AUSTRALIAN
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We have a date

Election called for May 18, p3

INSIDE

Key election health issues, p4
Conscientious objection, p10
Reader survey results, p11
Health Budget, p15
Budget reply, p20
Federal Council, P275

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In this issue

National News 3-7, 10-14

Health on the Hill 15-21

Research 31-34

World News 35-37

Columns

8 PRESIDENT'S MESSAGE
9 VICE PRESIDENT'S MESSAGE
22 GENERAL PRACTICE
23 PUBLIC HEALTH OPINION
24 RURAL HEALTH
25 AMSA
26 DOCTORS IN TRAINING
27 FEDERAL COUNCIL COMMUNIQUÉ
28 PUBLIC HOSPITAL DOCTORS
29 MEDICAL PRACTICE
29 ETHICS AND MEDICO LEGAL
38 MOTORING
40 MEMBER SERVICES

Nation headed for a healthy election

Australians have a date with the ballot box and health funding will be on their minds when they get there.

That is the message the AMA is sending to all political parties as the starter's gun is fired on the 2019 Federal Election.

Prime Minister Scott Morrison visited Governor-General Peter Cosgrove at 7am on Thursday, April 11 to ask that Parliament be prorogued, and writs be issued for a May 18 election.

Trailing in the opinion polls and already notionally three seats short of a majority in the newly redistributed House of Representatives, the Coalition has a tough battle over the five-week campaign.

There will be a half-Senate election on the same day.

Mr Morrison appeared confident of victory when fronting the media from his Parliament House courtyard after returning from Government House.

"Keeping our economy strong is how we secure your future and your family's future," the Prime Minister said.

"Keeping our economy strong ensures that we can secure your wage, your job, your business and, importantly, the business you are going to work for today. Particularly, those small and family businesses out there employing more than half of the Australians who go to work today.

"And it's also absolutely essential to guarantee the funding for the services that you rely on – hospitals, schools, roads, medicines, aged care, disability care – all of these now already at record levels of funding that only a strong economy can guarantee into the future. Not higher taxes."

Opposition Leader Bill Shorten, however, had his own message.

He said Australians had a choice between being stuck in the past and having a bright future.

"The case to vote Labor is that we will deliver more jobs, better health and education, take real action on climate change and renewable energy and help push energy prices down…" Mr Shorten said.

"If you want better than the last six years, if you want a fair go for all Australians, if you want a government who is united and not constantly trying to tear each other down, then vote Labor on May 18."

AMA President Dr Tony Bartone said health policy from each of the major parties will play a major role in the election's outcome.

He said Australians were acutely aware that the next government must invest heavily right across the health sector.

"Right at the top of the list is the call for significant investment in general practice," Dr Bartone said.

"For many years now, general practice has been underfunded, devalued, disinvested and it's not recognised as the engine room of the health system."

In releasing the AMA's *Key Health Issues for the 2019 Federal Election* document (see separate story), Dr Bartone said substantial, well-targeted health funding was required and expected.

"Doctors are uniquely placed to comment on health policy. We have the daily lived experience to know what works and what doesn't work. Our patients tell us what is good and bad about their patient journey," he said.

CHRIS JOHNSON

Election must result in greater funding for health sector

The AMA has released its *Key Health Issues for the 2019 Federal Election* – a summary of the major health issues the AMA considers must be addressed by the major parties during the election campaign and into the next term of Government, whichever party wins.

AMA President Dr Tony Bartone said health policy will be a vital factor in the outcome of the 2019 Federal Election, which has been called for May 18.

"Health policy influences votes at every election, and doctors are very good judges of health policy," Dr Bartone said.

"Doctors witness the best and worst of health policy every minute of every day across the country.

"We witness it in public hospitals, private hospitals, in general practice, in private specialist practice, in aged care facilities, mental health, in people's homes, in emergency situations, in medical research, in academia. In all settings.

"We witness it in the CBDs of our major cities, in the inner and outer suburbs, in the large regional centres, in towns and villages, in rural and regional outposts, in the outback, and in remote Indigenous communities. In all locations.

"We witness it at all stages of life – from pregnancy to childbirth to infancy to teens to adult years to aged care and end of life.

Election must result in greater funding for health sector ... continued

"Doctors are uniquely placed to comment on health policy. We have the daily lived experience to know what works and what doesn't work. Our patients tell us what is good and bad about their patient journey.

"Our *Key Health Issues for the 2019 Federal Election* document sets out what the AMA and the medical profession believe needs to be done to keep the Australian health system up there as one of the best in the world.

"And it is one of the best in the world, if not the best. But it will take strong leadership, hard work, good policy with long-term strategic vision, and significant well-targeted funding to keep it working efficiently to meet growing community demand.

"The health system has many parts, and they are all linked. Governments cannot concentrate on a few, and neglect the others. Otherwise, patients will be the ultimate losers. Whole patient care cannot be done in silos, in parts, or in isolation.

"The priorities remain the pillars of the health system – primary care led by general practice, public hospitals, prevention, and the private health system, which includes private hospitals and private health insurance – with the strong underpinning of Medicare.

"But other sectors are gaining in prominence and need, most notably aged care and mental health.

"We have seen some early policy announcements in the Budget and the Budget Reply. The Government announced a very welcome and much-needed significant investment in primary care, with the focus rightly on general practice.

"The Opposition responded with a considerable Medicare Cancer Plan, which will ease the financial pressure on cancer patients and their families.

"These are both worthy contributions to the health policy contest we need to see in this election campaign, but there is so much more to do across the health system.

"Primary health care, especially general practice, must be at the top of the list of the health policy agendas of the major parties at this election.

"General practice touches all parts of the health system. It is the glue that holds everything together.

"The AMA will urge the major parties to adopt the policies and recommendations detailed in this document. For our patients. For our communities.

"Health is the best investment that any government can make," Dr Bartone said.

JOHN FLANNERY

AMA *Key Health Issues for the 2019 Federal Election* covers:

- General Practice and primary care;
- Public hospitals;
- A futureproofed Medicare;
- Medical care for older Australians;
- Private health;
- Diagnostic imaging;
- Pathology;
- Task substitution;
- Mental health;
- Asylum seeker and refugee health;
- Climate change and health;
- Indigenous health;
- Prevention;
- Obesity;
- Alcohol;
- Tobacco;
- Addiction;
- Immunisation;
- Rural health;
- Medical workforce; and
- Supporting GP training.

***Key Health Issues for the 2019 Federal Election* is available at: https://ama.com.au/article/key-health-issues-2019-federal-election**

Election message from Greg Hunt MP, Minister for Health

The Liberal National Government has a long-term health plan to build a health system that is flexible, affordable, effective and accessible to all Australians.

The Government is investing a record $104 billion in 2019–20, up from $75 billion in 2012–13, as part of a comprehensive, patient-focused investment of $435 billion over the next four years.

It guarantees Medicare, makes a range of life-saving medicines and services more accessible and affordable, reduces out-of-pocket costs, strengthens primary care and mental health and invests in breakthrough medical research.

The Budget consolidates and continues our health reform agenda. It reinforces the four pillars of our long term national health plan – guaranteeing Medicare and improving access to medicines, supporting our hospitals, prioritising mental health and preventive health and investing in health and medical research.

Primary care is fundamental to our world class health system and the Government is committed to working with our GPs, specialists and consumers to continuously improve the delivery of care.

The 2017 landmark Compact paved the way for an incredibly productive partnership which has helped to shape our investment into the sector to strengthen and modernise the system.

The Government has recognised this in the recent 2019-20 Budget, and we will deliver a $1.1 billion 'Strengthening Primary Care' package, further building on the $512 million announced at the 2018-19 MYEFO, to support Australia's doctors and specialists to deliver improved access and outcomes for patients. This was designed was co-designed with the AMA, and includes:

- $448.5 million to deliver a new population-based funding approach to support GPs to deliver enhanced care and services, initially focusing on Australians over 70 years
- $201.5 million in additional funding for the Practice Incentives Program Quality Improvement Initiative which will help embed general practice quality improvement activities, while supporting better patient outcomes and broader primary care reforms – as part of this, the Aged Care Access Incentive will be retained, ensuring continued support for GPs to provide services in Residential Aged Care Facilities
- $187.2 million to increase the patient rebate for all remaining GP items on the Medicare Benefits Schedule (MBS) from 1 July 2019
- $62.2 million for a National Rural Generalist Pathway, to ensure rural generalists are trained, recognised and resourced to meet the health needs of rural Australians.

