

A U S T R A L I A N

Medicine

The national news publication of the Australian Medical Association

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AMA

ISSUE 31.04 MARCH 4 2019



A U S T R A L I A N

Medicine

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

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AMA LEADERSHIP TEAM



President
Dr Tony Bartone



Vice President
Dr Chris Zappala

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President gives evidence at Aged Care Royal Commission



Royal Commission into Aged Care Quality and Safety



AMA President Dr Tony Bartone at the Royal Commission into Aged Care Quality and Safety.

AMA President Dr Tony Bartone has appeared before the Royal Commission into Aged Care Quality and Safety, saying exchange of information between healthcare workers in nursing homes is critical to the continuity of patient care.

A lack of nurses in residential aged care facilities is compromising the handover process, he said.

“A good handover would consist of a number of elements. It would give some factual description about what has occurred, what are the current items in play, what are the current issues around the patient’s conditions, what things might be changing, what tests

might be expected to be received, and things to look out for in the ongoing period of time that you’re referring to,” Dr Bartone told the Commission.

“... That lack of opportunity to hand over, to receive the information and then to give back information after the visit is a critical part of the visit, a critical part of the care and that is of concern to our ... members...

“We have many different committees, many different opportunities for our members to meet. That feedback can be through the process of normal flow of the committee work. It can be anecdotal



President gives evidence at Aged Care Royal Commission

... from p3

in terms of other opportunities where members come together, but it's continual and consistent through many different venues in our association.

"It has a number of implications. First, directly, it is subjecting the Australians in said facilities to a lesser standard of care. So, it potentially could have unintended consequences in their own direct care. But it's also having a wider issue as well in terms of the drivers in terms of some of our members, members that have worked very hard, very long in this space, both in advocacy and directly with patients to then not continue to visit facilities because of that concern, that worry, that issue potentially around being involved in a lesser standard of care.

"If there is no one available to hand over, to have a good handover, that is – as we've already tried to address, it's potentially putting that patient at a disadvantage. That does have a concern then that things might be missed, that tests might not be followed up on or not be carried out, that vital bits of information may not have been passed on in the first place.

"A good clinical handover, good clinical communication forms the foundation of, you know, the basis of good clinical care, and that – you can't have one without complete confidence of having the other."

Dr Bartone has pointed out that while Australia is facing an ageing population with an increase in chronic, complex medical conditions, the aged care system is currently not keeping pace with these trends.

There is a lack of integration between the health and aged care systems. Doctors feel a sense of obligation to their older patients and many enjoy the work. However, there are significant barriers GPs face when visiting aged care facilities.

One major barrier is inadequate funding for GP services through Medicare.

A lack of equipment, facilities and appropriate staff members to work with, are also significant obstacles.

"The workforce issues and the coordination of that workforce is an extremely difficult, but extremely poorly coordinated exercise ... the proportionality of trained nurses has reduced as a proportion of the staff in total involved in absolute numbers," Dr Bartone said.

"It does point to the fact that... both training and conditions... are

part of that impact on the availability of the trained workforce...

"Given the increasing demand of aged care and both residents and aged care – home aged care places – that demand is going to require an even more significant impost (with the) importance on terms of training the right number. And it may be a very difficult number to achieve, especially in the short term."

Dr Bartone, a Melbourne-based GP who makes regular patient visits to aged care facilities, said many doctors who visited nursing homes had long-standing relationships with their patients and wanted to continue caring for them medically.

But some are now contemplating decisions to end nursing home visits because of the barriers faced.

"If you are continually meeting barriers to facilitating that care, that creates anything from frustration to concern to worry," he said.

"And ultimately, for some GPs, that worry leads them to decide that 'no, I'm not going to continue – either I won't take on any new patients, or I'm not going to continue to visit the facilities'.

"Both the AMA survey of doctors who visit residential aged care facilities and anecdotal feedback show that doctors are increasingly looking at cutting back on their visits or stopping altogether."

The AMA would like to see an appropriately resourced, trained, and abundant workforce in nursing homes and both policy and practice that places a greater focus on health and medical care within the aged care system.

The aged care sector needs more registered nurses and other staff, through an aged care staffing ratio that reflects level of care need of residents and ensures 24-hour on-site registered nurse availability.

More funding, through Medicare rebates, is needed for GPs to access residential aged care facilities. And more clinical governance and strategies are required to facilitate doctor visits to the nursing homes.

In addition to more staff, especially nurses, the strategies should look to providing more clinical software interoperability, more treatment rooms, and doctor car parking, among other things.

CHRIS JOHNSON

Not on track to close the gap

“We should today acknowledge that it’s not just the gap in life expectancy or health or educational results or employment opportunities, but the gap between words and actions”

The AMA is “very disappointed” that only two of the seven targets of the Close the Gap initiative are on track.

Prime Minister Scott Morrison released the 11th Closing the Gap statement early in February and handed down the 2019 report card.

The report states that year 12 attainment rates for Indigenous children were on track to meet the goal and that 95 per cent of Indigenous four-year-olds were attending early childhood education, meaning that goal was completely on track.

But scant progress was made anywhere else.

Life expectancy, child mortality rates, employment, reading and numeracy, and school attendance goals were all off track.

And the goals on track this year are one less than the number on track last year.

“This situation remains in an unforgiveable state, but we will never rest as a nation until we change this for good,” the Prime Minister told Parliament.

“I want Aboriginal and Torres Strait Islander children to have the same opportunity as any other child in this country.

“But, it’s not true for Aboriginal and Torres Strait Islander children growing up in Australia today, and it’s never been true and I don’t know when it will be true.”

Opposition Leader Bill Shorten said the Parliament had let Indigenous Australians down.

“We should today acknowledge that it’s not just the gap in life expectancy or health or educational results or employment opportunities, but the gap between words and actions,” he said.

AMA President Dr Tony Bartone has echoed both men’s sentiments and said the report highlights the urgent need to adopt all the recommendations of the Close the Gap Campaign and address the “unacceptable gap” in health outcomes

between Aboriginal and Torres Strait Islander peoples and non-Indigenous Australians.

“Progress against Closing the Gap is not what we all hoped for,” Dr Bartone said.

“While more Indigenous children are entering early education, improvements to life expectancy, infant mortality, and employment rates are not closing.

“After more than a decade, the lack of resourcing and investment in the health and well-being of Aboriginal and Torres Strait Islander peoples continues to see unacceptable gaps across a range of outcomes.

“The lack of sufficient funding to vital Indigenous services and programs is a key reason for this.

“The AMA is very disappointed that just two of the seven goals are on track.”

The AMA is a member of The Close the Gap Campaign, which was launched in 2006 to help address the gaps in life expectancy and other health indicators between Aboriginal and Torres Strait Islander peoples and non-Indigenous Australians.

The mortality rate for Aboriginal and Torres Strait Islander children aged 0-4 years is around twice the rate for non-Indigenous children. The mortality rate for Aboriginal and Torres Strait Islander peoples compared to non-Indigenous Australians is around 1.7 times higher. Homelessness rates for Aboriginal and Torres Strait Islander people are around double the rate of non-Indigenous Australians.

The Aboriginal Community Controlled Health Organisation (NACCHO) pointed out that Indigenous people still live in third-world conditions in many parts of Australia.

“We have to hold everybody to account,” NACCHO Chief Executive Officer Pat Turner said.”

CHRIS JOHNSON

Queensland MPS urged to act on mandatory reporting laws

The AMA will continue fighting for changes to national mandatory reporting laws, after the Queensland Parliament rejected amendments that would have adopted a Western Australia-lite model.

Federal AMA President Dr Tony Bartone and AMA Queensland President Dr Dilip Dhupelia, wrote to all members of the Queensland Parliament, urging them to amend draft mandatory reporting legislation so that doctors and medical students have the confidence and support to seek help when they are unwell.

Describing it as a historic chance for the Queensland Parliament to take a bipartisan stance, the doctors urged the politicians to help create national laws that will protect doctors and patients.

