

Two of Federal Council's committees are working with the secretariat to develop a new advocacy strategy for aged care with funding and technology identified as priority areas. Federal Council also agreed to campaign for additional funding for the incoming Practice Incentive Program Quality Incentive and strongly opposed recently flagged proposals to increase the return of service periods for future bonded medical places program participants.

The Federal Council noted updates on the two major Government reviews currently underway, the MBS Review and the Private Health Ministerial Advisory Committee review of private health insurance arrangements. An informal grouping of approximately 30 members is working with the AMA to inform its response to the draft reports. Work on the PHMAC review has slowed over the winter period although a new working group on risk equalisation has been established. The AMA will be advocating for changes to the risk equalisation pool to facilitate coverage of pregnancy under all levels of PHI cover.

Federal Council discussed the Government's review of the medical indemnity schemes. The AMA has worked closely with the Department of Health to shape the terms of reference and remains strongly committed to the schemes as an effective mechanism to moderate the cost impact on practices and patients. The AMA has been communicating to the profession the need for active engagement in the review by Colleges, Associations and Societies.

The AMA is represented on a small working group to review the Health Professional Online Services (HPOS) system, which emerged as vulnerable to fraud. The Minister for Human Services, Alan Tudge, kept the President informed of the steps taken to ensure integrity of the system prior to the establishment of the review of health provider access to Medicare numbers.

With a Senate inquiry underway into the value of private health insurance and medical out of pocket costs, the Federal Council set aside a policy session to consider the issues in depth. The AMA lodged its submission at the end of July (the submission can be read at https://ama.com.au/submission/submissions-out-pocket-costs-australian-healthcare).

The submission included data on billing practices collected from a poll of members.

Federal Council, noting the growing public commentary calling on limits on out of pocket medical expenses, agreed that the priority was to correct misleading statements about the role of doctors' fees in the debate about affordability of health care. An animated debate ensued with Councillors contributing a range of views based on their personal experience.

The issue has been largely driven by private health insurance and the growth in gaps in coverage and exclusions. Federal Council noted that there had been limited complaints to the Private Health Insurance Ombudsman about out of pocket expenses. Federal Council also noted that many medical services had always had an element of out of pocket contribution, not to be confused with the charging of an excessive fee which the AMA strongly opposes. Federal Council agreed that there needs to be greater clarity on what constitutes an excessive fee and that this needs to be clearly communicated to the public.

The President acknowledged the comments of Federal Council and noted that he had an opportunity to address these issues in his upcoming address to the National Press Club (the transcript of the President's address can be read at https://ama.com.au/media/dr-gannon-national-press-club-address-0).

The AMA's work on public health initiatives continues, ranging from road safety to obesity and physical activity. Federal Council heard progress reports from working groups led by Councillors and debated draft position statements on road safety, obesity and physical inactivity. Other working groups are considering nutrition, mental health and the social determinants of health. A revised position statement on mental health is in development in conjunction with the AMA psychiatrists' group.

Federal Council received reports from each of its practice group councils, and from its committees. The State and Territory AMAs and Australian Medical Students' Association provided reports on current areas of advocacy.

No place for photo ID checks in General Practice

BY DR RICHARD KIDD, CHAIR, AMA COUNCIL OF GENERAL PRACTICE

> "This is a good opportunity for the Government to assess the risks to its systems. However, the AMA has made it very clear that an excessive response could impact adversely on patients and practitioners."

Universal access to health care is highly valued by Australians. The furore caused when a badly designed co-payment model was proposed provided strong evidence that Australians will not tolerate any threat to their right to access medical care when needed. The AMA strongly advocated to protect vulnerable patients' access to care at the time.

Following the sale of a small number of Medicare numbers on the dark web, AMA advocacy is needed to ensure the Government's response is proportionate and that attempts to improve the security of Medicare numbers do not diminish patient access to care.

To the Government's credit, it was quick to react to security concerns raised by the alleged breach, commissioning an independent review of the accessibility by health providers of Medicare card numbers. The Review is being led by Professor Peter Shergold, with the AMA represented on the review panel. The panel recently released a discussion paper, giving stakeholders the opportunity to provide submissions, with a final report due by the end of this month.

The AMA President has met with both the Ministers for Health and Human Services on this issue and the AMA has also provided a submission in response to the discussion paper.

This is a good opportunity for the Government to assess the risks to its systems. However, the AMA has made it very clear that an excessive response could impact adversely on patients and practitioners.

The Department of Human Services' Health Professional Online Services (HPOS) is a valued service for health care providers and their delegates, enabling streamlined and secure access to Medicare Australia and Department of Human Services programs, services, tools and resources. Every day there are around 45,000 interactions with HPOS.

HPOS has continuously evolved since its introduction to ensure it increasingly enables secure and streamlined transfer of data between providers and Government entities and timely access to information. Nevertheless, there are still some clunky aspects to using HPOS, particularly when it comes to the use of PKI certificates.

The introduction of PRODA has made it much simpler for individual health care providers or delegates to securely access HPOS. However, PRODA is yet to provide the same secure business to business functionality of the PKI site certificate.

The AMA believes that introducing this functionality in PRODA as soon as possible would make it easier for providers to interact with HPOS. It would ensure provider systems flexibility by removing the need for a physical certificate tied to a physical machine, retain secure capability, and streamline provider access. We need to keep up with technological developments in an increasingly mobile, digital, online and cloud based world.

What we don't want to see as an outcome of this Review is over-the-top security measures that go well beyond the problem that has been identified. Ideas like requiring photo ID to see a GP are heavy handed and simply add to a practice's administrative burden. It could also see patients unable to access care and place reception staff in a very difficult environment, facing sick and often distressed people who will not be able to understand why their Medicare card is no longer sufficient enough evidence to access a basic right – health care.

Paying the piper. So what's the tune (and how good is it)?

BY **PROFESSOR STEPHEN LEEDER, EMERITUS PROFESSOR** PUBLIC HEALTH, UNIVERSITY OF SYDNEY

Healthcare funding challenges us as a nation on three levels. The most obvious and basic is: Where does the money come from? The second is: How can we be certain that the money is being well spent on health gain? The third is: How does our funding of health care match our values as a society? While these challenges interlock, looking at each separately can help us determine if we are on the right track. Let's look at values first.

How much do we value health care?

Most advanced economies agree that funding health care should be a major call on public money and hence paid for through taxation. This is a political response to social attitudes that see illness as capricious and accidental and hence not something for which the individual can be held to be responsible. Even when groups engage in risky behaviour – smoking or drinking for example – what happens to an individual remains very much a matter of chance.

Who pays? The individual or all of us?

Which smoker develops lung cancer is currently unpredictable. You cannot hold the sufferer responsible for their illness. As a reflection of social solidarity, most societies like ours choose to defray costs for health care by spreading them across all of us.