This builds on the 2018-19 Budget, which delivered the most comprehensive rural health package in decades, providing $550 million under the Stronger Rural Health Strategy to improve access to doctors, nurses and other health care services for all Australians, especially those in the regions.

A significant focus has been placed on Indigenous health and funding for child dental health.

These initiatives contribute to the Government's investment of an additional $6 billion in Medicare from $25 billion in 2018-19, $26 billion in 2019-20, $27 billion in 2020-21 and $29 billion in 2021-22 to support healthcare for every Australian.

It also complements the investment of $40 billion for life-saving and life-changing medicines included in the forward estimates, and investments in mental health including youth suicide prevention.

The Government recognises there is more to be achieved, and these announcements support our long term reform plan to improve the care, lives and health outcomes for all Australians.

These investments demonstrate our ongoing commitment to building a world class healthcare system.

Authorised by Greg Hunt MP, Liberal Party of Australia, Somerville, Victoria.

Election message from Catherine King MP, Shadow Minister for Health

Bill Shorten put health front and centre of this election campaign when he used his Budget Reply speech to announce our $2.3 billion Medicare Cancer Plan.

This is the most important investment in Medicare since Bob Hawke introduced it in the 1980s.

It's an acknowledgement that too many Australians face significant out-of-pocket costs when they're fighting for their lives.

Cancer makes you sick but it shouldn't make you poor.

Labor talks a lot about Medicare. That's because we created it, we value it and we'll always seek to protect and strengthen it.

But we're not just talk. We're putting our money where our mouth is.

Our Medicare Cancer Plan will deliver up to six million free scans and three million free consultations.

It will drive down cancer out-of-pocket costs across the whole system.

It will slash public hospital waiting lists for cancer patients.

And it will deliver new funding for new specialised cancer nurses, anti-tobacco measures, children's cancer groups, regional radiation centres – the list goes on.

By contrast, the Abbott-Turnbull-Morrison Government conducted an 18-month review of out-of-pocket costs and the best they could come up with was … a website.

So Bill and I will of course be talking much more about our cancer plan in the coming weeks.

But that's not the only thing we'll be talking about.

Throughout our time in Opposition we fought hard to end the Liberal's five-year Medicare rebate freeze, which was a wrecking ball through primary care and forced up costs for patients across the board.

Finally, a few weeks ago, the Government capitulated and matched Labor's long-standing promise to end this damaging freeze.

Call me a cynic – but it's hard to trust a government that stubbornly persisted with a policy for five years only to pledge to lift it six weeks before an election.

Bill and I will also be announcing more details about our plan for improved public hospital funding.

Last year we announced a $2.8 billion Better Hospitals Fund – to bridge the gap between the 45 per cent of efficient price growth the Morrison Government is delivering and the 50 per cent they promised to pay.

The AMA itself has said the Morrison Government's current funding formula will "doom our public hospitals to failure". We must do better.

We've already announced $1 billion of our fund will go towards targeted capital investments – building new units and wards, upgrading emergency departments, and delivering better infrastructure to provide expanded services.

We have already announced dozens of projects across the whole country, in the capital cities and the regions.

We'll have more to say about the rest of the money in this fund before election day – but every public hospital in the country will be better funded under Labor.

Some good optics in Budget – but no vision

BY AMA PRESIDENT DR TONY BARTONE

> "The new-found enthusiasm for primary care from all sides of politics is welcome. It is long overdue, but it does represent a turning point. We can build on it."

When I was elected AMA President in May last year, I declared that general practice would be one of my priorities when dealing with the Government. And so it was, and is.

I have spent 10 months, meeting after meeting, phone call after phone call, pushing Health Minister Greg Hunt to share my key priorities, including my passion for general practice. He soon began to understand and acknowledge the vital coordinating role of GPs in the health system.

He also learned that hardworking and dedicated GPs spend a lot of non-face-to-face time providing the possible care and advice for our patients. It is core business for us. We never get paid for it. But we do it. It is all part of quality holistic primary care. It is general practice.

Well, some of this non-face-to-face care will now be funded as part of the almost $1 billion of new investment for general practice announced in the Budget. Greg Hunt listened, learned, and delivered. It will be for patients over 70 who voluntarily nominate with a general practice. We see a lot of these patients. They need constant ongoing care.

It is a good start. It is due recognition of the value of general practice. We know there is more needed for primary care. So does the Minister. And so does the Shadow Health Minister. It is our understanding that Labor will match this funding. If they are elected, we will ensure they do.

The new-found enthusiasm for primary care from all sides of politics is welcome. It is long overdue, but it does represent a turning point. We can build on it.

While the optics on primary care in the Budget were positive, there were areas of disappointment.

The AMA has called on successive and future governments to adopt a long-term approach to health policy. Set the system up for the years ahead when demand will grow and grow. We want our policymakers to have a vision about where health care is headed in this country.

A strong Pharmaceutical Benefits Scheme (PBS) is vital. Minister Hunt has been a PBS champion and there was more funding in the Budget.

There has been some action on aged care, but still a long way to go.

But there was little mention of a prevention agenda. We need planning, programs, promotion, and resources to keep people active and healthy.

The need for significant long-term funding and a better funding formula for public hospitals were not addressed in the Budget.

Mental health needs a total rethink to build the role of general practice in coordinating patient care.

Governments must work together to plan and build the medical and health workforces – and get them working where they are most needed – to meet the growing demand that is with us now and will blow out in coming decades.

And then there is the unfinished business of the MBS Review and the bedding down of the private health reforms. Both these major pieces of work will have a huge impact on our patients and how we deliver care.

All these elements are linked. They work most efficiently when they are properly funded and resourced and complement each other to make the patient journey as smooth as possible.

This is the big picture. This is planning for future need. This is the vision.

We hope to see some visionary health announcements from all sides before the May election.

The case for medical leadership – part three

BY AMA VICE PRESIDENT DR CHRIS ZAPPALA

It is contended that medical leadership is a mechanism to achieve greater medical engagement in the running of organisations[1]. Engaged doctors can have a direct day-to-day input on the financial bottom line of hospitals and without medical engagement at a collective level and the individual alignment of doctors, there is no meaningful way to influence variations in practice or care[1].

Benefits to employing doctors in healthcare management roles include bottom-up leadership[2], greater political influence and improve communication between doctors and senior management. Medical leadership is necessary to link clinical decisions with those of strategic management. Doctors are key to embedding health service improvements[1] and overcoming the occasionally lugubrious perceptions of our colleagues. Primary care is no different in that to be successful, quality needs to be defined and measured in ways that are meaningful to general practice; this requires strong and consistent clinical leadership[3].

Is there anything to be said against medical leaders?

The argument against medical leadership include doctor over-identification with their professional clinical role, their tendency to be conservative individualists rather than team players, their lack of formal management training and their purported weakness in financial management and organisational strategy. I however believe appropriate training would enable doctors to overcome many, if not all, of these perceived deficiencies. Moreover, there is some suggestion that doctors are more willing to take on leadership roles after formal training[4].

Doctor-leaders may have lost some favour initially given the range of leadership styles that effective leaders must be able to deploy situationally. Unhelpfully, doctor leaders have traditionally defaulted to a 'command and control' style that fosters the concept of doctors as heroic, gladiatorial lone healers. The perverse effects of 'command and control' are that this style conspires against collaboration and tends to be perpetuated as aspiring leaders emulate their predecessors[5]. Furthermore, 'command and control' is widely considered to be among the least effective leadership styles – what Goleman and Boyatzis call a 'dissonant style' as opposed to the four other resonant styles such as visionary, coaching, democratic and affirmative styles[6]. Experience in organisations outside healthcare indicates an association between poorer organisational performance and the CEOs having a primary command and control style and conversely, better organisational performance with one of the resonant CEO styles[5].

This paradox – the tension between the need for collaboration in healthcare and medical system leadership with doctor's maladaptation to collaborate (with a focus on autonomous decision-making and personal achievement) – underlines the need to enhance doctor's leadership competencies[4]. Formal doctor leadership training also counters the perception that medical influence is diminishing and self-regulation is suffering. This aspect is very important in an increasingly litigious environment in which complaints against doctor are becoming significantly more frequent as regulators and Government strive to appear tough in managing misconduct or malpractice, even though the incidence of this remains stable and quite small.