They could do this, they said, by supporting doctors and medical students to seek the treatment they need, when they need it, without fear of being reported to authorities.

“Being a doctor is a stressful vocation. We deal with life-and-death situations every day. We are only human, and our work takes its toll,” Dr Bartone said.

“When doctors and medical students find themselves needing professional help when they are unwell, often caused by the stressful work they are doing, they can be deterred by national laws that compel their treating doctor to report them to authorities as ‘impaired’.

“This can lead to them fearing that they will spend months, even years, fighting possible sanctions, including losing their registration, for simply seeking the help that their patients ask for, and receive, every day without judgment or repercussions.

“Doctors and medical students must be accorded the same rights as any other patient – to be able to receive confidential, high-quality health care without fear of professional ramifications.

“While the fear of ramifications may be perceived, it still remains a palpable barrier to seeking help for many medical practitioners.

“We are still losing too many colleagues every year because they do not feel confident that they can seek help without risking their careers.

“We need consistent laws across the nation to ensure that all doctors and medical students can feel confident to seek medical help for all conditions.

“The Western Australian Parliament has already acted in a bipartisan way to pass legislation that exempts doctors who are treating other medical practitioners from having to report them to regulatory bodies.

“We support proposed amendments to the current Bill, where doctors would be exempted from reporting their medical

practitioner patients, except in cases involving sexual misconduct.

“This proposed approach protects patients and saves doctors.

“Doctors are also patients. They should have the same right to confidential, high-quality medical treatment as their patients have.

“Any barriers to treatment for medical practitioners, real or perceived, must be removed and not hinder the same timely access to care that we as doctors fight for on behalf of our patients.”

Under Council of Australian Governments (COAG) arrangements, if passed, the Queensland *Health Practitioner Regulation National Law and Other Legislation Amendment Bill 2018* will become law in all States and Territories except Western Australia.

In Western Australia, doctors who are treating other doctors or medical students for health conditions are exempt from mandatory reporting provisions under national registration legislation.

“The legislation before the Queensland Parliament is a step in the right direction, and is an improvement on the current laws, which may actively discourage doctors from seeking medical treatment,” Dr Dhupelia said.

“But it does not go far enough to ensure that doctors and medical students can seek the treatment that they need, when they need it, without worrying that they will be reported to authorities and possibly lose their right to continue studying or to practise.

“The current laws put patients and doctors at risk. Doctors must be able to seek help, and patients must be confident that their doctors are able to get help when they need it.

“We urge the Queensland Parliament to amend this Bill so that it moves closer to the WA model that has been shown to work.

“In 2017-18 alone, at least four Queensland doctors took their own lives. These deaths may have been prevented had they felt confident that they could seek help without the fear of being de-registered.

“At least one suicidal doctor calls the Queensland Doctors Health Advisory Program (DHAP) every two months, and DHAP receives up to six calls a week from doctors or their family members, as many doctors are too fearful to make the phone call.”

MARIA HAWTHORNE

The AMA submission to the Parliamentary Inquiry is at <https://ama.com.au/submission/ama-mandatory-reporting-submission-2018>

Political parties offer more for general practice as election draws near



As a federal election draws nearer, both major political parties have committed more funds towards general practice to allow for longer consultations, following strenuous campaigning from the AMA.

AMA President Dr Tony Bartone described the political promises as a good first step for each party.

The commitment by both major parties to invest an estimated \$170 million extra over five years into general practice to support longer health consultations is a welcome start to better investment in primary care, he said.

“The support for comprehensive health checks to tackle cardiovascular disease is an acknowledgement of the importance of general practice to preventive health care,” Dr Bartone said.

“Longer consultations enhance continuity of care, and the AMA looks forward to seeing further announcements detailing plans for investment in general practice in the lead-up to the next election.

“The recent report of the Medicare Benefits Schedule General Practice and Primary Care Clinical Committee recognised the central role of general practice in the health system and called for a significant new investment in general practice. All parties must heed this advice.

“Today’s announcements by the coalition and Labor, targeting one health condition, can be regarded as a good first step. However, much more is needed to support general practice in delivering holistic care to our patients and the whole community.

“It is heartening to see that, as we approach the federal election, the major parties have turned their attention to better supporting general practice.

“General practice is in urgent need of an injection of new funding as Australia tackles the growing burden of complex and chronic disease, and the need for prevention.

“High quality, GP led, patient-centred primary health care is key to improving the effectiveness of care, preventing illness, and reducing inequality, variation, and health system costs.

“There is no doubt that a significant investment now in general practice will bring the promise of long-term improvements in health care outcomes for patients and savings to the health system.

“The AMA’s priorities for investment in general practice are detailed in our 2019 Pre-Budget Submission. We will be calling on all major parties to release full details of their general practice policies and their vision for Australia’s health system well ahead of the election.”

MARIA HAWTHORNE

The AMA Pre-Budget Submission is at https://ama.com.au/sites/default/files/budget-submission/AMA_Budget_Submission_2019_20.pdf

Former Premier for AMA Tasmania



Former Tasmanian Premier Lara Giddings has been appointed Chief Executive Officer of the Australian Medical Association in Tasmania. She was the first female Premier of the State and stayed in the top job for more than three years.

Prior to leading the State and the Tasmanian Parliamentary Labor Party, Ms Giddings had also served as Health Minister under the premiership of Paul Lennon and oversaw the planning of the replacement Royal Hobart Hospital.

Even earlier, Ms Giddings served as the State's Economic Development Minister and Minister for the Arts.

She was first elected to the Tasmanian House of Assembly in 1996 at the age of 23, making her the youngest woman elected to an Australian parliament. She lost her seat in 1998 but returned to Parliament in the 2002 election.

She served as Tasmania's 44th Premier from January 24, 2011 until March 31, 2014. After her Government's defeat at the 2014 election, the former Premier remained in Parliament as a backbencher before retiring from politics at the 2018 State election.

Ms Giddings' substantial leadership, health and economic experience have made her a standout appointment for the position as AMA Tasmania CEO.

"As Health Minister, I loved working with the health sector and I was proud to work with doctors to help drive reform to our health system through the Tasmania Health Plan," she said.

"In this new role, I look forward to working with doctors to provide constructive advice to the Government on how to improve our health system as well as provide support to doctors in their everyday working lives.

"There are many issues confronting our health system across the preventative, primary and acute sectors as demand for services increases."

Ms Giddings steps into the role in March, taking over from Tony Steven, who was the CEO for ten years.

CHRIS JOHNSON

New faces in South Australia

AMA(SA) has some new faces in its executive team.

Dr John Woodall has been appointed as interim CEO, Heather Allanson as Media, Policy and Advocacy Manager in South Australia, and Karyn Hughes as Accountant.

Dr Woodall is a member of AMA(SA) Council. He has been general manager (medical director) of the Health Services Section of the Royal Flying Doctor Service, Central Operations, and a rural anaesthetist and general practitioner in Bega (NSW),

Ceduna (SA) and the Nganyatjarra Lands (WA). He is also a member of the Australian Society of Anaesthetists and RACGP.

The appointments follow the departure of the former joint CEO of AMA(SA) and South Australian Postgraduate Medical Education Association (sapmea), Joe Hooper; accountant Stewart Gillies; and Director of Policy and Communications Eva O'Driscoll following changes to their employment agreement with sapmea. AMA(SA) thanks them for their contribution to the Association over many years.

Intern program ripening well in the Apple Isle



With medical practices in rural Tasmania under pressure to recruit doctors to meet local patient demand, one of the State's private providers of rural healthcare services, Ochre Health, is actively rising to the challenge by training young doctors with an interest in rural medicine.