This approach is not universal: when money is scarce health care costs are sheeted home to the individual. The proportion of government expenditure going to health care is lower as a proportion of GDP in low- and middle-income countries.

The slow slide to privatising health care

Gradually, since the inception of Medicare in 1984, a decade after Medibank, successive Australian governments have sought to contain health care costs by shifting more of them to the individual. This matters – for equity and fairness.

The New York-based Commonwealth Fund ranks health care in eleven economically advanced nations every two years.

It compares health care on 72 indicators in five domains: Care Process, Access, Administrative Efficiency, Equity, and Health Care Outcomes. Australian health care comes second overall but has lost its top-ranking on the dimension of equity. This is because of rising co-payments that now rival those of the US.

Although this "privatisation" was not the focus of the Mediscare furore before the 2016 federal election, it could have been. Rather, it passes almost without comment.

The latest survey can be found here: http://www.commonwealthfund.org/publications/fund-reports/2017/jul/mirror-mirror-international-comparisons-2017

Funding for activity and outcome

Other strategies to ring-fence the amount of public spending employed in Australia include payments made by the Commonwealth to the States and Territories based on hospital activity as measured by the volume of services they provide.

Efforts put into this approach were mentioned recently in an article in *The Australian* by Sean Parnell. Parnell wrote that: "Before the last federal election, Prime Minister Malcolm Turnbull struck a deal with the States that the Commonwealth would fund 45 per cent of the growth in activity-based funding, capped at 6.5 per cent nationally each year." The problem, of course, will be whether growth can be limited to this figure.

This move has liberated us from complete ignorance of what it is that we are paying for and opens the door for the next step – to find out not just what we are doing but what it is achieving. This requires better information about clinical outcomes and this may follow from improved IT systems.

Getting more value for what we spend is a necessary corollary of capping activity. We must rearrange our processes of care to match the decades-long needs of people with chronic problems in the community rather than in hospital.

We can do better with programs of prevention – directed at nutrition, activity, alcohol and tobacco use for example and the commercial forces that determine these. We should continue our efforts to sort through the lengthy Medical Benefits Schedule to remove those items we now know do not work. We are fortunate to live in a country that enjoys good health and high-grade health care. Ensuring that this remains the case for the future would be fine legacy.

Tough toes a requirement in the bush

BY DR SANDRA HIROWATARI, CHAIR, AMA COUNCIL OF RURAL DOCTORS

Rural Doctors need to have fairly tough toes. They get stepped on so often. We know when our toes have been stepped on because it hurts. Stepping on rural doctors' toes can take on subtle forms.

Role Substitution

Throughout Australia this is happening: nurse practitioners prescribing medications; pharmacists giving out medical certificates and flu shots; physician assistants doing colonoscopies. In the rural regions this role substitution was based on a dire need for manpower – understandable but if the doctor is there, please mobilise these role substitutes elsewhere. Further, it would be nice to let local rural doctors know and have a say in how the allied professionals will be liaising with us.

When another cook comes into the kitchen, it's okay if we invited them. However it is toe crunching when they come into the kitchen, chuck out the soufflé, move the pots and pans around and tell the diners they cook better than we do. I ask you, is this going to motivate me to stay in the kitchen?

The other day a patient said she would wait for the visiting pap smear nurse to visit to get her routine pap smear done. Ouch. I am a pap smear queen. I travel with my pap equipment, what's wrong with me, the good ol' family doctor doing it?

The Non-Existent Discharge Summaries

Patients often come to us saying: "Back two or three months ago they cut out my appendix. You know, they must have told you." Or: "They told me to get my blood pressure and sugars checked as soon as I got back home." Or even: "Sorry, doc I just remembered I was supposed to show you my scar." I cover for my hospital colleagues by saying their bookkeeping must be behind, I am glad they are okay, I regret that I did not know until this minute that they just about died two months ago.

Retrieval Service Extraordinaire

They swooped into my ED, looking through me as If I was not there, stern blue with flashy fluorescent stripes on their trouser side seams. Efficient, military precision, hardly saying a word. They pulled out the IV I had carefully started and replaced it. They took off the splint I fashioned and replaced it, hoisted my patient on their snap-snap stretcher and they were off. At one point I tried to introduce myself: "Hi, I'm Dr S....". I think one of them nodded, never introduced themselves, never gave me a thump on my shoulders to tell me "well done", and they did not tell me what was wrong with my IV and splint. Later I commented to the nurse they could have just kidnapped my patient. I have every confidence my patient is okay, but my toes hurt.

Rolled Up Eyes

Oh, that doctor from St Elsewhere put the patient on the wrong "xyz" drug, they missed the "abc" sign of the obvious disease called blankety blank. Yes we make mistakes, but we need the support from you, not the criticisms. When we catch our own failings, we step on our own toes in shame and self-recriminations. Can you be kind and advise us to not to crunch our own toes so hard? It will help keep us here in the outback healthy.

Continuing Medical Education

How do you think it feels to hear that nurses and medics who take the exact same rural procedural courses pay almost half what we do to attend? Do we pay more because we get a $2000/day stipend for taking rural procedural courses? Why should a rural GP spend precious Government funds on attending a course that has only the intrinsic value of less than the quoted price? Shouldn't the course reflect the unique difficulty of the work of a rural medical officer and not the allied health provider? The Department of Health's toes must hurt this time.

The Visiting Specialist

Please remember you are visiting. I live in this God-forsaken part of the world. Scabies, chronic suppurative otitis media, syphilis, rheumatic heart disease, post streptococcal glomerulonephritis, chronic disease management plans, is my meat and potatoes work. So how do you suppose my toes feel when a visiting team tells the community they have come to "clean up" the scabies, the CSOM, and get "caught up" with all the management plans? Hey guys, I am trying to do the same thing, with limited resources, could we join forces?

In the end it comes to patient care. It is their toes we are all looking after.

My gender and my degree

BY **DR DANIKA THIEMT**

The first documented English-speaking female doctor was Dr James Miranda Barry, a medical officer of the British Army between 1813 and 1865. Dr Barry devoted her life to the British Army, earning the highest medical rank available: Inspector General of military hospitals. In an era when academic professions were the sole privilege of male members of society, it was necessary for Dr Barry to conceal her gender, living and practising medicine as a man. Her sad reality was exposed only posthumously where examination revealed her secret. Even in death, she was denied her right to her true identity; her gender kept secret for a further 100 years.

> "Female medical trainees are now thriving, with female medical graduates in Australia outnumbering men since the mid-1990s."