How to build more credible medical leadership

It was recognised that in regard to the NHS, if they were to achieve a position where medical leadership was of a consistently high standard and embedded throughout the NHS, they needed all doctors to be able to take a macroscopic view on healthcare provision and resource allocation and to understand the political, economic, social and technological drivers for change that would influence this view throughout their careers.

Doctors, who until now had been taught little of the NHS, would need to learn about the funding, organisation, governance and management that are integral to its workings. They need to be supported by well-developed systems, clear lines of reporting and responsibility, and an organisational culture that provides good information and encourages its use as a vehicle for performance improvement. Finally, all doctors, whether they remain predominantly as medical practitioners, move to lead organisations or take on more strategic roles, need to learn more about 'followership' – an increasingly discussed concept that recognises the importance of participation and allowing others to lead. Without doing these things, doctors will remain significantly disadvantaged, unable to participate in discussions regarding service delivery, unable to navigate and lead others through the organisation and system in which they work and on occasions perceived, sometimes rightly, to be barriers to change or toxic influences within their organisations.

The profession still has much work to do in order to extinguish discrimination, bullying and sexual harassment completely from the training landscape and workplace. The Royal Australasian College of Surgeons has shown that an evidence-based

Vice President's message ...continued

approach can be brought to bear and that positive change is possible. Significant cultural change remains necessary to make perpetrators aware that their behaviour will no longer be tolerated[7]. Enlightened and empowered medical leadership is clearly a fundamental step in achieving this. The AMA, Medical Colleges and every doctor individually has a vital role to play in honouring the 'societal contract' between the profession and our patients ensuring that discrimination, bullying and sexual harassment are never tolerated. Together we can champion unimpeachable professionalism and integrity through abolishing the disconnect between organisations' stated values and the explicit professional values we espouse and teach, with the responses in individual cases of alleged abuse.

The goal of producing better qualified and confident medical leaders in order to emphasise the importance of doctor-led healthcare and promote medical leadership with a positive organisational culture is therefore critical. Acceptance of this need, a profession-wide push in this direction and credible learning opportunities to facilitate it are urgently required. I hope the AMA is going to be able to work with the Royal Australasian College of Medical Administrators to design a program that will achieve exactly this. We have some good examples worthy of approbation already where RACMA has developed such a program in Tasmania and in conjunction with Queensland Country Practice offering a conjoint AFRACMA with rural generalist training.

Ideally, the leadership program should align with an organisational culture that regards (medical) leadership as being important to success, coupled with the respect garnered from clinical prowess. This is where the wider profession has a role – we must create this culture where medical leadership is regarded and valued as fundamental. Doctors respond positively to leadership development when the framework follows principles established for continual medical education – there is a growing body of evidence which gives advice on curricula and principles of good leadership and education in this context[8]. The core realisation for policy makers is that medical leadership development programs increase doctor leadership competencies and add value to healthcare institutions[7].

It is time to actively reclaim and develop our management potential and not shrink from this important aspect of our jobs. Let us all please support and/or get involved in medical leadership and be active participants in the running of our practices, institutions or healthcare systems. Robust leadership/management training and profession support for our colleagues in management positions can anneal our collective resolve and capacity to contribute. I genuinely believe Australian health care and our patient outcomes will be better for it – plus it will be a more safely efficient and happier workplace.

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Rules around conscientious objection

The AMA has updated its *Position Statement on Conscientious Objection*. It is the first update since 2013.

Dr Chris Moy, Chair of the AMA Ethics and Medico-Legal Committee, explains more about the new Position Statement in his column for the April 15 edition of *Australian Medicine* (page 28).

The concept of 'effective referral' is dealt with at length.

In short, the AMA states that medical practitioners are entitled to have their own personal beliefs and values as are all members of the community.

A conscientious objection occurs when a doctor, as a result of a conflict with his or her own personal beliefs or values, refuses to provide, or participate in, a legal, legitimate treatment or procedure which would be deemed medically appropriate in the circumstances under professional standards.

A conscientious objection is based on sincerely-held beliefs and moral concerns, not self-interest or discrimination.

It is acceptable for a doctor to refuse to provide or to participate in certain medical treatments or procedures based on a conscientious objection, but doctors have an ethical obligation to minimise disruption to patient care.

Doctors must never use a conscientious objection to intentionally impede patients' access to care.

The updated Position Statement can be found at:

https://ama.com.au/position-statement/conscientious-objection-2019

Australian Medicine reader survey results

Results of the 2018-19 *Australian Medicine* reader survey are in!

The survey was open for AMA members between November 2018 until the end of January 2019.

There was a total of 414 respondents.

Results were informative and constructive, and overwhelmingly positive.

"I like reading it; up to date and concise, and succinct medical knowledge."

"Previously I didn't find the time. I thought of it as study or hard work. I didn't have my mindset in the right place. Now I sit down and enjoy it from cover to cover with a cup of tea."

"Skim through it and read sections of articles. Useful updates but lots of politics."

"I read it regularly."

"I read it fairly regularly because it provides a locoregional perspective that other journals lack. The digital versions are also a welcome change in a field where hard copy is often considered king."

"Very little about my specialty."

"Mostly politics, occasionally useful in GP practice."

"Usually read the copies in our practice."

By far, **national health policy** is what *Australian Medicine* readers want to know about. This is followed by articles on medical education, hospitals, medical ethics, lifestyle, public health, GP issues, and rural health.

The online edition is read the most (43.80 per cent), followed by the hard copy print version (35.28 per cent) and then the PDF download (20.92 per cent).

Readers are encouraged to read the magazine mostly because of its cover, its headlines, content and pictures, but also through fortnightly email alerts. Not so much through Twitter or Facebook alerts. Most would prefer *Australian Medicine* to be published monthly (53.17 per cent), followed by fortnightly (25.61 per cent), and quarterly (21.22 per cent).

The President's column is highly read, as is the Vice President's column. Other specific committee columns have solid readerships. National news reigns supreme.

Constructive criticisms went to layout, length of articles and the desire for more case studies and specialist news. And plenty of readers would like to see more competitions, quizzes and lighter articles.

Australian Medicine is taking it all on board and will incorporate as many of your ideas as we can.

The survey asked: **How can we make *Australian Medicine* more interesting for you?** The results were pleasing, with some excellent suggestions and lots of praise. Below are just some of the comments left in response to that question:

"More opinion columns."

"Keep doing what you are doing."

"I would like to read more stories about individual doctors and their challenges and how they overcame them; both personal and work related."

"Carry on steady as she goes."

"It is very informative. Thank you for putting so much effort in putting it out regularly."

"It is useful for updates of the wider health setting. Sometimes articles are too long."

"Bolder headlines for current news."

"Keep me up to date with health issues."

"A few more enthusiastic medical writers like Dr Clive."

"It is difficult to cater for all specialties, but I think the current format works reasonably well."

"A regular technology and arts column would be most welcome. Although the music column is a nice distraction from clinical work, a further extracurricular vantage would be fantastic."

"Interesting cases."

"Happy."

"Plenty of stories about people and places."

"Specific sections for each specialty. Non-medical things like travel and fellowship opportunities etc."

"I think it is fine. I would not read cover to cover. I read everything on Indigenous health, refugee health, child health and public health, particularly climate change and health."

"More pros and cons of political situation. Explanation of funding of different health sectors."

"It's fine as it is. By Drs for Drs."

"Keep doing what you are doing. Its already interesting."

"More modern look/greater visual appeal."

"Chance to contribute articles."

"It's great in its current format."

"More succinct articles."

Survey results ... continued

"No particular changes recommended."

"I am pretty satisfied with the present production. I always go to President's message and motoring straight off. (Petrol head person)."

"It's fine as is, just get a lot of things to read."

"More Australian research and impacts on changes in clinical practice."

"International medical news, rural and regional health news coverage, Indigenous health issues."

"Maybe some outside perspectives about health policy? Too often the articles are just preaching to the choir."

"I mostly like it the way it is."

"For me, it is the medico-political content I look for and learn from."

"Keep it up."

"More reference on benchmarking against other health systems."

"More articles about current medical issues; more medical cases."

"More competitions."

"Good as it is. Enjoy the variety."

"It's pretty good as it is."

"Medical trivia."

"Contemporary views from regular members, especially junior ones."

"Keep up the great work!"

"Good as it is."