Ochre Health owns and operates nine medical centres across Tasmania and 33 centres nationally. In 2018, the company was awarded the Commonwealth Government's Rural Junior Doctor Training Innovation Fund – the first of several programs designed to train, mentor and support doctors on each step of their rural medical career. In partnership with the Tasmanian Health Service (THS) and the University of Tasmania, Ochre Health is coordinating 60 intern placements over a three-year period – making it host to the greatest number of approved internship locations in Australia from 2018 to 2020.

Ochre Health will place its fifth cohort of interns into four of its remote Tasmanian medical centres: Flinders Island, King Island, Scottsdale and Queenstown. Others will complete their placement at an independent medical centre in the Huon Valley. Interns can elect in subsequent years to go on and acquire advanced rural skills, culminating in recognition from the Royal Australian College of General Practice (RACGP) and Australian College of Rural and Remote Medicine (ACRRM).

Professor Dennis Pashen, Ochre Health's Medical Coordinator for Tasmania and President of the ACRRM Quality and Safety Council, welcomes the next intake of junior medical officers, who are set to begin their training.

"We are excited that these medical graduates have opted to complete their rural primary care rotations in remote areas of Tasmania," Professor Pashen said.

"The hands-on nature of these posts will increase the rural skills of these interns by exposing them to a greater breadth of medicine and, with their increased sense of responsibility, ultimately further their careers."

Last year, Ochre Health nurtured Dr Ben Dodds through his 13-week internship placement at Ochre Medical Centre Queenstown. He was recently named Intern of the Year for 2018 – a prestigious health service award that recognises his excellent work as a junior doctor.

For Dr Dodds, his exposure to a variety of clinical work at Ochre Medical Centre Queenstown was an important part of his decision to pursue a ruralist general practice career, citing the ability to make an instantaneous, direct and positive impact on someone's life as what he had been looking for as a junior medical officer.

"Growing up on the northern coast of Tasmania, I was aware of the important role that local health services play in rural communities," Dr Dodds said.

"Being able to work closely with emergency medicine, as well as the close connection to your local healthcare team – both your community and patients – makes rural generalist practice a great career choice, and it can open doors to other specialities that you don't always see in metropolitan hospitals."

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 Learning



Police concern over mental illness



The Police Federation of Australia is taking action to address the level suicide within its own ranks.

It has initiated a program to build awareness and offer support to police and their families suffering the effects of mental illness.

Police all around Australia are devastated every time one of their fellow officers takes his or her own life, PFA President Mark Carroll said.

“The tragic and unnecessary deaths of three police officers in just two weeks show that holding the thin blue line comes at a very significant cost,” he said.

“Unfortunately, these quality police officers were not the only ones to take their own lives in recent years.

“The PFA and its members extend their deepest sympathies to the heartbroken families and friends of all officers who have died so tragically.

“For simply performing their job, police officers and their families can pay a very high price: mental ill health, psychological injury and, in the worst cases, suicide.”

Mr Carroll quoted a recent Beyond Blue study, which showed that suicidal thoughts are twice as common among first responders than they are in the general population. Police and other emergency services workers are three times more likely to have some sort of suicide plan.

“The scourge of mental ill health, which destroys lives, families and careers, cannot go unaddressed,” Mr Carroll said.

Last year, the PFA sought funding assistance from the

Commonwealth Government to mount a national mental-health program on behalf of Australia’s police officers and their families.

Along with awareness-raising posters and cop-specific handbooks like *Head Notes* and *A Cop in the Family*, the PFA will launch a compelling and powerful telemovie called *Dark Blue*, the likes of which has not been produced in Australia.

“The PFA is expending its own funds on the program too – and we’re very grateful for the Government’s support,” Mr Carroll said.

“Over the past 12 months, we’ve been working on the production of a suite of compelling, cop-specific materials. In the next few months, we’ll unveil the fruits of this work.

“Our program has many elements – and we’re fortunate to have been guided by some eminent psychologists and psychiatrists.

“It’s important to stress that this won’t be a miracle cure, but it will start critical conversations in critical circles.

“Just like the rest of Australia, we need more access to more mental health professionals, more dedicated facilities and more services.”

Mr Carroll acknowledged that police departments around Australia were also taking up the mental health challenge.

“These are important efforts but the PFA’s program is unrestrained by bureaucratic niceties,” he said.

“Our program tackles mental ill health and psychological injuries in policing head-on. We simply tell it like it is: now is not the time to hold back. We all need to understand what’s going on, especially our families who suffer very much too.”

Mr Carroll said one or two of the program elements are specifically designed to be shared with the general public. The PFA hopes the public will come to understand the price police officers and their families pay in the course of serving the community.

“This is a long fight but one the PFA is up for,” Mr Carroll said.

“We intend to approach the Government again to help us continue this critical work. We’re confident of its support.”

CHRIS JOHNSON

Know your heart age



If you are 45 but your heart age is 50, your risk of having a heart attack is elevated.

To build awareness about this, the Heart Foundation has launched its new Heart Age Calculator to kickstart a national heart disease information campaign.

The online calculator helps people understand their risk of having a heart attack or stroke by comparing their 'heart age' to their actual age.

It helps people understand their own risks and provides advice on what to do next.

According to the Australian Bureau of Statistics, in 2017 an average of 21 Australians died each day from heart attack, while 22 a day died from stroke. Australians of all ages are impacted; more than 30,000 Australians under the age of 55 have had a heart attack that has affected their lives for at least six months.

The Heart Age Calculator is for Australians aged 35 to 75 years who do not have a known history of heart issues.

It asks questions about age, sex, smoking and diabetes status, Body Mass Index, blood pressure levels and if they take medication, cholesterol levels, and whether there is a close family history of heart attack or stroke before the age of 60.

The answers are analysed to determine if a person's heart age is above, equal or below their actual age.

Heart Foundation chief medical advisor Professor Garry Jennings said: "Alarming, one in five Australians aged 45 to 74 have a moderate to high risk for heart attack and stroke in the next five years.

"Don't wait for a heart attack to be your first sign of trouble. Knowing your risk is the first step towards avoiding a heart attack or stroke.

"The higher your heart age compared to your actual age, the higher your risk of having a heart attack or stroke. If your heart age is greater than your actual age, we advise you to make an appointment with your doctor for a heart health check.

"High blood pressure or high cholesterol are some of the leading risks for heart disease, which remains the biggest killer of Australians.

"These conditions often have no obvious symptoms, yet they can be a ticking time bomb for people's heart health. Critically, too few people understand the significant impact these risks have on their heart health."

Professor Jennings added that close to 40 per cent of Australians aged 18 and over have three or more risk factors which is putting millions at risk of premature death or chronic ill health.

"There's no one cause for heart disease, but the more risk factors you have, the higher your chance of getting it, and these risks only increase with age," he said.

"Filling out the Calculator does not replace the need to see your doctor for a Heart Health Check. We recommend having a regular heart health check if you're 45 years old and over, and for Aboriginal and Torres Strait Islander peoples, from 35 years and over.

"The good news is by taking some small steps to change your lifestyle – through eating a healthy, balanced diet, being smoke-free and getting at least 150 minutes of moderate physical activity per week – you can reduce your risk for heart disease and lower your heart age," Professor Jennings said.

The Heart Age Calculator can be found at: <https://www.heartfoundation.org.au/your-heart/know-your-risks/heart-age-calculator>

Rural health conference is better together



The 15th National Rural Health Conference is a biennial event being held in Hobart from 24 to 27 March 2019. With a theme of 'Better Together!' the conference program highlights how we can work better together to improve the health and wellbeing for everyone living in country areas.

The four-day event provides learning and networking opportunities to public and private healthcare professionals, health consumer advocates and carers, students and researchers, and interested people from sectors such as education, transport and housing.