In Australia, medical training was opened to women in the late 1800s, and our first female graduate was registered to practice in 1891. Female medical trainees are now thriving, with female medical graduates in Australia outnumbering men since the mid-1990s. Women currently make up more than two-fifths of vocational trainees, focused largely in obstetrics and gynaecology (74.5 per cent), paediatrics (72.8 per cent) and general practice (63.1 per cent). Contrast this to the figures from oral and maxillofacial surgery, intensive care and surgery and female trainees make up less than a third of trainees. How, when we see women making up half or more of medical graduates and provisional trainees, are we still seeing unequally representation in the ongoing workforce? What is happening along the way? How and why does a speciality that starts out gender-neutral result in a specialist workforce that is predominantly male?

Fixing gender inequity in medicine requires supporting women in leadership. Diversity in the boardroom enhances corporate performance and, to advance as a profession, we need to attract and retain female leaders. Female specialists, on average, earn 16.6 per cent less than their male counterparts. Although differences in average hours worked account for some discrepancies, other contributory factors include a lack of women in senior positions and a lack of part-time or flexible senior roles. There are already inspiring and engaged female leaders within our profession, leading the world in clinical practice, medical research and education. We should be harnessing their talent to inspire the next generation.

The changing demographic of our workforce could, in part, be to blame. Trainees are graduating from medical school later and spending more time in vocational training. This leads to greater family and social pressures on trainees and possibly an increase in the need for breaks or flexible training options. Evidence shows that access to flexible training helps to retain female trainees and is desired by both female and male trainees regardless of parental status. We need to dispel the belief that trainees must choose between career and family and instead focus on how we enable trainees to have both.

Gender inequity extends beyond medical workforce. Many of my female colleagues report being mistaken for nursing or allied health staff, a rare occurrence among my male colleagues. Similarly, senior female doctors are often overlooked by patients who prefer to talk to the male junior by her side. How do women thrive in medicine and become leaders when public perception seems to favour male doctors? I watch senior medical staff respond to "Miss" in conversation rather than the respectful "Dr". Although this seems petty in the scheme of everyday practice, it is easy for female doctors to believe that our degrees come second to our gender. Although the actions of some do not make a rule, it is time that we stand together as a profession to advance women in medicine. It is time to advocate for female leadership not only in the eyes of the profession but also in the eyes of the public.

Equity isn't about creating a false forced equality. We aren't all equal and that should be celebrated. It certainly shouldn't hold us back. Opportunities to become leaders won't be taken by all of our trainees, but they should be provided to all, regardless of gender.

(A version of this article first appeared in *Emergency Medicine Australasia* in 2016.)

Tobacco smoking – enough of the puff

BY ROB THOMAS, PRESIDENT, AUSTRALIAN MEDICAL STUDENTS' ASSOCIATION

It is no surprise that the smoking of tobacco has decreased significantly from a generation ago, amid targeted and widespread programs to deter its use. Indeed, in Australia we seem to view our stringent tobacco legislation and divestment movements as huge wins for public health. However, what may come as a surprise is that our smoking rates are still roughly one in seven people, and it continues to cause more deaths than alcohol and illicit drugs combined.

> "We must be wary of these products, none of which have yet proved to be useful as cessation tools, and in their use and marketing make smoking more socially acceptable."

As a young person, I'm astounded when I see friends and other young people lighting up. On the one hand, it's probably good that myself and others have such a cultural distaste for this deadly habit, but on the other it's tragic to see people beginning something that they will inevitably struggle with for years.

Like many medical students, I've spent time in respiratory medicine and seen patients dying of cancer, infection and chronic obstructive pulmonary disease, where people describe their existence as "slowly drowning". There is simply no safe level of tobacco consumption. It shocks me that this harsh reality, not just the threat of cancer, causes more than 15,000 Australian deaths per year and yet young people continue to pretend they're invincible.

Interestingly, in the US and UK, smoking rates are now dropping to comparable or even lower levels than in Australia, where our plain packaging and advertising laws are very strong. On a pure price disincentive, we still have some of the most expensive cigs in the world, yet perhaps we are starting to see diminishing returns on smoking rates. Clearly, more needs to be done.

Earlier in the year, AMA President Dr Michael Gannon gave out the "Dirty Ashtray Award" to the State most behind on their smoking crackdown. The Northern Territory, 11-time recipient of that award, has a rate of smoking of more than one in five, with comparatively lax laws regarding smoking in pubs, clubs and even schools. We cannot sit by while children and young people are indoctrinated into a culture where smoking is tacitly accepted.

Some advocates for smoking reduction have looked at the possibility of e-cigarettes as a tool for cessation or alternative. We must be wary of these products, none of which have yet proved to be useful as cessation tools, and may in their use and marketing make smoking more socially acceptable.

Many universities have some form of a tobacco-free policy available on their websites. However, many of these are not enforced or incomplete, meaning that smoking and particularly passive smoking continue. As medical students, we call for more stringent tobacco-free policies to reduce prevalence and change attitudes.

While universities are a great target, we need also to ensure that smoking-related disease does not become a disease of the poor. There is a significant gap in smoking rates between the highest and lowest economic quintiles (8.0 per cent and 21.4 per cent respectively). Although this gap is slowly closing, we need to pursue methods of education and intervention that promote equity and work for the people most at risk.

At the patient level, it's important for doctors to remain vigilant, to work with smokers to quit. We acknowledge this is not easy, it is often a long and relapsing process, but ultimately it cannot just be ignored. Thankfully in medical school we are taught some of the tools of motivational interviewing, but we can't afford complacency.

Complacency cannot be afforded at the Government level, too. The Council of Australian Governments several years ago made the target of 10 per cent daily smokers by 2018, a rate we may just fall short of. Continued efforts, including banning in public places, availability of support to quit programs and widespread public education need to continue. This is not a fight we can say we've won just yet.

Twitter: robmtom
Email: rob.thomas@amsa.org.au

Indigenous sexual health

BY AMA PRESIDENT DR MICHAEL GANNON

While successive governments have made significant efforts to address major chronic health problems experienced by Aboriginal and Torres Strait Islander people, sexual health issues are often left off the agenda. The rates of HIV and sexually transmitted infections (STIs) within Indigenous communities are increasing at alarming rates, and Aboriginal and Torres Strait Islander people are disproportionately affected by these conditions.

The serious consequences of untreated STIs are well documented, some of which are known have long-term effects on health. Syphilis, for example, is highly infectious and can cause heart and brain damage, while diseases such as gonorrhoea and chlamydia can lead to infertility and chronic abdominal pain. Not only do STIs affect a person's physical wellbeing and further increase the risk of HIV infection, but the stigma attached to STIs can result in social isolation.

In 2015, the rate of syphilis among Aboriginal and Torres Strait Islander peoples was over six times higher than that of the non-Indigenous population, and in some remote areas, this rate rose up to a staggering 132 times higher. Indeed, almost 80 per cent of STIs among Indigenous Australians are found in remote communities, and a number of underlying risk factors such as poor access to health services, culturally inexperienced clinical staff, and a particularly young population contribute to such high infection rates.