"More competitions or things to do e.g. crosswords, sudoku etc., which are great for downtime/mindfulness."

"More current national and international medical news."

"It's fine as it needs to meet relevance for a broad audience."

"Keep up the good work."

"Less self-congratulatory."

"Like it as is – quick and easy to read."

"Happy with the current format."

"I quite like it."

"Keep providing interesting or novel articles."

"Make it more relevant for junior doctors."

"Continue present format."

"Continued political influence/focus."

"I am satisfied."

"Mostly interested in national health policies."

"I like to read feel-good medical stories or breakthroughs."

"Concise, factual, to the point."

"I like the Christmas edition. More lighthearted articles would be nice."

"More lifestyle."

"Expand the travel section."

"Interesting enough."

"I quite like the current version. Make sure there is a good mix of articles to suit the readership."

"Horizon scanning – what will impact practice in 5-10 years."

"More clinical case studies."

"Continue print version."

"Change the title to something more interesting."

"Enable us to write in and ask questions of columnists."

"Some light read articles mixed in."

"It's already good."

"All good so far. Keep up the good work."

"Keep going as you are."

"The current format is good."

"I am quite happy with present format. A good mix of readable topics of general interest."

"It depends on the topics, but great work overall."

"You are doing a fine job."

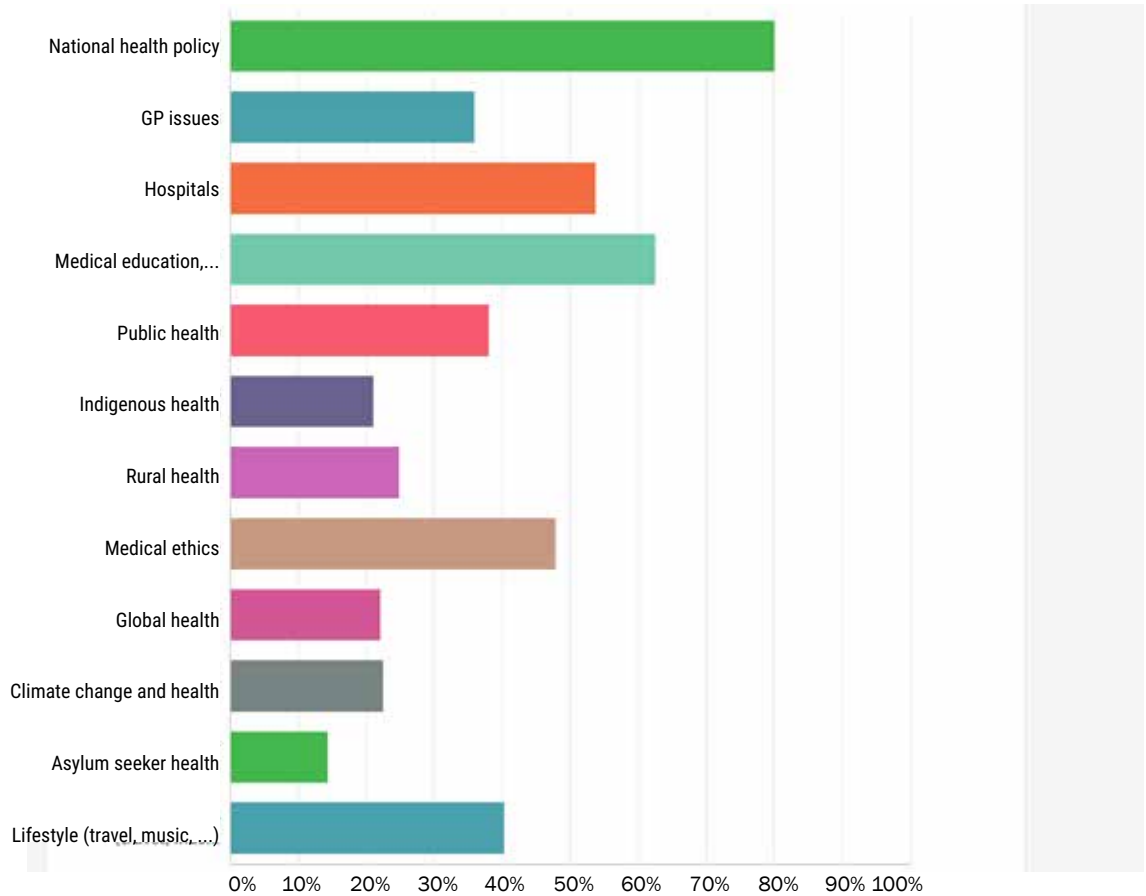
"It's already excellent."

"More ethics and morals about how to be a better doctor."

"More research based articles."

Survey results ... continued

If you read *Australian Medicine*, what topics are you most interested in?



ANSWER CHOICES	RESPONSES	
National health policy (Medicare, MBS Review, private health insurance, PBS, health funding, legislation)	80.20%	328
GP issues	35.94%	147
Hospitals	53.79%	220
Medical education, training, and workforce	62.59%	256
Public health	38.14%	156
Indigenous health	21.03%	86
Rural health	24.94%	102
Medical ethics	47.92%	196
Global health	22.25%	91
Climate change and health	22.49%	92
Asylum seeker health	14.43%	59
Lifestyle (travel, music, wine, books, films, motoring)	40.34%	165
Total Respondents: (5 skipped)		**409**

Bupa agrees to changes to Garrison Health contracts

As many members are aware, Bupa has been appointed by the Government to coordinate the provision of Garrison Health Services to Australian Defence Force (ADF) personnel on and from July 1, 2019.

In February, Bupa issued its proposed terms and conditions to doctors for the provision of off base medical services for ADF members. The AMA had significant concerns with these, particularly due to their potential impact on clinical decision making as well as the extra red tape involved.

Since then, the AMA has met with Bupa and the ADFs Joint Health Command (JHC), seeking significant changes to the proposed terms and conditions on behalf of members. During these negotiations, both Bupa and JHC agreed to work collaboratively with the AMA to address the concerns we had raised.

Bupa has now released a new set of terms and conditions for healthcare providers, responding positively to many of the comments provided to them by the AMA. This is available at:

https://www.bupa.com.au/-/media/Campaigns/Files/Health-Insurance/Project-Green/adf-hsc_provider-terms-conditions.pdf

While Bupa has not addressed all of the issues raised by the AMA, in a welcome move, it has accepted the majority of the amendments sought by the AMA. These include:

- a commitment to review fees annually
- an express statement that the standard care is measured by doctors' peers (rather than Bupa)
- an express statement about how the doctor's overriding obligation to the patient interacts with Bupa's preferred provider network, including in emergency situations
- removing provisions that related to services that were not being funded by the ADF
- aligning the standards for medical records to practitioners' professional obligations and removing a new clause which had sought to give Bupa ownership of records and reports
- better aligning the terms and conditions with practitioners' obligations under the Privacy Act
- reducing the administrative burden on doctors, including by clarifying the incidents and issues that need to be reported to Bupa

Bupa has also committed in writing to the AMA that, with respect to annual fee indexation, due consideration will be given to the CPI.

While any member considering signing Bupa's proposed terms and conditions should consider obtaining independent legal advice, it is clear that Bupa has made substantial changes to its terms and conditions that represent a significant improvement on its original documents.

For more information on the concerns that the AMA raised with Bupa and JHC, along with the details of how Bupa responded, please visit:

<https://ama.com.au/sites/default/files/documents/Detailed%20comments%20-%20New%20provider%20Agreement%20Terms%20and%20Conditions%20-%2011.04.2019.pdf>

AMA

New occupational cancer e-learning module

In some Australian workplaces, employees are exposed to a diverse range of possible carcinogens at higher concentrations and for longer periods of time than the general public. It has been estimated that 3.6 million Australians are exposed to at least one carcinogen at work and about 5000 cancers each year are caused by workplace exposures.

It is essential GPs have the knowledge and skills to be able to assist patients in monitoring their health, identifying potential risks and be able to provide or direct patients to further information if working in high-risk jobs with known carcinogens.

Cancer Council has developed an e-learning module to increase GPs' awareness of workplace carcinogens and cancers. The module includes sections on occupational carcinogens in the Australian context, the role of an exposure history, common occupational cancers including lung, skin, bladder and mesothelioma, and the Australian compensation system.

The 60-minute module is accredited with both RACGP and ACRRM. Visit www.elearning.cancer.org.au/courses for more information and to register for the module.