The conference will feature a number of prominent Keynote speakers presenting on a range of topics, including:

- **Isabelle Skinner**, CEO of the International Council of Nurses, on how addressing the United Nation's Sustainable Development Gals will lead to healthy people in a healthy world;
- **James Buchan**, World Health Organization Collaborating Centre, will provide a global view of the rural health workforce;
- **Sir Harry Burns**, Professor of Global Public Health at the University of Strathclyde, Scotland, on early childhood trauma, social determinants of health and an anticipatory care approach;
- **Bo Remenyi**, Paediatric Cardiologist and NT 2018 Australian of the Year talking about her work tackling Rheumatic Hear Disease in the NT;
- **Kelvin Kong**, an otolaryngology head and neck surgeon and Fellow of the Royal Australasian College of Surgeons on hearing loss and poor educational outcomes for rural children;
- **Saul Eslake**, economist and Vice Chancellor's Fellow, University of Tasmania, on a Tasmania case study for education, employment participation and health outcomes;
- **Sandro Demaio** from ABC's Ask the Doctor, Chief Executive Officer of EAT; and founder of the Sandro Demaio Foundation;
- **Cassandra Goldie**, Chief Executive Officer of the Australian Council of Social Services will join **Richard Di Natalie**, Leader of the Australian Greens, and **Kalinda Griffiths** from the Centre for Big Data Research, University of NSW to discuss managing health into the future; and
- **James Ward**, Head Aboriginal and Aboriginal Health Infectious Disease, South Australian Health and Medical Research Institute will be addressing sexually transmitted infections in remote Australia.

The full list of keynote presenters and the conference program can be found on the Rural Health Alliances conference website at www.ruralhealth.org.au/15nrhc where online registration is also available.

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Yes, you do need to see your doctor for this

BY AMA PRESIDENT, DR TONY BARTONE

I was surprised to read a recent article in *Australian Doctor* that included patently incorrect claims about general practice, a confused perspective on Medicare funding, and a one-dimensional understanding of health care in general.

I was not surprised to see that the source for the article was a senior member of the Pharmacy Guild.

Despite the outstanding contribution general practice continues to make to Australian health, this poorly-informed article attacked GPs in what can only be described as a cynical attempt to bolster the retail presence of Guild members, regardless of the impact on health care.

Let's be clear: GPs are the beating heart of the Australian healthcare system. Around 88 per cent of Australians see a GP at least once a year, and we manage 90 per cent of the problems we encounter. The 2019 Productivity Commission Report on Government Services (ROGS) showed that we do it well, with extremely high levels of satisfaction with GPs, as well as high levels of accessibility. We do this despite years of chronic underfunding and poorly structured payment models.

GPs are the highest trained general health professionals in Australia. We have the training and the skills required to not just deal with a patient's health issue when they present at our practice, but to discuss our patient's health and wellbeing with them, and to identify other issues before or as they emerge.

When a young man visits his GP for the first time in 12 months for an acute illness, his GP has an opportunity to discuss his general state, his mental health, his lifestyle and behaviours. This is the value of a consultation with a GP – prevention and whole-person care. It is also why the average GP consultation lasts around 15 minutes.

The 2019 ROGS reported that there were about 2.9 million GP-type presentations public hospitals in 2017-18. The AMA is concerned by this figure, but not surprised. General practice has been underfunded for a decade or more. Investment in general practice can help address this, but we are not just asking for more money, we are asking for support to provide the services that Australians need.

In our 2019-20 Pre-Budget Submission, we called for funding for a care coordination program for patients with chronic disease through a quarterly payment to GPs, supporting a more pro-active and team-based approach to care. We also called for improved access to after-hours GP services and MBS

items for GP telehealth consultations. These programs will reduce unnecessary hospitalisations. We want an end to the disincentives the current Medicare scheme has built into the system that penalise GPs for providing high-quality care.

Reports that 7 per cent of Australians delayed or avoided purchasing medicines highlight that pharmacy has problems of its own that it must address. And let's not forget the booming complementary medicines industry which is now worth \$4.9 billion; much of this now sold over the counter in pharmacies. If Australians have to spend money on their health, the AMA wants them to spend it on medicines and therapies that are supported by evidence, and that work.

General practice does not upsell its patients. It identifies an illness, it manages it with the patient, it leverages relationships with patients to discuss those difficult topics during routine encounters. When a patient comes in with a urinary tract infection, for example, it is a chance to discuss any number of other issues which a pharmacist does not have the training nor the understanding to treat. Simplistic proposals that encourage patients to visit pharmacists instead are a poor option for patients, and fragment care. The opportunity for early intervention is lost, which ultimately costs the health system more.

We know that health systems in countries with comprehensive primary health care are the most efficient and effective, both in terms of lower overall costs and generally healthier populations. Patients have every right to see an appropriately trained and qualified practitioner – a GP. Pharmacists have their role in the health system, but the reality is that they do not have the same training, skills or experience as a GP.

General practice is the foundation upon which the Australian health care system is built. Issues with this foundation have emerged from years of neglect and underinvestment. The solutions are not simple, and they won't occur overnight, but the AMA has a simple message: start by funding general practice properly.

We all have our roles to play in the health system and we must work together to ensure that we achieve the best outcomes. The AMA respects pharmacists and our members have good collaborative relationships with them at the local level. We have led the way to develop a model to support non-dispensing pharmacists to work in general practice and from July onwards, general practices can apply for funding to employ a non-dispensing pharmacist. Collaboration, not fragmentation, is the key.



Health on the Hill

POLITICAL NEWS FROM THE NATION'S CAPITAL

BY CHRIS JOHNSON

Yes to disability Royal Commission; no to date

Parliament has agreed to establish a Royal Commission into disability treatment, but no one should expect it to begin any time soon.

Initially, the Government voted against a disability Royal Commission when it came before the Senate in mid-February.

The Government lost that vote and appeared to stall a vote in the House of Representatives by extending Question Time until Parliament rose for the week.

When the bill eventually came before the House, however, – the following week – the Government voted in favour of it.

But Prime Minister Scott Morrison has declined to set a date for the inquiry.

He said State and Territory Governments must okay it, suggesting they posed hurdles to getting the Royal Commission underway.

The Prime Minister said when a disability Royal Commission was considered by the Council of Australian Governments (COAG), there was little support for one.

But Greens Senator Jordon Steele-John, whose bill it was when it initially appeared in the Senate, said things had moved on since COAG rejected the idea of a disability Royal Commission.

“Which State Premier or Minister would oppose this now? Nobody’s going to oppose this,” Senator Steele-John said.

Opposition Leader Bill Shorten said he was very much in favour of the inquiry.

“The abuse and mistreatment of people with disability is Australia’s hidden shame,” Mr Shorten said.

“We have been on notice about the issues for a very long time.

“We need to address what is the core reason why people with a disability suffer disproportionate abuse, neglect and violence.

“It’s because, as a nation, despite progress we might have made on the National Disability Insurance Scheme and other things, we still as a nation devalue people with disability.”

National Disability Services (NDS), which represents non-government disability service providers, welcomed the vote. Acting Chief Executive Officer David Moody said he looked forward to a commencement date being announced soon.

“We are committed to continuing what we started more than five years ago, to embed zero tolerance approaches to disability abuse in all disability service organisations,” Mr Moody said.

“NDS and our members across Australia will look forward to supporting the Royal Commission in the development of its terms of reference and subsequent inquiry.

“NDS leads an initiative called Zero Tolerance in partnership with the Australian disability sector. This is our national approach to promoting human rights and preventing and responding to abuse, neglect, violence and exploitation experienced by people with disability.

“We know that people with disability are 1.5 times more likely to experience abuse, neglect, violence and exploitation than people without a disability.

“We support a Royal Commission because we understand that people with disability, like everyone else in our community, have the right to live free of the fear of abuse or neglect.”

Canberra launch for heart attack awareness report

Health Minister Greg Hunt has launched a new report revealing that more than a million heart attack patients do not survive a second heart attack.

The report *No Second Chances* was launched at Parliament House, Canberra in February, and was developed by the Baker Heart and Diabetes Institute and sponsored by Bayer.

It states that Australians who have been diagnosed with heart disease are candidates for a secondary event such as a heart attack or stroke, which can lead to disability or death.