In recent years we have seen significant progress in both the diagnosis and treatment of STIs and other preventable diseases. However, a syphilis outbreak across northern Australia has recently caused the number of STIs to rapidly rise and has already led to the death of at least four Indigenous Australians. This is completely unacceptable.

These statistics, while incredibly concerning, highlight a growing problem facing Indigenous Australians when it comes to their sexual health and wellbeing. It is clear that urgent action must be taken to address the high rates of STIs in Indigenous communities.

The Federal Government has shown some promise in addressing sexual health issues in Indigenous communities, by forming a Multi-jurisdictional Syphilis Outbreak Working Group to help prevent disease transmission and outbreak, and supporting the South Australian Health and Medical Research Institute to partner with the Aboriginal Nations Torres Strait Islander HIV Youth Mob to deliver awareness and education campaigns to Indigenous Australians across the country.

Yet, in March 2017, the Government confirmed the inexplicable scrapping of federal funding for both the Northern Territory AIDS and Hepatitis Council and the Queensland AIDS Council, all without conducting any community consultations or directly evaluating the programs themselves. For more than two decades, both services have delivered vital sexual health programs to remote and regional communities that experience difficulties accessing mainstream health services, and have developed close relationships with the communities that they serve. The cut in federal funding is set to bring these programs to an unfortunate and indefinite close, but it is services like these that play a key role in improving sexual health outcomes for Aboriginal and Torres Strait Islander people.

Living with a sexually transmitted disease is not just an individual health issue, but one that can impact the entire community. As HIV and STI rates for Aboriginal and Torres Strait Islander people continues to rise, we should not be cutting existing services aimed at improving sexual health practices in Indigenous communities.

The AMA understands that the Government has confirmed it will undertake an evaluation of a $24 million funding proposal to address STIs in Indigenous communities through eliminating syphilis, preventing HIV, health education, and STI screenings through outreach in vulnerable regions. However, we also understand that an outcome on this evaluation has yet to be announced.

The AMA would like to see the Government invest in areas to support ongoing efforts to address Indigenous sexual health problems, and ensure that culturally safe health care remains accessible to all Aboriginal and Torres Strait Islander people to help control the spread of STIs.

Commitment to safety and quality or new cuts to Commonwealth hospital funding?

BY ASSOCIATE PROFESSOR SUSAN NEUHAUS, CHAIR, HEALTH FINANCING AND ECONOMICS COMMITTEE

A key focus of the Health Financing and Economics Committee (HFE) is the pricing and funding of public hospitals.

Public hospitals are a critical part of our health system but remain historically and chronically underfunded. They struggle to manage the demands of aging populations, the burden of chronic disease and new technologies and treatments.

At the April 2016 COAG meeting, the Commonwealth committed an extra $2.9 billion to hospital funding. At the same time they secured State and Territories agreement to:

> *"Incorporate safety and quality into the pricing and funding of public hospitals services with the aim of improving health outcomes, avoid funding unnecessary or unsafe care and decrease avoidable demand for public hospital services." (IHPA, Consultation Paper on the Pricing Framework for Australian Public Hospital Services 2018-19 p4)*

In February 2017, the Commonwealth Minister for Health directed the Independent Hospital Pricing Authority (IHPA) to reduce the level of Commonwealth contribution to activity based hospital pricing for:

i. Sentinel events;

ii. Hospital acquired complications (HACs); and

iii. Avoidable readmissions.

The events listed in each category are developed by the Australian Commission on Safety and Quality in Healthcare. See Sentinel Events List of Hospital Acquired Complications (HACs). The list of avoidable readmissions is due for release later in 2017.

The Independent Hospital Pricing Authority Consultation Paper on the Pricing Framework for Australian Public Hospital Services 2018-19 detailed implementation timeframes and pricing adjustment methodology for the three categories of safety and quality events.

1 July 2017 Sentinel events will not be funded.

1 July 2018 HACs funding will be reduced by a patient "risk adjusted" factor.

1 July 2018 Avoidable hospital readmissions funding will be reduced.

The AMA supports sensible and well-considered initiatives to improve safety and quality in our public hospitals. The AMA wants to see a reduction in HACs and avoidable readmissions but does not endorse the use of Commonwealth financial penalties as an effective way to achieve this. Adverse outcomes result from a complexity of patient and institution factors. If hospitals are overstretched and under-resourced, errors are more likely to occur and less likely to be recognised or remediated.

Safety and quality funding penalties will not assist these hospitals to lift performance. It will instead entrench a spiralling decline in the hospital's capacity to undertake the internal changes needed to focus on safety and avoid future penalties.

The HAC list

The HFE Committee also questioned the validity of some of the HACs that will incur a financial penalty. Examples include:

i. **Malnutrition** - Patients admitted to hospital with pre-existing skin eruptions that have, with exclusion of other causes, been diagnosed in hospital as nutrition related. The hospital should not be financially penalised for diagnostic accuracy;

ii. **Respiratory complications** – aspiration pneumonia. Superficially this seems a reasonable HAC inclusion except it may occur through no negligence, for example as a non-preventable consequence of "grand mal" fit;

iii. **Gastrointestinal bleeding** – A patient with gastric bleeding secondary to biopsy of melanoma metastasis. While bleeding in this setting is an identifiable risk, it was not avoidable; and

iv. **Delirium** is another poorly defined HAC that should be excluded.

Patients are unique and respond to treatment differently. Unless a root cause analysis is undertaken it will not be possible to justifiably attribute the event or apportion all of the adverse consequence to "poor or mismanaged public hospital care".

The timeframe before HAC penalties take effect from 1 July 2018 is too rushed. A three to four month HAC shadow data collection (July–Sept 2017) will not permit reliable indications of financial impact on jurisdictions or identify unintended negative outcomes for patients as hospitals adapt to the financial penalty risks.

We raised similar concerns about the rush to penalise public hospitals for avoidable readmissions from 1 July 2018. The AMA wonders how genuine the planned stakeholder consultation will be given the avoidable admissions list will not be known until late 2017 and IHPA must report to COAG before they meet on 30 November 2017.

The AMA wants to see significantly less HACs and genuinely avoidable readmissions in public hospitals but does not

Supervisors – powerhouses of the medical workforce

BY **AMA VICE PRESIDENT DR TONY BARTONE**

I recently had the opportunity to reflect momentarily on how our well-oiled training allows us to so confidently and expeditiously care for our patients in a vast array of situations. One of my colleagues in the clinic had to attend to a patient with chest pain in the treatment room, something most of us have had to deal with. Making sure he did not need extra assistance, I observed the calm yet confident manner with how he dealt with the critical situation.

We can do all of those things because of our medical training and education, the clinical and professional skills we learned from working with dedicated supervisors, who in many cases become our mentors and friends.