Health on the Hill

POLITICAL NEWS FROM THE NATION'S CAPITAL

AMA welcomes Health Budget as a good start to election

Treasurer Josh Frydenberg delivering his Budget Address to Parliament.

The Government has delivered a welcome boost to general practice, with an almost $1 billion investment detailed in the Federal Budget.

Treasurer Josh Frydenberg has delivered his first Budget, which is also the first Budget under the Prime Ministership of Scott Morrison, and has announced a $7.1 billion surplus.

But AMA President Dr Tony Bartone said it was obvious that Health Minister Greg Hunt had been listening to the AMA and has delivered a strong Health Budget, which has a particular emphasis on primary care.

Dr Bartone said the Government's Budget announcements have set up a genuine health policy competition for the upcoming election.

"Australia's hardworking GPs will be happy to see a commitment of almost $1 billion to general practice. This includes matching Labor's promise to bring forward by a year the lifting of the freeze on rebates for a range of Medicare GP items," Dr Bartone said.

"Overall, the Government has delivered a much-needed significant investment to general practice – the driving force of quality primary health care in Australia."

The GP package includes:

- $448.5 million to improve continuity of care for patients over 70 with chronic conditions;
- Quality Incentive Payments for general practices ($201.5 million);
- $62.2 million for rural generalist training; and
- $187.2 million for lifting of the freeze on GP items.

The AMA also welcomes:

- Funding for new Pharmaceutical Benefits Schedule (PBS) medicines;
- Retention of the Aged Care Access Incentive (ACAI); and
- A rural workforce program.

But Dr Bartone said there were obvious gaps in mental health, prevention, Indigenous health, pathology, and public hospital funding to improve all hospitals.

"We expect to hear more on these key areas from all parties before the election," he said.

"Health Minister Hunt has worked closely with the AMA, especially on the primary care element of this Budget.

"Overall, the Government has produced a good start for a quality health policy platform for the election.

"We look forward to the Opposition making health a real contest when they roll out all their policies."

Dr Bartone said there is still unfinished business with the Private Health Insurance reforms as they are implemented from this month, and with the ongoing work of the Medicare Benefits Schedule (MBS) Review, which must return any savings to new and improved MBS items.

In his speech to Parliament, Mr Frydenberg said the Budget built on the Government's plan to for a stronger economy.

Specifically on health, the Treasurer said it was front of mind for all Australians and this year the Government will spend more than $80 billion.

"An amount that has increased every year we have been in Government," Mr Frydenberg said.

"More MRI machines. More life-changing medicines on the PBS. More funding for mental health. Better access to dental services. Better access to hospitals. And better access to regional GPs.

"In this Budget, we are: funding upgrades to regional hospitals, the first being in Townsville; establishing Australia's first comprehensive children's cancer centre in Sydney; helping to build a new Brain and Spinal Ward in South Australia.

"In this Budget, we also list more medicines on the PBS to treat kidney, bladder, liver and skin cancer.

"And tonight, we announce the listing of Besponsa, a medicine for people with acute Leukaemia.

"Instead of costing $120,000 a course, patients will now have access to the medicine at a cost of only $6.50 per script for concession card holders and around $40 for general patients.

Health on the Hill

POLITICAL NEWS FROM THE NATION'S CAPITAL

"This brings the total number of new listings to more than 2,000 since we came to government, costing more than $10 billion.

"A real and profound dividend from a strong economy, and done without increasing taxes."

The Treasurer repeated the Government's assurance that Medicare is guaranteed and new services are being added to the Medicare Benefits Scheme

A Heart Kids Project for new research to treat and prevent heart disease affecting thousands of Australian children is being established.

The Government will invest $461 million in Australia's most significant youth mental health and suicide prevention strategy, with 30 new headspace centres.

Support for Indigenous youth including through mentoring and peer support is also being funded.

And the Budget includes an investment of $725 million into aged care that aims to deliver 10,000 new home care packages.

The AMA Pre-Budget Submission 2019-20 is available at:

https://ama.com.au/sites/default/files/budget-submission/AMA_Budget_Submission_2019_20.pdf

Labor tackles cancer costs head on – AMA welcomes commitment

The AMA has welcomed Labor's $2.3 billion commitment to slash costs for cancer patients and help them better cope with the burden of the disease.

In his Budget reply speech, Opposition Leader Bill Shorten made health a central policy feature and unveiled a cancer care package to fund scans, medical treatment, and specialists appointments. It also aims to help regional families have better access to care.

"For so many people, cancer makes you sick and then paying for the treatment makes you poor," Mr Shorten said.

"A lot of Australians would be surprised to learn that all those vital scans and tests and consultations with specialists aren't fully covered by Medicare."

Describing it as the "most important reform to Medicare since it was introduced by Bob Hawke," Mr Shorten promised the "biggest cancer care package in Australian history".

"To summarise what our first four years of Labor's Medicare

Opposition Leader Bill Shorten delivering his Budget-In-Reply address.

cancer plan means for Australians – up to six million free cancer scans, three million free appointments with specialists and an affordable medicine guarantee," he said.

"This is our vision for the future, our vision to build Medicare. We can pay for it and we can deliver it because of our reform decisions. We choose our healthcare system over bigger tax loopholes."

AMA President Dr Tony Bartone welcomed Labor's decision to make a significant investment to ease the cancer experience of Australian patients and their families.

"It is a sad reality that every Australian is touched by the scourge of cancer, directly or indirectly, through their own experience or that of a family member, neighbour, colleague, workmate, or loved one," Dr Bartone said.

"Easing the financial burden of many cancer patients and families will help them focus on the primary challenge of treatment and recovery."

The AMA will now consult with Shadow Health Minister Catherine King on the finer details of the policy and exactly how they affect patients and their doctors.

"There are key elements of this policy that accord with AMA policy," Dr Bartone said.

"The AMA has for many years lobbied successive governments that Medicare patient rebates do not reflect the true cost of providing high quality care, and this has certainly been the case with cancer consults, treatments, scans, and tests. The Labor plan fundamentally acknowledges this.

"We support the evidence-based listing of life-saving and life-improving medicines on the Pharmaceutical Benefits Scheme

Health on the Hill

POLITICAL NEWS FROM THE NATION'S CAPITAL

(PBS) for cancer patients and other conditions. Both the Government and Opposition support the PBS.

"And the AMA has called, as recently as in our Budget Submission 2019, for all MRI machines to be eligible for Medicare rebates, if they meet appropriate standards."

Dr Bartone said it was pleasing that Labor had committed significant investment to an important segment of the health system, and the AMA looks forward to more announcements regarding the broader health system throughout the election campaign.

"This is a great start, but we need to take a much more universal, whole-of-health view of the system that also looks at primary care, mental health, Indigenous health, aged care, prevention, and other neglected parts of the system," he said.

Following Mr Shorten's address, Finance Minister Mathias Cormann criticised the commitment and questioned whether Labor would deliver it if it did form government.

"We (the Coalition) have made significant investments in better treatment and better access to high-quality medicines for cancer patients across Australia," Senator Cormann said.

"What I would point out is that when Labor was last in government, not only did they deliver $240 billion in total deficits over a six-year period, they also stopped listing medicines, recommended medicines on the PBS because they ran out of money, literally.

"They delayed the listings of key medicines, including for cancer treatment, until fiscal conditions permitted. So, I mean our track record is one where we have listed $10 billion worth of new medicines on the PBS. About 2,000 new medicines. Many new medicines for cancer treatment. We are always doing as much as we can in relation to all of this very important and essential services that Australians rely on."

CHRIS JOHNSON

Budget invests in patients, says Minister

Health Minister Greg Hunt has described the Health Budget as a "comprehensive, patient-focused investment" with a record $104 billion in 2019-20 and a $435 billion spend over the next four years.

But the Opposition says the Budget is "too little, too late" with "reheated announcements" that do not make up for years of inaction.

Mr Hunt said the Budget guarantees Medicare, makes a range of life-saving medicines and services more accessible and affordable, reduces out-of-pocket costs, strengthens primary care and mental health and invests in breakthrough medical research.

"The Budget consolidates and continues our health reform agenda. It reinforces the four pillars of our long term national health plan – guaranteeing Medicare and improving access to medicines, supporting our hospitals, prioritising mental health and preventive health and investing in health and medical research," the Minister said.