The Baker Institute calls for new measures, including a secondary prevention campaign, increased focus on cardiac rehabilitation and research into wider use of new therapies.

Its report highlights that prevention of secondary heart attacks and strokes is critical to combatting cardiovascular disease, Australia’s number one killer.

About 4.2 million Australians are living with a cardiovascular condition, and of those, 1.2 million have been diagnosed with heart disease and are five to seven times more likely to suffer future heart events than those without heart disease.

Currently, one Australian dies every 12 minutes and there are 1.1 million hospitalisations every year due to cardiovascular events – up to half of which are due to readmissions.

The report also shows:

- If you’ve had a heart attack, you are twice as likely to die prematurely compared to the general population;





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Health Minister Greg Hunt (centre) joined by (L-R) Eduardo Pimenta (Bayer), Professor Tom Marwick (Baker Institute), Professor Dianna Magliano (Baker Institute), Terry Lonergan (heart attack patient) and Anna Karelis (Bayer) for the launch of the *No Second Chances* report at Parliament House.

- If you have two or more heart attacks, you are three times more likely to die prematurely;
- Within 12 months, one in ten heart attack survivors will have another heart attack; and
- In just 7 days, about 10 per cent of people who have a stroke will have another.

Professor Tom Marwick, Director of the Baker Institute, said when it comes to heart disease, more can be done to give patients a second chance.

“Although the focus has traditionally been on primary prevention of heart disease, this report demonstrates that the people at the greatest risk of a cardiovascular event are actually those who have already had a heart attack or stroke and are currently receiving sub-optimal care,” Professor Marwick said.

Despite clear evidence of the health and financial benefits of secondary prevention, not enough is being done.

Only 50 per cent of Australian heart patients receive guideline-based care after a heart attack or stroke. Patients can also do more to adhere to treatment and lifestyle advice. The impact of this is costly. Cardiovascular disease is the most expensive disease group costing Australia \$12 billion a year; a figure estimated to rise to over \$22 billion by 2032.

“The *No Second Chances* report, developed to assess the current state of secondary prevention in cardiovascular disease, calls for a re-evaluation of risk and treatment in this area,” Professor Marwick said.

Governments must deliver a national rural and remote health strategy, report says

Risk-averse governments have not formulated a cohesive national rural and remote health strategy, despite 25 years of evidence, a new perspective published online by the *Medical Journal of Australia* says.

Professor John Wakeman, Associate Dean of Flinders Northern Territory in Darwin, and Emeritus Professor John Humphreys, from Monash University's School of Rural Health, wrote that the lack of progress in improving rural and remote health outcomes was largely due to a lack of an overarching strategy that draws on available evidence to guide its development, implementation and evaluation.

“Despite this considerable evidence of what works well and where in rural and remote communities, risk-averse governments have been reluctant to formulate a national strategic framework, preferring a patchwork of political





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responses, mostly without rigorous evaluation of their effectiveness,” they wrote.

“Extant evidence shows how to ensure an appropriate workforce and maximise access to viable, high quality, affordable, comprehensive primary healthcare services that meet community needs. This evidence provides the basis for informing the [five] key policy pillars of a national rural and remote health strategy.”

Those pillars include:

- an integrated rural training pipelines for non-medical health professions, together with an effective, flexible, bundled retention strategy, in order to prepare and retain a fit-for-purpose workforce;
- the diversity of rural and remote Australia needs to be reflected in an agreed set of core services that all communities should be able to access locally, agreed practice principles governing effective visiting services to communities lacking in situ services, a range of models appropriate for specific contexts, and a regional governance approach to optimise service coordination and integration;
- sustainability of rural and remote PHC services is underpinned by adequate funding, including for workforce support; efficient financing mechanisms; good governance, inspirational leadership and effective service management; adequate physical and information technology infrastructure that enables ongoing monitoring and assessment of performance and quality; and service coordination;
- a national, needs-based funding mechanism; and,
- substantive community input into all aspects of the planning and provision of PHC services through regional governance structures, which take into account existing Aboriginal community-controlled governance structures.

“Longstanding problems of workforce shortages and maldistribution, difficulties with recruitment and retention, and inadequate access to, and availability of, appropriate services persist,” the authors wrote.

“These contribute to the poor health status of many non-metropolitan Australians, especially Aboriginal and Torres Strait Islander populations, despite the fact that governments spend millions of dollars annually on specific rural and remote health programs.

“Using available evidence, a national strategy can improve access to high quality, comprehensive primary healthcare in a way that results in greater efficiency, improved equity and more

effective service provision that will bring about improved health outcomes in rural and remote areas.”

Government helps fast track early stage research with a \$22 million boost

The Government is providing more than \$22 million for early stage research that will lead to new interventions, cures and treatments of major diseases and illness.

Arthritis, asthma, back pain, cancer, cardiovascular disease, chronic obstructive pulmonary disease, diabetes and mental health conditions are all being targeted in the project.

Health Minister Greg Hunt said early stage research is the key first step to better diagnosis, treatment and ultimately cures.

“Through the Government’s Medical Research Future Fund, we will provide \$22.3 million to MTPConnect to operate the new Biomedical Translation Bridge initiative,” Mr Hunt said.

“MTPConnect will partner with BioCurate (University of Melbourne and Monash University) and UniQuest (University of Queensland), both pre-eminent organisations in the commercialisation and translation of health and medical research in Australia.

“These organisations bring decades of industry-based experience to this major research effort. Successful research projects will receive between \$200,000 and \$1 million over a maximum of three years. MTPConnect will also seek additional funding for these research projects from philanthropic and third party sources.”

Industry, Science and Technology Minister Karen Andrews said the funding builds on the \$10 million dollars committed by last year to allow the MedTech and Pharma Growth Centre to continue its work through to 2021.

“These programs have been making headway in helping to accelerate the growth of the sector by forging stronger connections between research and industry,” Ms Andrews said.

“Boosting opportunities to translate and commercialise our scientific discoveries means more medical breakthroughs to help everyday Australians, as well as stimulating our economy and creating jobs.”

This funding is made available through our Medical Research Future Fund — an endowment fund which will mature at \$20 billion, providing a sustainable source of funding for vital medical research.





Health on the Hill

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Government welcomes new resource for aged care pain management



Aged Care Minister Ken Wyatt has lauded the latest edition of *Pain in Residential Aged Care Facilities: Management Strategies* as a vital tool in the effort to improve pain management in the sector.

The publication of the 2nd edition of *Pain in Residential Aged Care Facilities: Management Strategies* will help Australia's aged care workforce to identify, assess and manage pain felt by people in their care, the Minister said.

Its release comes as the Royal Commission into Aged Care Quality and Safety continues in Adelaide.

Fiona Hodson, President of the Australian Pain Society and co-author of the book, said the second edition, which is the first update since the 2005 original, is more user friendly and included new supporting resources.

"This is a one-stop shop for pain management and information for residents, clinicians and carers," she said.

"It highlights resident-centred care, while acknowledging families as key partners in care.

"Best-practice pain management is important, as pain affects both quality of life and physical function."

Mr Wyatt congratulated the organisation for producing the resource.

"This is about making a real difference to the daily quality of life of tens of thousands of senior Australians," Mr Wyatt said.

"I commend the Australian Pain Society and the dozen dedicated co-authors of this critical resource. Australia has around 2,700 residential aged care homes, caring for up to 240,000 people a year. It is estimated that as many as 80 per cent of people in care experience pain of some kind."

He said the Government was committed to driving aged care improvements by encouraging innovation and excellence in residential facilities and home-based care.

The newly established Aged Care Quality and Safety Commission has used the document to develop its guidance material to support Australia's new Aged Care Quality Standards relating to personal, clinical and palliative care.

"Access to high-quality pain management is a human right," the Minister said.

"Many aged care residents also have dementia and may have difficulty communicating their pain, which can lead to the risk of under-treatment."