The standard of medicine practised in Australia is consistently ranked among the best in the developed world. This is because we have a highly trained medical workforce based on the established apprenticeship model, with our Colleges maintaining education and independently determined training standards.

However, this model which has served us so well in the past is now at risk. Insufficient postgraduate positions and increasing numbers of graduates and aspiring trainees are stretching the system.

Continual advocacy by the AMA has ensured that there is a growing awareness that we do not have enough prevocational and specialist training places for the increasing number of new doctors. Whether governments and health policymakers are fully awake to the urgency of these worsening shortages is a topic for another time.

Unfortunately, I think it's forgotten sometimes that clinical supervisors are the powerhouses of our apprenticeship model of training doctors. For the AMA, it is clear that to meet the challenge of training the expanding medical workforce, more clinical supervisors need to be found, supported and properly recognised and rewarded.

Boosting supervision capacity is a pivotal issue for our doctors in training, and the AMA has developed a significant suite of policy proposals and ideas in recent years.

To assist our ongoing advocacy, the AMA, led by the Medical Workforce Committee, has prepared a position statement that brings together these policies into a stand-alone document.

Building Capacity for Clinical Supervision in the Medical Workforce 2017 affirms our view that training and supervising new doctors is just as important as delivering services in the health system.

The document emphasises that the apprenticeship model of medical training is as relevant as it was as five decades ago, and shows that building supervision capacity across the spectrum of public, private, general practice and rural settings has common and unique sets of challenges and solutions.

Any discussion on this issue should not neglect the importance of ensuring that clinical supervisors have the support they need to train the next generation of doctors, as well as fostering a culture within medicine that encourages teaching and training.

From a personal perspective, many of my colleagues and I have found supervising junior colleagues to be a demanding yet thoroughly rewarding experience, with much gained in return.

Regrettably, I hear from different sources that protected time is not always available for teaching and training and simply added onto other responsibilities. Worse still, I hear many stories of those who have ended their roles because of a lack of support time or resources. I also know of VMOs and staff specialists who are actively discouraged from setting aside time for these activities. This makes no sense at all. Surely, now is the time to be boosting, not diminishing support for our supervisors.

Building Capacity for Clinical Supervision in the Medical Workforce 2017 outlines what the AMA believes has to be done from the industrial, financial, regulatory and cultural perspectives. I encourage you to take a look.

https://ama.com.au/advocacy/position-statements

Commitment to safety and quality or new cuts to Commonwealth hospital funding?

endorse the rushed, bizarre notion that financial penalties will lead to a positive culture of hospital improvement in a severely underfunded and chronically overloaded system. Safety and quality improvement is more likely in "no blame" hospital reporting cultures such as those adopted in Norway and Denmark and recommended in 2014 by the European Commission. I have grave concerns that much of the progress public hospitals have made to date in areas of open reporting and transparency will be lost in the move to a defensive, financially penalised performance system.

Medical Indemnity

BY ASSOCIATE PROFESSOR JULIAN RAIT

As previously covered in this publication, the profession's concerns about medical indemnity insurance have re-ignited since the Government announced reviews of all Commonwealth funded medical indemnity schemes and the underpinning legislation.

At the height of the indemnity crisis in the 2000s, many practitioners faced uncertainty about the future of their practice, with some thinking about leaving the profession all together.

Everyone was vulnerable.

The AMA played a pivotal role in stabilising the industry by bringing the profession together, and working with Government, to design schemes that were more equitable and affordable for practitioners.

However, these protections put in place by then Health Minister Tony Abbott looked to be under attack of late – indeed a saving has already been garnered through the MYEFO in December, along with the announcement of the review.

Since December, we've had a new Minister and thankfully, as it appears, a new approach. Following extensive lobbying by the AMA, the Terms of Reference (ToR) for the reviews into the Medical Indemnity Schemes appear to be far more informed.

The review has just commenced and the ToR appear to be more focussed on stability, understanding the importance of affordable indemnity insurance and affordable health care, and considering the international experience.

From an AMA perspective the schemes have been a resounding public policy success. They should remain and be strenuously defended.

We're also aware that Medical Defence Organisations (MDOs) have been discussing what they wish to achieve through the review – including insuring that the outcome continues to promote stability in the industry, and maintains affordable premiums.

It is also expected that the role of insurers in providing universal cover – that is the requirement to be an 'insurer of last resort' in a particular jurisdiction, will come under review.

From an AMA perspective, there is a strong belief in the importance of universal cover, and that all indemnity insurers should be required to provide it, and that the arrangements should be fair and equitable. The last thing we want to see is a situation where an insurer, rather than a regulator, decides who can effectively practise in the medical profession.

From an insurance perspective, there is a desire to be able to charge a premium that reflects the level of risk in providing coverage, and to have a mechanism to encourage a practitioner to engage with the MDO and improve their practice.

One of the issues related to the indemnity review is any legislation changes that may be considered as part of ongoing AHPRA and MBA work. This potentially includes requiring indemnity insurers to disclose civil claims to AHPRA.

As all members know, the AMA does not support poorly performing practitioners. However, in absence of any level of detail about how these proposals will work we remain highly wary. Furthermore, a civil claims settlement, and poor medical practice, are not necessarily one and the same thing.

However, it is clear that there is an appetite in some jurisdictions for looking at mechanisms to reveal potentially poorly performing doctors – this builds on previous attempts via the revalidation agenda.

It is therefore critical that the AMA continue to advocate on behalf of our members on the importance of indemnity insurance; the critical requirement for the insurer and the regulator to be separate; and to address any ill thought out or underdeveloped approaches that unfairly target practitioners.

To that end, the AMA will closely watch the forthcoming proposed legislative changes, and the revalidation work underway by AHPRA.

In the meantime, Federal Council has reaffirmed our support for universal cover arrangements, and work has begun on our submission to the indemnity reviews.

But in the immediate term, this review needs to hear from the whole profession. The AMA has written to the Colleges, Associations and Societies, and in this publication, encouraging contributions to the Government's indemnity review.

Providing affordable insurance flows directly through to affordable care, which is an issue the profession is focussed on right now. We need to ensure our voices are heard. For those who wish to make a submission, please see:

http://www.health.gov.au/internet/main/publishing.nsf/content/medical_Indemnity_First_Principles_Review

AMA Members are also welcome to directly contact me via my email address as follows:

jrait@eyesurgery.com.au

Health on the Hill

POLITICAL NEWS FROM THE NATION'S CAPITAL

Minister to co-chair Indigenous Suicide Prevention Committee

Indigenous Health Minister Ken Wyatt will co-chair a new steering committee working directly with Aboriginal communities to address Indigenous suicide prevention.

Mr Wyatt made the announcement as the Kimberley Suicide Prevention Trial begins detailed planning and delivery of potentially lifesaving initiatives across the region.