"We are addressing community need through a range of investments under our $1.25 billion landmark Community Health and Hospitals Program (CHHP) to keep people healthy and out of hospital. We are acting on aged care reform. Improvements to accessibility, quality and safety continue apace with a further investment of $7 billion since the last Budget."

Shadow Health Minister Catherine King, however, said with this Budget, Prime Minister Scott Morrison had locked in cuts to hospitals that he had written into previous Budgets as Treasurer.

"This was Morrison's last chance to fully reverse his savage hospital cuts – and he failed," Ms King said.

"Budgets are about priorities. For six years, the Liberals have prioritised an $80 billion tax handout for the top end of town over Medicare, schools, hospitals...

"Patients will suffer because of these cuts as they are confronted with longer emergency department and elective surgery waiting times, or are forced to travel far from home for treatment."

But Mr Hunt said the Government had increased funding for public hospitals by $5 billion, up from $13.3 billion in 2012–13, to $21.7 billion in 2018–19, to $26.2 billion in 2022–23.

On other Health Budget initiatives, the Minister said the Government was committed to reducing out-of-pocket costs and supports all the recommendations of, and will implement the first stage of its response to, the report of the Ministerial Advisory Committee on Out-of-Pocket Costs.

And, he said, the Government was delivering a $1.1 billion 'Strengthening Primary Care' package, building on the $512 million package in the 2018–19 MYEFO, to support Australia's doctors and specialists to deliver improved access and outcomes for patients.

Health on the Hill

POLITICAL NEWS FROM THE NATION'S CAPITAL

Spotlight on aged care

Funding for aged care has increased by $7 billion over the forward estimates, up from $13.3 billion in 2012–13 to $20.5 billion in 2018–19 to $25.4 billion in 2022–23.

But the Opposition insists there are no new announcements for older Australians in this Budget.

Aged Care Minister Ken Wyatt said the Government has increased the number of home care packages from 60,308 in 2012–13 to 124,032 in 2018–19 and 157,154 in 2022–23 as part of an ongoing response to senior Australians' "clear preference" to receive aged care in their own homes and live independently for longer.

"With the rapid growth in home care, the Government is providing $5.6 million to strengthen compliance to tackle the risk of poor quality service and fraud," Mr Wyatt said.

"The Aged Care Quality and Safety Commission – Australia's new cop on the aged care beat – will have a key role, including increasing home care audits.

"The Commonwealth Home Support Program will be extended for a further two years to 30 June 2022, representing an investment of $5.9 billion. This will give certainty to around 1500 organisations, such as meals-on-wheels, supporting almost one million older Australians as they age and start to require assistance while still living in their own home.

"In residential aged care, the Government has invested $320 million in 2018–19 as a one-off increase to the general subsidy through to 30 June 2020. This will support the increase in residential places from 186,000 in 2012–13 to 212,000 in 2018–19 to 243,000 in 2022–23."

The Minister said the Government would also work to significantly improve monitoring and reporting of serious incidents involving residents, including incidents involving physical or chemical restraint.

Funding of $7.7 million will help to ensure the use of medication, in particular inappropriate use of psychotropics and antibiotics, in residential aged care is brought into line with best practice and community expectations. Clinical pharmacists will work directly with aged care providers to better inform them about appropriate use. Providers will be obliged to provide medication management data.

But Shadow Minister for Ageing Julie Collins described the Budget as "cruel hoax" on older Australians.

Ms Collins said seniors had been left behind with this Budget, they are now waiting years for care they have been approved for.

"There is nothing new in this Budget for older Australians – the Liberals are all out of ideas," she said.

"128,000 older Australians are now waiting for a home care package but the Budget does not deliver one new package the Government hasn't already announced."

Extracts of Budget Speech 2019-20

BY THE HONOURABLE JOSH FRYDENBERG MP TREASURER OF THE COMMONWEALTH OF AUSTRALIA

Guaranteeing essential services

Mr Speaker, a strong economy is not an end in itself. It's what you do with it that counts.

With a strong economy, we can guarantee the essential services that Australians need and deserve.

Health is front of mind for all Australians, and this year the Government will spend more than $80 billion on healthcare.

An amount that has increased every year we have been in Government.

More MRI machines.

More life-changing medicines on the PBS.

More funding for mental health.

Better access to dental services.

Better access to hospitals.

And better access to regional GPs.

In this Budget, we are:

Funding upgrades to regional hospitals, the first being in Townsville.

Establishing Australia's first comprehensive children's cancer centre in Sydney.

Helping to build a new Brain and Spinal Ward in South Australia.

In this Budget, we also list more medicines on the PBS to treat kidney, bladder, liver and skin cancer.

And tonight, we announce the listing of Besponsa, a medicine for people with acute Leukaemia.

Instead of costing $120,000 a course, patients will now have

Health on the Hill

POLITICAL NEWS FROM THE NATION'S CAPITAL

access to the medicine at a cost of only $6.50 per script for concession card holders and around $40 for general patients.

This brings the total number of new listings to more than 2,000 since we came to government, costing more than $10 billion.

A real and profound dividend from a strong economy, and done without increasing taxes.

Under the Coalition, Medicare is guaranteed.

Bulk-billing is at a record high.

And we are adding new services to the Medicare Benefits Schedule, including diagnostic imaging for breast cancer and heart health checks.

We're establishing a Heart Kids Project for new research to treat and prevent heart disease which affects thousands of Australian children.

Mr Speaker, mental health is an issue of deep concern to all Australians.

It is a national tragedy that we lose so many people to suicide and that so many people live a life of quiet desperation.

Tonight I say: we hear you and we are with you.

This issue demands our ongoing attention and resources.

We must work together to combat youth suicide as a national priority.

In this Budget, the Government will invest $461 million in Australia's most significant youth mental health and suicide prevention strategy.

30 new headspace centres.

Reduced waiting lists.

More support for Indigenous youth including through mentoring and peer support.

Treatment for early psychosis.

A perinatal mental health program.

And extra counselling services for communities who have suffered from natural disasters.

All of this is about looking after each other.

It reflects the best of Australia and its values.

Looking after older Australians

Mr Speaker, a stronger economy also allows us to invest more in looking after older Australians.

Australians deserve to age with dignity and have earned the right to expect the highest standards of aged care services.

In some cases, these services have badly let Australians down.

That is why we established the Royal Commission into aged care.

This Budget includes a significant investment of $725 million that will deliver:

10,000 new home care packages.

Bringing to 40,000 the number of new packages announced over the last 18 months.

Additional financial support for residential care.

A capital works program with a focus on regional Australia.

And a series of new measures to improve the quality and safety of aged care services.

We achieve this without new taxes and without raiding retirees' hard earned savings.

Mr Speaker, we also recognise the pressure energy bills place on those who can least afford it.

That's why we are providing additional cost of living relief for pensioners through a one-off Energy Assistance Payment of $75 for singles and $125 for couples.

This payment will be paid this financial year and comes on top of other actions the Government has taken to reduce power bills.

Mr Speaker, we know that Australia's carers are our nation's unsung heroes.

Their job is 24/7 and it's emotionally as well as physically demanding.

Many carers need and deserve a rest.

So tonight we are announcing $84 million to enable carers to leave a loved one in safe hands and get a much needed break.

Mr Speaker, supporting people with disability is a moral imperative, recognised by both sides of politics.

Growing to $22 billion, it takes a strong economy to fund the NDIS fully and sustainably.

This is what our Government has done.

Health on the Hill

POLITICAL NEWS FROM THE NATION'S CAPITAL

In this Budget, we have also set aside half a billion dollars for a Royal Commission into the mistreatment of people with disability.

Affordable housing is also a priority for this Government.

Just over a week ago, the National Housing Finance and Investment Corporation, established by this Government, successfully issued the largest social bond in Australia's history.

Over $300 million was raised, providing a significant injection into the community housing sector.

Extracts from Budget-In-Reply Address – 4 April 2019

BY THE HONORABLE BILL SHORTEN MP, LEADER OF THE OPPOSITION

If we win the next election, we will put back every single dollar the Liberals have cut from public schools and public hospitals.

Now Mr Speaker, to be fair, there was one new feature in this Budget, albeit troubling.

The short-changing of the National Disability Insurance Scheme by $1.6 billion, to prop up a flimsy budget surplus forecast. Now it looks a lot more like dodgy accounting than good economic management.