The Health Department is assisting with promotion of the new pain resource and is also considering a funding request to support its distribution and update the Pain Management Guidelines Kit for Aged Care.

The politics, ethics and legal impacts of euthanasia

Legislators in Canberra and in State jurisdictions around Australia are preparing for the June 19 start of Victoria's Voluntary Assisted Dying (VAD) Act.

Just four months before the Act comes into effect, experts have detailed the challenges involved in turning the laws into clinical practice. Their work forms an ethics and law article published online by the *Medical Journal of Australia*.

The VAD Act allows eligible Victorian resident adults with decision-making capacity to seek assistance to die under the following circumstances: they must have an incurable disease, illness or medical condition that is advanced, progressive and expected to cause death within six months (or 12 months for neurodegenerative conditions); that condition must also be causing suffering that cannot be relieved in a manner that the person considers tolerable; the person must be seeking VAD voluntarily and without coercion.





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Eligible people can either be prescribed a VAD substance to administer themselves, or if they are physically incapable of doing so, a doctor can administer it.

Authors from the Australian Centre for Health Law Research at the Queensland University of Technology, led by Professor Ben White, wrote that implementation of the Act required a balance between two important policy goals.

“It must facilitate access to VAD, but restrict that access to only those who are eligible under the legislation,” they wrote.

Other implementation challenges include:

- making sure the complexities of the Act do not unfairly prevent eligible people from accessing VAD;
- translating prescriptive legislative processes into appropriate clinical practice across the variety of settings and disease contexts where VAD could arise, involving the engagement of key health and medical stakeholders, as well as people likely to seek VAD, in designing how the regime operates;
- implementing the legal prohibition on doctors and other health professionals from initiating VAD discussions with patients, while maintaining meaningful end-of-life discussions;
- meeting legal requirements of how the substance is to be prescribed, handled, stored and returned (unused portions); and,
- supporting and managing conscientious objection by health professionals, while not impeding access for eligible persons.

The 18-month VAD implementation period in Victoria was a result of observing a contrasting situation in Canada where: “Political delays led to their medical assistance in dying law coming into effect without an extended opportunity to prepare,” the authors wrote.

Continuing implementation monitoring, improvement and refinement was critical after the Act comes into force, they wrote, involving real-time on-the-ground feedback about how the VAD law is working in practice; data generated within the VAD system; and empirical research undertaken from outside the system.

“Translating this complex law into appropriate clinical practice will be challenging.

Victoria has strategically designated both time and resources to a period of planned implementation,” they wrote.



Research

BY CHRIS JOHNSON

Dementia drug regime found lacking in nursing homes

One-quarter of residents living with dementia in Australian aged care homes are nine times more likely to be prescribed antipsychotic drug risperidone while generally less likely to be checked for cardiovascular or respiratory treatments, new research has found.

At the same time, the study of hundreds of residential nursing homes also reveals the group of more advanced dementia patients are also more likely to be medicated for urinary tract infections – another sign of reduced awareness and communication of the needs of these residents.

Differences in over-prescription and under-prescription may reflect reduced awareness of, or ability to communicate, symptoms by those residents living with dementia, researchers at Flinders and Sydney University say.

“While we can’t be certain of the reasons for this difference, it is possible that greater confusion or worsening cognition in residents with dementia is sometimes being attributed to urinary tract infections, prompting an increase in treatment and testing,” geriatric clinician Dr Craig Whitehead said.

“Awareness by clinicians and pharmacists of these patterns of medication use could improve management of this vulnerable population.”

Dr Whitehead worked on the study, which was led by the Rehabilitation, Aged and Extended Care research group at the Flinders University College of Medicine and Public Health.

More than 436,000 Australians are living with dementia, with numbers predicted to rise above 589,000 people by 2028 and above one million people by 2058.

The Flinders study, with key collaborators at the University of Sydney, investigated dispensing data from the individual pharmacy records of 541 residents (average age 85.5 years and 74.5 per cent female) at 17 Australian nursing homes. Of these, 348 (64.3 per cent) had dementia and 193 did not have dementia.

The study found nursing home residents are more likely to be prescribed medications for treatment of behavioural and psychological symptoms of dementia, pain and urinary tract infections, than for other possible comorbidities.





In total, about 95 per cent of participants were prescribed medications for the nervous system and 94 per cent were prescribed medications for alimentary tract and metabolism.

Of an average 14.5 different prescriptions over a year, the most frequent comorbidities were osteoarthritis (48.4 per cent), hypertension (47.1 per cent), depression (42.9 per cent), urinary incontinence (39.2 per cent), and faecal incontinence (22.5 per cent). The next most common medication classes were those for cardiovascular system (72.1 per cent), anti-infectives for systemic use (68.9 per cent) and dermatologicals (54.1 per cent).

Those with dementia were less likely to have comorbidities of airway diseases, angina, back pain, congestive cardiac failure, diabetes mellitus, dysphagia, hypertension, ischaemic heart disease, osteoarthritis, rheumatoid arthritis and stroke, but were more likely to have faecal or urinary incontinence.

In all, 98 per cent of residents were prescribed more than five different medications, and 71 per cent were prescribed more than 10 different medications over the 12-month period.

The research paper, '*Patterns of medication prescription by dementia diagnosis in Australian nursing home residents: a cross-sectional study*', by Enwu Liu, Suzanne M Dyer, Craig Whitehead, Lisa Kouladjian O'Donnell, Emmanuel S Gnanamanickam, Stephanie L Harrison, Rachel Milte and Maria Crotty, has been published in the *Journal of Pharmacy Practice and Research*.

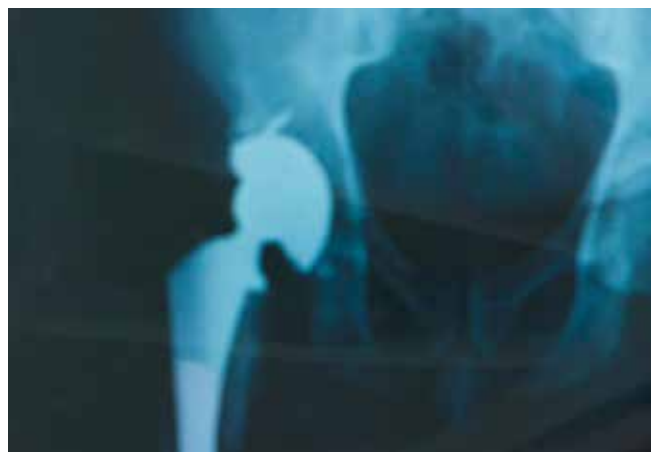
This study was funded by the National Health and Medical Research Council (NHMRC) Partnership Centre on Dealing with Cognitive and Related Functional Decline in Older People.

Joint study into hip and knee costs

Knee and hip replacements for osteoarthritis are expected to rise by up to 276 per cent by 2030, costing Australia's health care system more than \$5 billion, according to new research.

A new study has found that obesity and an ageing population will be the main drivers of growth in joint replacement surgeries for osteoarthritis (OA), with people aged over 40 more likely to undergo surgery.

The 2030 projections are based on data obtained through the Australian Orthopaedic Association National Joint Replacement Registry (AOANJRR), which includes joint replacement



procedures performed across Australia from 2003 to 2013.

The study, published in *BMC Musculoskeletal Disorders*, found:

- Knee-replacement procedures for OA were forecast to increase by 276 per cent (from 42,920 procedures in 2013 to 161,231 in 2030).
- Hip replacement procedures for OA were predicted to rise by 208 per cent (from 25,945 procedures in 2013 to 79,795 in 2030).
- The proportion of Australian adults who are overweight or obese is anticipated to exceed 70 per cent by 2030, resulting in an extra 25,000 knee replacement surgeries, costing an additional \$521 million.
- Reducing obesity levels in Australia by five per cent could result in up to 8,062 fewer procedures – saving \$170 million.