"This is where the rubber hits the road, working very closely at the community level, involving young people, families and elders," the Minister said when attending a recent suicide prevention roundtable in Broome.

Mr Wyatt said he believed it was important in establishing a strong working partnership between local Aboriginal communities and the Commonwealth, especially through younger people.

"We now have a strong operational plan based around the communities, to bring promising and proven strategies together in liaison with local people, to make a difference on the ground," he said.

The Minister praised a presentation by Kimberley Aboriginal Youth Suicide Prevention Forum members Jacob Corpus (aged 20) from Broome and Montana Ahwon (19) from Kununurra, and said young people must be supported to play key roles in reducing suicide.

"Both Montana and Jacob are incredible and inspiring young leaders who have helped identify key factors that impact on Kimberley youth, which the steering committee will now consider," Mr Wyatt said.

He also recognised the importance of including young Aboriginal people on advisory groups, to help empower them to take up future leadership roles.

Youth forum recommendations included: support for emerging young leaders, positive role models and mentoring; teaching in school of local culture and country traditions; the dangers of drugs and alcohol, and the importance of resilience; and strong youth engagement and networking through sports, arts and local cultural activities.

The steering committee will be co-chaired by Kimberley Aboriginal Medical Service Deputy CEO Rob McPhee and will report to the Kimberley Suicide Prevention Working Group.

The Government has committed funding of up to $1 million per year over three years to June 2019 to the Kimberley Suicide Prevention Trial, to support suicide prevention activities developed by the working group.

The Minister for Indigenous Affairs, Senator Nigel Scullion, has also announced the Government will commit $10 million to expand nationally the suicide prevention trials conducted in WA over the past year.

The Critical Response Team (CRT) model involves trained crisis team visits to families affected by suicide and other traumatic events to co-ordinate support services to help them deal with loss and to build resilience by communities for communities.

Suicide rates among Indigenous people in the Kimberley region of Western Australia are among the highest in the world, according to the World Health Organization. During the period 2001–2010, age-adjusted suicide rates among Indigenous and non-Indigenous Australians were respectively 21.4 and 10.3 per 100 000 population per year.

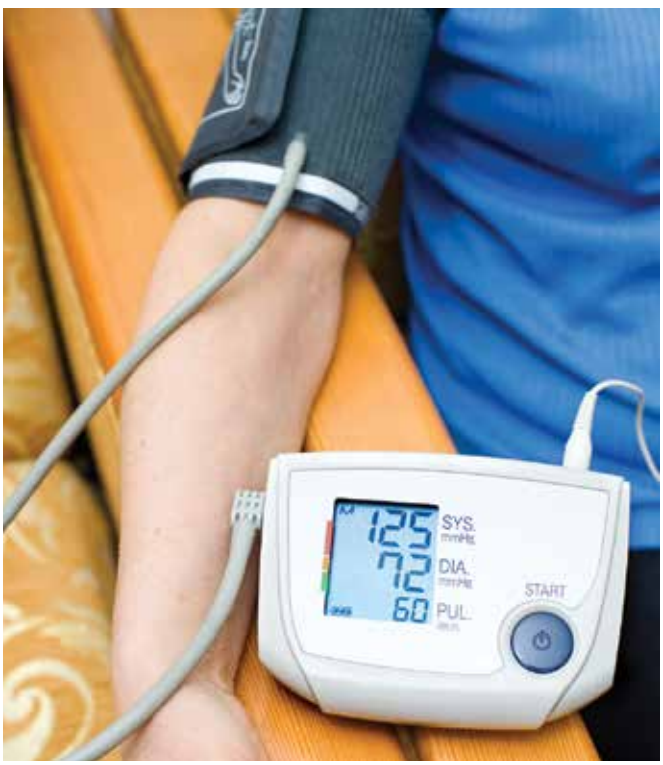
The AMA remains committed to working in partnership with Aboriginal and Torres Strait Islander groups to advocate for government investment and cohesive and coordinated strategies to improve health outcomes for Indigenous people. The AMA recognises Aboriginal and Torres Strait Islander peoples are among the most disadvantaged groups in Australia, and experience high levels of mental ill health and low levels of social and emotional wellbeing.

To read more on the AMA's position go to https://ama.com.au/position-statement/aboriginal-and-torres-strait-islander-health-revised-2015.

MEREDITH HORNE

Research

New treatment for resistant hypertension with ultrasound



Researchers at The University of Western Australia (UWA) have taken a step forward in the fight against high blood pressure, after the first human trials of a ground-breaking treatment produced successful results at Royal Perth Hospital.

The cutting-edge procedure targets carotid bodies, the tiny organs found on either side of the neck, which regulate the cardiovascular and respiratory systems.

The procedure guides a catheter through the femoral vein in the groin up to the neck and ends adjacent to the carotid body. The device then specifically targets the organ with short ultrasound energy pulses, rendering it ineffective.

Exposing a carotid body to ultrasound could permanently lower blood pressure in patients who failed to respond to medication or lifestyle changes, the research has shown.

"We know that patients with uncontrollable high blood pressure will often have an overactive carotid body, so we're looking to silence it or at least reduce its activity," said Professor Markus Schlaich, a team leader in the research at UWA.

Professor Schlaich said the therapeutic ultrasound can emit waves of energy that travel through tissue and target the organ of interest.

Cardiovascular disease is an enormous burden on health and society, with more than 30 per cent of Australians affected by high blood pressure and more than 8.5 million deaths each year worldwide, directly attributable to uncontrolled blood pressure.

One of the participants in the study was 78-year-old patient Agnes Johnson, who suffered from high blood pressure for 30 years and was the first person in Australia to undergo the procedure in 2016.

After the treatment, Mrs Johnson said her blood pressure dropped from 220 over 90 to a more manageable 140 over 80 mmHg.

"The medications I tried kept making me sick so having this done was of huge benefit to me. The procedure was fine, I had no side effects and now I feel much better," she said.

Professor Schlaich said the world-first catheter based approach had been performed on 29 patients in Australia and Europe and he hopes to have the procedure readily available around the world in three to four years.

"There is clear evidence to demonstrate that if you manage to reduce blood pressure you can dramatically reduce the risk of heart attack and stroke," he said.

The researchers point out that this approach won't be used for everyone with hypertension but it could be a great approach for those patients whose blood pressure cannot be controlled with medication or lifestyle changes.

The Australian Stroke Foundation warns that high blood pressure can have many harmful effects which can eventually lead to a stroke; can speed up common forms of heart disease that can lead to stroke; and can cause blood clots or plaque (cholesterol and other fat-like substances) to break off artery walls and block a brain artery causing a stroke.