I freely acknowledge government members sincerely care about people with disability. But the truth is, the record of the last six years, the Government has made a record of poor decisions regarding the NDIS.

Sacking the board. Delaying the signing of funding agreements with the States. Capping staff numbers for the National Disability Insurance Agency – leading to an outbreak of contractors and consultants undermining the system.

And then – after all these policies that hamstring delivery of services – the Government shrugs, and say the $1.6 billion wasn't needed, because of a lack of demand.

Mr Speaker, there are thousands of Australians who have embraced the promise of the NDIS but whose legitimate demands have simply not been met.

The young man in Ballarat who has waited more than two years for a wheelchair, waited so long that he ended up in hospital with pressure sores. The family whose daughter has an intellectual disability, who have waited ten months for funding for the speech therapy she needed to learn to make friends at school. Or the family of a profoundly deaf young man who was denied interpreters and training in Auslan and has spent the last two and a half years appealing the decision.

All these people… the carers seeking modest respite…the parents, the loved ones, filling out the forms, calling time and time again for promises not fulfilled, waiting on the phones.

They do not tell me there is a lack of demand, they're talking about a desperate need. Mr Speaker, working with the Member for Jagajaga, with people with disability, their carers and an army of advocates to help create the National Disability Insurance Scheme is one of the most rewarding things I've ever been part of.

And tonight I can give every Australian living with disability and the people who love them this personal commitment: that if we are elected as the next government, we will lift the NDIA cap on staff numbers, so we can get the support out the door, keep the promises made to people with disabilities.

And we will put people with disability back at the centre of decision-making in the National Disability Insurance Scheme.

We will get the NDIS back on track.

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Tonight, I want to conclude by talking to you directly in your lounge rooms, about our vision for the most significant investment in Medicare in a generation.

Cancer is one of the biggest killers in our national. Not for nothing is it called the Emperor of all Maladies. One in two of us will be diagnosed with cancer at some stage in our life. 145,000 of our fellow Australians are diagnosed with cancer each year. And 50,000 die.

One way or another, we will all witness the ordeal. I saw it with my Mum and her battle with breast cancer. Chloe and I have seen it with dear friends of ours – some old, some far too young.

Cancer is frightening, it's isolating, it's exhausting. And – all too often though – it is impoverishing. For so many people, cancer makes you sick and then paying for the treatment makes you poor.

And I think a lot of Australians would be surprised to learn that all those vital scans and tests and consultations with specialists are not fully covered by Medicare.

Instead, they cost hundreds of dollars, adding up to thousands, out of your own pocket.

Australia has the highest rates of skin cancer in the world – and most people pay over $5000 for the first two years of their treatment.

One in four women diagnosed with breast cancer pay over

Health on the Hill

POLITICAL NEWS FROM THE NATION'S CAPITAL

$10,000 for two years of scans and tests. Some men with prostate cancer are paying more than $18,000.

And if you're in Stage 4 cancer, you have to quit work, so your finances are already under horrendous strain. If you live in the regions, there are the added costs of travel and accommodation.

Every year 300,000 Australians who need radiology just don't get it – because they can't afford it. That's three hundred thousand of us.

We are a smart country, we've got the best health care staff, we are a rich country, we are a generous country – and we are better than the statistics I read out.

If someone you love has cancer, you'd sell the roof over your head if it would help, you'd sell the shirt off your back - but should you have to?

Our fellow Australians pay your taxes to Canberra. You pay your Medicare levy.

And if I am elected Prime Minister, I'm going to make sure the health care system is there for you when you need it most.

So tonight, I am announcing the most important investment in Medicare since Bob Hawke created it.

Labor's $2.3 billion Medicare Cancer Plan. To my fellow Australians, I will explain what that will be used for.

First, if we win the election, we will invest $600 million towards eliminating all of the out-of-pocket costs for diagnostic imaging.

Over four years, this will mean six million free cancer scans, funded by Medicare.

- CT scans
- PET scans
- Mammograms
- X Rays
- Ultrasounds

Reducing the out-of-pocket costs for cancer patients from hundreds of dollars, to zero. And this will apply to MRIs too.

Today, only half the MRI machines, that amazing technology - half the machines in Australia are covered by Medicare. People in the bush and the regions often have to drive hours, or pay thousands.

If we win the election, not only will we provide new MRI machines to communities where they are needed most. We are going to change the game.

We will guarantee that every single MRI machine which meets national standards, every single machine is covered by Medicare for cancer scans - full stop.

The second part of our plan is to deal with the cost of seeing a specialist. As anyone knows, treating cancer relies on a marvellous team of experts.

Medical oncologists in charge of your diagnosis and ongoing chemotherapy and immunotherapy.

Surgeons performing your operations and monitoring your recovery.

Radiation oncologists designing targeted radiation therapy plans to destroy cancer cells.

These appointments are part of your weekly routine, often for years. There is the trips, the waiting, the treatment, the recovery. Thousands of dollars.

A new Labor Government will invest $433 million to immediately cover specialist consultations for cancer patients.

What this means over the next four years, is it means that an additional 3 million appointments will be bulk-billed – with no out-of-pocket costs.

Reducing what you pay from hundreds of dollars – to zero.

And thirdly: our Affordable Medicine Guarantee.

Every drug recommended by the independent experts, will be listed on the Pharmaceutical Benefits Scheme. Not just cutting the cost of your treatment – cutting the cost of your cancer medication too.

Cancer is a curse. I wish I could stand here tonight and guarantee you that we will find a cure. But no politician can give that promise.

We will continue to support our scientists in their work, we will invest in the research and the clinical trials. And until the day that we find a cure, I promise the men and women of Australia this:

Under Labor - if you are battling cancer, you can focus on getting well, without worrying about going broke.

I can promise that if you are in the fight of your life - a Labor Government will be alongside you every step of the way.

Mr Speaker, To summarise what our first four years of Labor's Medicare Cancer Plan means for Australians:

- Up to 6 million free cancer scans
- 3 million free appointments with specialists

And an affordable medicine guarantee

This is our vision for the future. This is our vision to build Medicare. And we can pay for it – and deliver it – because of our reform decisions.

We choose our health care system over bigger tax loopholes.

Make your voice heard

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

With the federal election just weeks away, it is important that our politicians are left with no uncertainty as to the importance of investing in general practice and in supporting GPs to deliver the right care at the right time.

Who is going to tell them this you might say? The AMA will continue to do so of course, but who they really need to hear it from is you. Afterall, you vote, and you know better than anyone what needs to change so you can provide timely preventive care, manage the array of health problems patients present with, provide cost-effective care and deliver better outcomes for patients.

> "If ever there is a good time to make your voice heard it is in the lead up to an election. Now is the time to step forward and lay it on the line for them."

You have the lived experienced of how Government health policies help or hinder you in providing quality patient care. You know you are managing more problems in each consultation than you did a decade ago. You know the population is ageing and the incidence of chronic disease is rising. You know the impact to the patient journey if care is fragmented and poorly coordinated. You know the impact of repetitive cuts to GP funding and the freezing of Medicare rebates, the increased pressure it puts you under in delivering quality care, what it means for patients' out of pocket expenses and how that impacts the ability for some patients to access the care they need.

You have the power to influence the health policies of the major parties as the Federal Election approaches. If ever there is a good time to make your voice heard it is in the lead up to an election. Now is the time to step forward and lay it on the line for them.

We need our grass-roots GPs to talk to their local MPs, Senators and standing candidates, to write letters to their local paper, journals and newsletters, and to respond to the call from local media in the lead-up to the election. How much of this you want to do is up to you, but I encourage you to do at least one of these. Take the opportunity to fight for better resourcing of general practice both now and for the long term.

The AMA knows this can be a challenging prospect which is why we have developed a GP Federal Election Campaign Kit. The kit will support you with:

- talking points for lobbying;
- candidate (and patient) handouts;
- template letters for the editors of local papers; and
- up to the minute media releases to support lobbying activities.

It will also contain a copy of *Key Health Issues for the 2019 Federal Election*, which outlines measures to improve the way general practice is funded, with a focus on improved access to care, reward for quality care and quality improvement, system level outcome measures, and the long-term viability of general practice.

In terms of immediate measures for general practice, the AMA is focusing on seven priority areas that include: preventing unplanned hospitalisations, investment in quality care and quality improvement, funding to support longer consultations with patients; improved access to after-hours GP services, MBS rebates for GP telehealth consultations, wound care, and enhanced access to GP-led team-based care via the Workforce Incentive Program.