Hip and knee replacements remain cost-effective operations for patients with end stage arthritis and numerous studies have demonstrated decreased pain, improved function and better quality of life following joint replacement.

But study author, Associate Professor Ilana Ackerman, from Monash University's School of Public Health and Preventive Medicine, said the study raised concerns about Australia's capacity to meet future national demand for joint replacement surgery.

"If surgery trends for osteoarthritis continue, Australia faces significant healthcare budget and health workforce implications," Professor Ackerman said.





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“These results provide a strong policy and public health argument for supporting weight-loss campaigns and interventions. Strategies to reduce national obesity could produce important knee replacement-savings.”

Co-author and AOANJRR Deputy Director Richard de Steiger said meeting the large growth in surgical demand will also prove challenging for Australia due to pressures on the surgical workforce and health budgets.

“Careful planning is needed to manage the impact of the expected rise in hip and knee replacements on the surgical workforce, operating theatre wait-times, and the pressure on hospital administration,” Professor de Steiger said.

“Maintaining patient access to these procedures to enable improved quality of life and reduced pain is essential.”

The study was conducted to raise awareness of the problem and to inform future healthcare resource planning policies.

Associate Professor Ackerman said: “In order to meet joint replacement demand in 2030 and beyond, investment in prevention programs designed to limit obesity and other causes associated with hip and knee burden in Australia demands serious consideration.”

Research finds cervical cancer could be gone by end of century

A new study by Cancer Council NSW, in partnership with the International Agency for Research on Cancer, has found that cervical cancer has potential to be eliminated as a public health problem by the end of the century in most countries globally. Cervical cancer is the fourth most common cancer in women worldwide and the leading cause of cancer death in some of the world’s poorest countries, for example those in sub-Saharan Africa.

The new research found that achieving widespread global coverage of both human papillomavirus (HPV) vaccination and cervical screening, from 2020 onwards, could potentially prevent up to 13.4 million cases by 2070 and has potential to achieve world-wide elimination of cervical cancer in most countries by 2100. This news follows last year’s announcement that Australia is on track to be the first country in the world to eliminate cervical cancer as a health problem, due to the success of the

HPV vaccination program and the 2017 changes to the National Cervical Screening Program. If vaccination and screening coverage are maintained at their current rates, this target is set to be reached by 2035 in Australian women.

Professor Karen Canfell, Director of Research at Cancer Council NSW said: “Our research follows on from the recent call-to-action towards cervical cancer elimination by the World Health Organisation. We have shown what might be possible in terms of the lives that could be saved. This is the kind of news that every cancer researcher lives for.

“It’s incredibly exciting for women all over the world. However, we are only in the early stages of the push towards elimination, as implementation efforts towards achieving global scale-up of vaccination and screening have just begun.”

The research provides the first estimates of the potential timeline to cervical cancer elimination by quantifying the impact of two key steps: the rapid dispatch and administration of HPV vaccinations to 80-100 per cent of the world’s population of young girls and effective delivery of twice-per-lifetime HPV-based screening in all less-developed countries, with a 70 per cent coverage rate. If high coverage vaccination and screening can be scaled up together, this will avert a cumulative 12.5 to 13.4 million cervical cancer cases over the next 50 years and will see average cervical cancer rates decline below what could be considered as elimination thresholds, less than four cases per 100,000 people, by the end of the century.

“Just over 30 per cent of young females in developed countries have received the HPV vaccine. When you consider that this figure dips below three per cent in less-developed regions, you can see just how far we have to go. If we don’t act now, over the next 50 years, 44.4 million cervical cancer cases are predicted to occur. Given that 85 per cent of cervical cancers occur in less-developed regions, these countries must be our first priority for implementation of high coverage cervical screening and HPV vaccination programs,” Professor Canfell said.

“While I’m so proud that Australia is leading the way towards cervical cancer being eliminated as a public health problem, it’s vital that we don’t grow complacent. Women must continue to participate in the National Cervical Screening Program and girls and boys must all be vaccinated against HPV through the national HPV immunisation program, if we want to achieve national and global elimination of cervical cancer.”





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Public consultation to boost clinical trials



Reforms are underway to boost Australia's clinical trials sector and attract more clinical trials – giving Australian patients increased access to potentially life-saving treatments and medications.

To promote Australia's reputation in clinical trials research, a national consultation process is now underway to develop the National Clinical Trials Governance Framework. The framework will support the integration of clinical trials service provision into routine hospital care and reinforce Australia's standing as one of the world's leaders in medical research.

Consultations began on February 6 this year, with a series of stakeholder workshops to be held across all States and Territories until March 22. Development of the framework is being led by the Australian Commission on Safety and Quality in Health Care, which was engaged by the Health Department on behalf of all jurisdictions to deliver the framework by mid-2019.

The Commission's work is a key element of a clinical trials agenda endorsed by all Health Ministers in March 2017, and supports related national clinical trials efforts underway, including the *Encouraging More Clinical Trials in Australia* budget measure. The initiative is driving reforms nationally to improve efficiencies, better engage sponsors and improve trial start-up times – with the ultimate aim of growing the number of clinical trials conducted in Australia.

The nation's Chief Medical Officer, Professor Brendan Murphy, said boosting cohesion and productivity across the clinical trials

sector would benefit both Australian patients and the health sector.

"Australia has a world-class reputation for conducting excellent research through clinical trials. The Clinical Trials Governance Framework is the first step toward accrediting health services undertaking clinical trials," Professor Murphy said.

"Our high-quality clinical trial sites have been attracting companies from across the globe for over three decades. To build on this success, Australia must build on its reputation for quality trials and reduce the variation between sites. The framework will position Australia to be a preferred destination for clinical trials."

Commission Chair, Professor Villis Marshall, said Australian patients will benefit from better outcomes due to these reforms. Australians are keen to be involved in clinical trials, and research provides access to cutting edge treatments and interventions of the future.

"The revitalisation of the clinical trials environment also supports the wider medical sector. Researchers will gain global recognition for their work and improve their technical skills, while industry will thrive from rising international R&D expenditure and the decline in the so-called 'brain drain' of highly qualified Australian researchers seeking opportunities overseas," Professor Marshall said.

Clinical trials are undertaken in a number of therapeutic areas in Australia, including oncology, respiratory, central nervous system, infectious disease, metabolic disorders, cardiovascular, aged care and mental health.

Examples of recent successes of Australia's collaboration in research with global pharmaceutical companies have resulted in the development of Gardasil, a vaccine against human papillomavirus and Relenza, the first effective drug to treat all strains of influenza.

Consultation on the Governance Framework is open to key organisations and individuals with an interest in or working in the clinical trials sector. The Governance Framework and high-level implementation strategy will be released later this year.

For more information visit: <https://www.safetyandquality.gov.au/our-work/clinical-trials/current-consultation/>

Grand Canyon radiation fright



Visitors to one of the world's greatest natural tourist attractions may have been exposed to higher than acceptable radiation levels for almost two decades.

Reports out of the US say uranium stored at the Grand Canyon National Park museum could have exposed visitors and workers to levels of radiation that are higher than the federal limit.

The park's safety manager Elston Stephenson told CNN he had raised the alert with officials last year but was ignored.

He said he had asked management at the National Park Service and Department of the Interior to warn workers and tourists that they had possibly been exposed to unsafe levels of radiation.

But when no action was taken, Mr Stephenson emailed all park staff at the Grand Canyon on February 4 this year.

"If you were in the Museum Collections Building (bldg 2C) between the year 2000 and June 18, 2018, you were 'exposed' to uranium by OSHA's (Occupational Safety and Health Administration) definition," he wrote.

"Please understand, this doesn't mean that you're somehow contaminated, or that you are going to have health issues. It merely means essentially that there was uranium on the site and you were in its presence. ... and by law we are supposed to tell you."

The National Park Service is now investigating what happened and is working with OSHA and the Arizona Department of Health Services.