MEREDITH HORNE

Research

Drink and drugs, a time bomb for baby boomers

In both the UK and Australia, risky drinking is declining, except among people aged 50 years and older, new research has found.

Researchers at Flinders University and South London and Maudsley NHS Foundation Trust in England, published their findings in The *BMJ*, in August this year.

The authors believe that Western countries are sitting on a time bomb of health and social issues arising from drug and alcohol overuse among baby boomers, including a worrying trend for episodic heavy drinking in this age group.

"Alcohol is the most common substance of misuse among baby boomers which presents the most concern because of the larger number of users and wide range of negative consequences," said Professor Ann Roche, Director of the National Centre for Education and Training on Addiction at Flinders University.

The research also found that this generational trend is not restricted to alcohol.

"Some of the pharmaceutical drugs such as opioids also have severe consequences associated with their use," Professor Roche said.

In Australia, the largest percentage increase in drug misuse between 2013 and 2016 was among people aged 60 and over, with this age group mainly misusing prescription drugs.

However, people over 50 also have higher rates than younger age groups for both past year and lifetime illicit drug misuse (notably cannabis).

The authors are keen to highlight that this older age group's alcohol and drug use presents specific issues that are not common in younger demographics.

"Ageing reduces the body's capacity to metabolise, distribute and excrete alcohol and drugs, and older people are also more likely to have pre-existing physical or psychological conditions or take medicines that may negatively interact with alcohol and drugs," Prof Roche said.

"There is also a reduction in lean body mass, resulting in higher alcohol-drug blood concentrations," she said.

The authors of the research are calling for a coordinated international approach to manage this rapidly growing problem, including treatment programs adapted for older people with substance misuse rather than those aimed at all age groups.

"There remains an urgent need for better drug treatments for older people with substance misuse, more widespread training, and above all a stronger evidence base for both prevention and treatment," they state in the *BMJ* editorial.

Dr Rao and Professor Roche said the growing influence of baby boomer substance misuse will continue to present challenges for healthcare service delivery for older people.

The study also notes that it is an additional concern the increasing proportion of women drinking in later life, particularly those whose alcohol consumption is triggered by life events such as retirement, bereavement, a change in home situation, infrequent contact with family and friends, and social isolation.

The AMA questioned the priorities of the recently released *National Drug Strategy 2017-2026*, noting whilst alcohol in Australia is associated with 5,000 deaths and more than 150,000 hospitalisations each year, the Strategy puts it as a lower priority than ice.

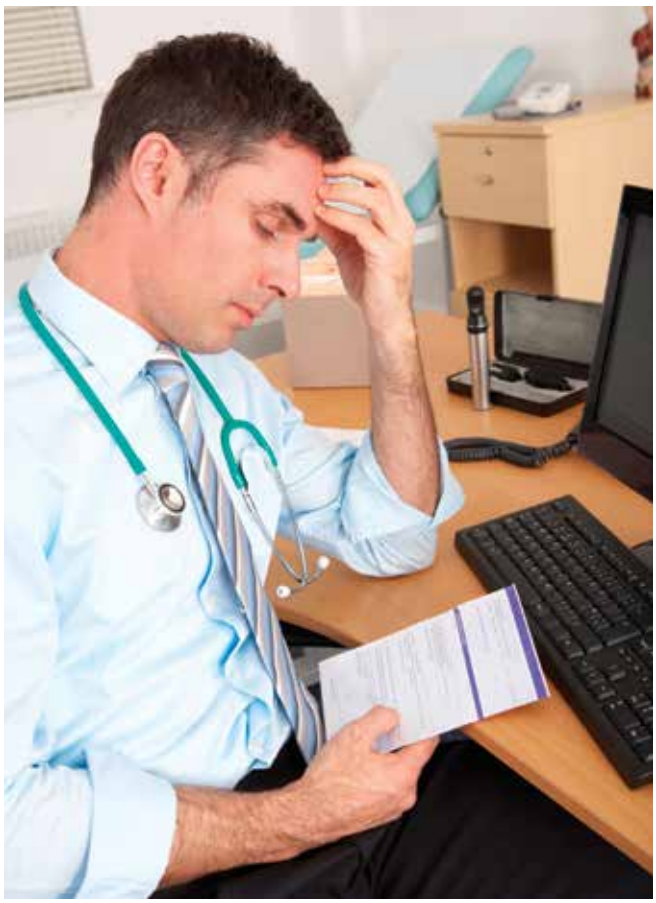
AMA President Dr Michael Gannon said he believes support and treatment services are severely under-resourced, even though the costs of untreated dependence and addictions are staggering. Alcohol-related harm alone is estimated to cost $36 billion a year.

The broader community impacts of those affected by dependence and addictions are more likely to have physical and mental health concerns, and their finances, careers, education, and personal relationships can be severely disrupted, Dr Gannon said.

The AMA's *Harmful Substance Use, Dependence, and Behavioural Addiction (Addiction) 2017 Position Statement* can be read at https://ama.com.au/position-statement/harmful-substance-use-dependence-and-behavioural-addiction-addiction-2017.

MEREDITH HORNE

Survey shows Canadian doctors have an alarming burn-out rate



A recent survey conducted by the Canadian Medical Association (CMA) suggests that 54 per cent of Canadian doctors have symptoms of burn-out and it is a problem that physicians themselves don't like to talk about.

The outgoing CMA President Dr Granger Avery said doctors have many pressures in their daily lives, and are exposed to high levels of stress in the course of their profession.

The CMA believes that building resiliency and addressing systemic issues impacting physicians' health must be addressed to deal with physician burnout.

Dr Avery believes doctors face mountains of paperwork and increasing regulatory requirements. When doctors begin to suffer from overload, stigma often prevents them from seeking the help they need.

"That's whether looking for a consultation, following up on an operation, whether it's transferring a patient from one level of service to another, these things often require the doctor to make repeated phone calls, repeated interventions to get what should be a relatively simple piece of work done," he said.

"So, that's very frustrating and annoying for a physician who has been brought up and trained and focused on helping people, not doing that administrative work."

Dr Avery believes the issue should be confronted head-on beginning at medical schools with discussions about resiliency. The survey of Canadian medical student survey shows 37 per cent are burned out at any one time.

"We're trained with a requirement for perfection and nobody wants to hear that the doctor made a mistake. Nobody wants to hear that the doctor isn't 100 per cent and yet we're human," he said.

The CMA also believes that the health care system should nurture its support for health care workers to ease the burden on doctors and provide good health care results to have them work in teams with other health care professionals.

The CMA meeting in Québec City had more than 600 participants from across Canada and the world, and featured discussion on a wide range of health care issues, including physician health and burnout, opioid use in Canada and medical aid in dying. The Canadian Medical Association represents more than 80,000 doctors.

The AMA is keenly aware of doctors' health issues in Australia.

The latest AMA audit of working conditions for doctors in Australian public hospitals shows that one in two doctors (53 per cent) are working unsafe shifts that place them at a higher risk of fatigue, with one doctor reporting an unbroken 76-hour shift.

The AMA recently welcomed the COAG Health Council decision to develop a nationally consistent approach to mandatory reporting provisions for health practitioners, following months of lobbying and advocacy from the Federal and State AMAs, highlighted by discussions in face-to-face meetings between Health Minister Greg Hunt and AMA President Dr Michael Gannon.

MEREDITH HORNE

Fast food plans to slow down antibiotic use

Fast food giant McDonald's has recently announced that it aims to serve up more antibiotic-free meat at its restaurants around the world.

McDonald's has said that from 2018 it will begin implementing a new chicken antibiotics policy in markets around the world, which will require the elimination of antibiotics defined by the WHO as Highest Priority Critically Important ("HPCIA") to human medicine.

This plan includes Australia. McDonald's estimate that each year it purchases 21.4 million kilos of Australian chicken.

The world's largest burger chain will also work toward limiting the use in cattle and pigs of antibiotics important to human medicine, a significant move because McDonald's is such a significant purchaser of beef and pork.

Antimicrobial resistance is the ability of a microorganism (like bacteria, viruses and parasites) to stop an antimicrobial (such as antibiotics, antivirals and antimalarials) from working against it.

As a result, standard medical treatments become ineffective, infections persist and may spread to others. Resistance to current antimicrobials is increasing faster than the development of new drugs, and so effective treatments cannot keep pace. The World Health Organization (WHO) describes AMR as a looming crisis in which common and treatable infections will become life threatening.

More than 1,000 cases of almost-untreatable superbugs were reported in Australia in the 12 months to March this year.

For the first time, the Australian Commission on Safety and Quality in Health Care has tracked dangerous bacteria resistant to the last line of antibiotics.

Speaking to *SKY News* earlier this year, AMA Vice President Dr Tony Bartone said: "The over-prescription of antibiotics is a problem because, world-wide, we've seen the emergence of what we call anti-microbial resistance – that is, resistance by bacteria to antibiotics, life-saving antibiotics in the past.

"Now with this emerging resistance, it's becoming more and more difficult to treat these resistant bacteria, and we've all got a role to play in trying to reduce that incidence and that spread."

In April 2014, WHO released its new global report, *Antimicrobial resistance: global report on surveillance*, which states '... this serious threat is no longer a prediction for the future, it is happening right now in every region of the world and has the potential to affect everyone.'

The Australian Government and other international governments have already identified antimicrobial resistance (AMR) as a high-priority issue.

MEREDITH HORNE

Hope I live before I get old

BY **SIMON TATZ**

In The Who's 1965 hit *My Generation*, Roger Daltry sang what is possibly one of the most famous lyrics in the history of rock 'n roll: "I hope I die before I get old."

It turns out that The Who couldn't have been further from the truth.

Last year the Rolling Stones, Sir Paul McCartney, Bob Dylan, The Who, Neil Young and Pink Floyd's Roger Waters performed at the Desert Trips Festival in California's Coachella Valley.

You need an abacus to add up the collective ages of the headline acts. The two surviving members of the Who, Roger Daltry and Pete Townsend, are both over 70. Sir Paul McCartney, who will be returning to Australia later this year for a national tour, was born in 1942. Roger Waters arrived a year later, in 1943. Bob Dylan, born in May 1941, began his 'Never Ending Tour' in 1988 and there are no signs of it actually ending.

Fifty years ago it would have been inconceivable to picture these baby-boomers of World War II still creating the same level of interest. Rock and roll is now intergenerational. It has broken through the glass ceiling of age. Unlike film and TV, where "older" actors (and newsreaders for that matter) seem to be relegated to cameos or "serious" films, music fans disregard age.

It was Mick Jagger who famously told *People* magazine: "I would continue to write and sing, but I'd rather be dead than sing *Satisfaction* when I'm 45." Sir Michael Philip Jagger (AKA Mick, born 26 July 1943) is still singing *Satisfaction*. He sang that song, released 52 years ago (May 1965), when the Rolling Stones last toured Australia.

Rock and roll has not only grown more popular with age, it has aged with a style and authenticity few could have predicted back in the day. This was a music style that was supposed to be about youth and rebellion. It was born from conflict. Your parents were never meant to understand the music you liked, let alone take you to gigs.

The children of the revolution, as T-Rex described them, had an attitude, energy and swagger – not to mention sex and drugs – that wasn't supposed to last past the age of retirement.

In *Hey Hey, My My* Neil Young (born 1945) immortalised the phrase: "It's better to burn out, than to fade away."

It turns out he was wrong too – rock and rollers are neither burning out nor f-fading away; they're playing into their 70s and 80s. And what's really perverse is that the older generation – mums and dads, grandparents, uncles and aunts – are sharing this love of rock with children and grandchildren.

When Black Sabbath toured here recently, I sat behind a middle aged couple and their teenage children, all bouncing about in their seats as if in competition. The venue was a demographer's fantasy: from fans in walking frames to kids who probably thought a seven inch single was someone very short and unattached.

When I was young, the thought of seeing Black Sabbath with my parents would have been laughable, and embarrassing. (The first concert my dad took me to was the French violinist Stephane Grappelli.) Yet at an AC/DC concert, I saw three generations of one family at the gig: grandad with his children and grandchildren, all wearing T-shirts from concerts they had attended over the past 30 years. These are now commonplace sightings.

Madonna's tour of Australia is another example. The sensational Madge (born 1959), was living proof that age is not a factor in popular entertainment – nor is it an issue for fans. Before Madonna started (several hours late, of course) I stood outside and watched the crowd: older blokes like me, women wearing giant conical breasts, drag queens in leather and chaps, a bloke in his rugby top, an ageing frail grey haired women, young hipsters, and the usual assortment of whips, studs, satin, suits and singlets.

Before Madonna, I was fortunate to see Prince (born 1958) deliver a truly sensational performance at the Sydney Opera House to a mostly younger audience. There are plenty of others who have toured Australia that are worth mentioning: Fleetwood Mac (Mick Fleetwood born 1942, Lindsey Buckingham 1947, and the youngster Stevie Nicks, born 1948), Brian Wilson (1942) of Beach Boys fame, Leonard Cohen (who died last year but was born in 1934 and toured here a few years ago to overwhelming acclaim while in his late 70s), Rod Stewart (1945) and of course Bruce Springsteen (1949), still one of the greatest entertainers of the modern era.

A barrier has been broken: older artists attract an indefinable fan-base. Once, a band's audience would be literally uniform, be it mods, rockers, hippies, metal, disco, middle-of the-road, and so on.

It turns out that we got it all wrong – rock and roll isn't any one's generation.

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1235-5/03-17/0811