But Mr Stephenson told CNN that in June last year he found out about three five-gallon (20-litre) buckets of uranium ore that had been stored next to a taxidermy exhibit at the park's museum for almost 20 years.

The Department of the Interior, which oversees the park service, issued this statement to CNN: "Uranium naturally occurs in the rocks of Grand Canyon National Park. A recent survey of the Grand Canyon National Park's museum collection facility found radiation levels at 'background' levels – the amount always present in the environment – and below levels of concern for public health and safety. There is no current risk to the public or Park employees."

More countries spending more on health



Spending on health is growing faster than the rest of the global economy, accounting for 10 per cent of global gross domestic product, but people are still paying too much out of their own pockets, according to a new report from the World Health Organisation.

The out-of-pocket expenses are forcing 100 million people into extreme poverty each year, worldwide.

The report reveals a swift upward trajectory of global health spending, which is particularly noticeable in low and middle-income countries where health spending is growing on average six per cent annually compared with four per cent in high-income countries.

Health spending is made up of government expenditure, out-of-pocket payments, and other avenues that include voluntary health insurance, and employer-provided health programs.

Governments provide an average of 51 per cent of a country's health spending, while more than 35 per cent of health spending per country comes from out-of-pocket expenses.

One consequence of this is 100 million people are pushed into extreme poverty each year. This despite reliance on out-of-pocket expenses declining around the world. It is just happening too slowly.

The report highlights a trend of increasing domestic public funding for health in low and middle income countries and declining external funding in middle-income countries

"Increased domestic spending is essential for achieving universal health coverage and the health-related Sustainable Development Goals," said WHO Director-General, Dr Tedros Adhanom Ghebreyesus.

"But health spending is not a cost, it's an investment in poverty reduction, jobs, productivity, inclusive economic growth, and healthier, safer, fairer societies."

In middle-income countries, government health expenditure per capita has doubled since the year 2000. On average, governments spend US\$60 per person on health in lower-middle income countries and close to US\$270 per person in upper-middle income countries.

When government spending on health increases, people are less likely to fall into poverty seeking health services. But government spending only reduces inequities in access when allocations are carefully planned to ensure that the entire population can obtain primary health care.

In low and middle-income countries, new data suggests that more than half of health spending is devoted to primary health care. Yet less than 40 per cent of all spending on primary health care comes from governments.

"All WHO's 194 Member States recognised the importance of primary health care in their adoption of the Declaration of Astana last October," said WHO Director for Health Systems, Governance and Financing, Dr Agnes Soucat.

"Now they need to act on that declaration and prioritise spending on quality health care in the community."

The report also examines the role of external funding. As domestic spending increases, the proportion of funding provided by external aid has dropped to less than one per cent of global health expenditure. Almost half of these external funds are devoted to three diseases – HIV/AIDS, tuberculosis and malaria.

While the report clearly illustrates the transition of middle-income countries to domestic funding of health systems, external aid remains essential to many countries, particularly low-income countries.

The new WHO report points to ways that policy makers, health professionals and citizens alike can continue to strengthen health systems.

"Health is a human right and all countries need to prioritize efficient, cost-effective primary health care as the path to achieving universal health coverage and the Sustainable Development Goals," Dr Soucat said.

YouTube gets tough on anti-vaxxers

YouTube has demonetised anti-vaccination content to make it harder for anyone promoting such dangerous views to profit from their propaganda.

A BuzzFeed News report revealed that the US-based video sharing website will prevent advertising on anti-vax programs, describing such videos as dangerous and harmful.

Advertisers had been pulling their ads from the anti-vax videos in increasing numbers.

Some advertisers said they were not aware their ads were appearing on anti-vax videos and upon discovering that they were, asked YouTube to take them off.

Now YouTube has gone further and is denying any ads on these

programs that campaign against immunisation of children.

The channels that have been demonetised include VAXXED TV, LarryCook333, which is part of StopMandatoryVaccinations.com, and iHealthTube.

In a statement to BuzzFeed, a YouTube spokesperson said: “We have strict policies that govern what videos we allow ads to appear on, and videos that promote anti-vaccination content are a violation of those policies. We enforce these policies vigorously, and if we find a video that violates them, we immediately take action and remove ads.”

The company has also introduced an information panel about immunisation.

British youth suffer more from asthma, report



Great Britain tops the list of wealthy countries whose young people could die from asthma.

A study from the think tank Nuffield Trust and the Association for Young People’s Health, recently analysed 17 measures of health and wellbeing for 10 to 24-year-olds in countries that included Australia, the US, Germany, France, Italy and Japan.

A total of 19 countries were analysed, including 14 European nations.

The research found that people in that age group were more likely to die from asthma than those from the other countries studied.

The asthma death rate was the highest in the UK.

The UK also had the highest obesity rates for 15 to 19-year-olds among all the European nations.

The report found that while young people in the UK were making some healthier choices than in the past, and were drinking and smoking less, more of them were becoming adults with long-term serious health conditions.

Almost one in five young Brits are living with conditions such as type 2 diabetes.

The statistics, especially for obesity, appear to be worse for young people from poor families.

The report states: “Despite living in the world’s fifth largest economy, young people aged 20 to 24 in the UK are experiencing one of the highest rates of severe material deprivation among the countries in our international comparison.

“Reducing poverty among young people is key to improving their health outcomes in the UK.”

Nations meet to discuss food safety



World leaders attending the first International Food Safety Conference have declared that greater international cooperation is needed to prevent unsafe food from causing ill health and stalling progress towards sustainable development.

The conference, held at Addis Ababa in February, was organised by the African Union (AU), the Food and Agriculture Organisation of the United Nations (FAO), the World Health Organisation (WHO) and the World Trade Organisation (WTO).

Food contaminated with bacteria, viruses, parasites, toxins or chemicals causes more than 600 million people to fall ill and 420,000 to die worldwide every year. Illness linked to unsafe food overloads healthcare systems and damages economies, trade and tourism.

The impact of unsafe food costs low- and middle-income economies around \$95 billion in lost productivity each year. Because of these threats, food safety must be a paramount goal at every stage of the food chain, from production to harvest, processing, storage, distribution, preparation and consumption, conference participants stressed.

“There is no food security without food safety,” said FAO Director-General José Graziano da Silva during his remarks.

“This conference is a great opportunity for the international community to strengthen political commitments and engage in key actions. Safeguarding our food is a shared responsibility. We must all play our part. We must work together to scale up food safety in national and international political agendas.”

African Union Commission chairman Moussa Faki Mahamat said the partnership between the AU and the UN has been longstanding and strategic.

“This food safety conference is a demonstration of this partnership. Without safe foods, it is not possible to achieve food security,” he said

Dr Tedros Adhanom Ghebreyesus, Director-General of the World Health Organisation, said: “Food should be a source of nourishment and enjoyment, not a cause of disease or death. Unsafe food is responsible for hundreds of thousands of deaths every year, but has not received the political attention it deserves. Ensuring people have access to safe food takes sustained investment in stronger regulations, laboratories, surveillance and monitoring. In our globalised world, food safety is everyone’s issue.”

WTO Director-General Roberto Azevedo said: “Food safety is a central element of public health and will be crucial in achieving the 2030 Sustainable Development Goals. Trade is an important force to lift people out of poverty... when we reconvene in Geneva in April we will consider these issues in more depth.”

About 130 countries participated in the two-day conference, including ministers of agriculture, health, and trade. Leading scientific experts, partner agencies and representatives of consumers, food producers, civil society organisations and the private sector are also taking part.

The aim of the conference was to identify key actions that will ensure the availability of, and access to, safe food now and in the future.

This will require a strengthened commitment at the highest political level to scale up food safety in the 2030 Agenda for Sustainable Development, the conference concluded.

A follow-up event, the International Forum on Food Safety and Trade, which will focus on interlinkages between food safety and trade, is scheduled to be hosted by WTO at Geneva in April.

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