The AMA is also calling on the major parties to commit to working with the profession to design and implement a more robust long-term funding model for general practice, which builds on existing fee-for-service arrangements and enables patients to access improved care in the community.

All GP members can expect an email about the GP Federal Election Campaign Kit soon after the election is announced.

You are at the coalface of general practice and together we can make a difference to urge Governments to commit to the investment in general practice we know it deserves.

Still grinning and bearing the cost of dental care

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

Stop for a moment and meditate on teeth.

Think of the painful advent of baby teeth, making way in a few years for adult teeth and even wisdom teeth followed by carious teeth and (one hopes not) prosthetic and false teeth. It is a strange progression and our relationship with our teeth is, well, somewhat weird.

But does this odd developmental pathway explain why we do we not consider teeth to be a part of our bodies as much as hands and feet? We have Medicare and private insurance to pay for therapy for illness and injury of just about everything but our teeth.

A recent report *Filling the gap: A universal dental scheme for Australia* from the Grattan Institute, a policy think tank, argues for a ten-year plan to bring dental care into the publicly funded tent. It was authored by Stephen Duckett, a health economist and former senior health bureaucrat, Matt Cowgill, a senior associate, and Hal Swerissen, an expert in health policy research and analysis. They were assisted by a dozen experts in the field of oral health.

The problem that *Filling the Gap* addresses is expressed as follows:

> When Australians need to see a GP, Medicare picks up all or most of the bill. When they need to see a dentist, Australians are on their own. There's no compelling medical, economic, or legal reason to treat the mouth so differently from the rest of the body. Australia should move towards a universal primary dental care scheme, funded by the Commonwealth Government.
>
> Most spending on dental care comes straight out of patients' pockets. As a result, people who can't afford to pay don't get dental care, unless they go on long (often multi-year) waiting lists for public care. About two million people who needed dental care in the past year either didn't get it, or delayed getting it, because of the cost. Low-income people are most likely to miss out on care – about a quarter of Australian adults say they avoid some foods because of the condition of their teeth; for low-income people, it's about a third.

When the Federal Government committed to assisting financially with health care in the immediate post-World War II years, the focus was on life-saving drugs and services. Over decades the subsidy for pharmaceuticals was extended well beyond the original narrow limits so that now it costs over $12 billion a year and rising at about 10 per cent per annum, and the contribution to medical services is vast. So, dental services may well have been put to one side and left there. Also the dental profession showed no enthusiasm for Medicare.

A further factor in the dental services saga is the effect of fluoride. Australia has experienced serious positive changes in the incidence of dental caries so much that Australian "children at age 12 have one of the best oral health records in the world with 65 per cent children completely free of any dental disease," according to Heiko Spallek, Head of School and Dean, at the Sydney Dental School. "The deterioration of oral health happens in young and adolescent age groups." Thus there has been a shift in the demography of oral health problems away from the very young, yet programs for dental care for this age group are still regularly proposed.

Another consequence of fluoride and changing community expectations is the opportunity it creates for increasing popularity of orthodontic dentistry for more cosmetically pleasing dental appearance. The near-perfect, dazzling white smile of flight attendants is an example of what can be achieved and legitimate questions arise as to who should pay for these dental adjustments and treatments.

Given the historical complexities surrounding dental care, the report argues that:

> The first step is for the Commonwealth to take over funding of existing public dental schemes, fund them properly to the tune of an extra $1.1 billion per year, and enable private-sector providers to deliver publicly-funded care. Coverage should then be expanded – first to people on Centrelink payments, then all children. After that, the Commonwealth should take the final step to a universal scheme, ideally within a decade.

Such an approach would allow for workforce development, new approaches to the education and training of a new oral health profession and its time for adjustment. It may seem a slow process, but we have not got to where we are in a hurry. It will take time to unravel and move forward. All this assumes there is political and professional will to change.

Time for action on rural health

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

Here we go again.

That's what we hear when another election rolls around. Politics has been ugly in recent times, so people tune out. But we have a duty to our communities, to our patients, and to our fellow rural docs – we have to get the politicians to listen and act on rural health.

Some of our rural and remote communities have received a lot of attention and support in recent times through the tragedies of the drought and the floods in Queensland. We have appreciated the support and the concern, but we don't just need emergency relief, we need continued and meaningful support year-round.

We saw a glimpse of this with the Stronger Rural Health Strategy announced at the 2018 Budget. It showed that the Government was listening to the AMA on rural health. Support for teaching and training doctors rurally was desperately needed. This will help solve the issue of the critical lack of doctors outside of the cities.

We know that if a medical student spends two to three years training in regional hospitals and general practice, they are four times more likely to choose a rural career.

We know that students who spend one-year training rurally are almost twice as likely to work in the same region. We also know that training doctors from rural and remote areas increases the chances of them returning to practice medicine rurally.

But we want to see more of this. We need our politicians to support more opportunities for students and junior doctors to gain rural experience. We need to increase the targeted intake of medical students from a rural background from 25 per cent of all new enrolments to one-third of all new enrolments. We need the proportion of medical students required to undertake at least one year of clinical training in a rural area to be lifted from 25 per cent to one-third.

We also need more support must be provided to supervisors. This is a critical issue that is continually ignored. The More Doctors for Rural Australia Program (MDRAP) is a perfect example of where this has happened. The MDRAP supports non-vocationally registered doctors to join a pathway to Fellowship in a rural area. What is does not support is the GPs who will have to supervise them. Our rural GPs are already working well beyond their limits and now we are asking them to provide months of direct supervision with no financial support?

We also need support to serve our communities. Everyday we are challenged by infrastructure limitations with internet and phone service, equipment, and physical space. We already have an answer to this: infrastructure grants. Previous infrastructure grant funding delivered real results for rural communities, supporting practices to improve patient access and to teach. The Australian National Audit Office showed that infrastructure funding grants are effective and a good value-for-money investment. It's time to remind the politicians.

Tell your local candidates: we want a further 425 rural GP infrastructure grants of up to $500,000 each.

This will support rural general practices to improve their infrastructure, expand their services and provide patients with access to nursing and allied health.

We don't just need more GPs, we need more specialists too. We want the major parties to expand the successful Specialist Training Program to 1,400 places by 2020. Give a higher priority to training places in regional and rural areas, generalist training, and specialties that are undersupplied.

There is so much that we need better policy on: climate change, indigenous health, and the closure of rural maternity services to name just a few. The AMA has asked you what your key issues are in the Rural Health Issues Survey. We have listened and we will make sure that your voice is heard, but that doesn't mean you can't get involved.

Rural doctors – you are respected in your communities and you have influence. Speak to the candidates about the pressure you are under, explain to them what is needed at the Federal level and at the local level. Talk to your colleagues and your friends, write to the local newspaper so that your letter makes one of the bi-weekly editions. The greatest strength of the AMA is its members. Let's all stand together at this election and make sure that our voice is heard.

Lessons outside the classroom – medical students join school climate rally

BY JESSICA YANG, PRESIDENT, AUSTRALIAN MEDICAL STUDENTS' ASSOCIATION

On March 15, thousands of Australian school students marched through city streets around the country to demand the Government take more action on climate change. Medical students joined this cohort of young Australians to raise awareness of the impact of climate change on human health.

Australian medical students recognise climate change to be the most significant global health challenge of our generation. As global citizens we worry how this will impact us, and as future doctors we are concerned how the changing climate will affect our patients. The impacts are already happening: emergency room admissions are spiking during more frequent adverse weather events, droughts have affected crop yields and heat-waves have become hotter and longer. These effects disproportionately affect developing and remote locations where hospitals have not sufficiently adapted to manage the crisis. In fact, Australia is particularly susceptible to these impacts: an ageing population who are vulnerable to extreme heat, a firm reliance of agriculture is under threat by water scarcity, and we have a high population density in flood zones.

Our current health systems are not equipped to manage the increase in vector-borne diseases, exacerbations in mental health and consequences of precarious food security. Climate change training for medical professionals, including its subsequent impact on health is essential to ready us to adequately respond to climate-related events and address the present and future burden on the healthcare sector.

The Australian Medical Students' Association (AMSA) is committed to being part of the solution to our planet's health emergency. At a grass-roots level, our Code Green team runs environmental advocacy and education initiatives across all Australian medical schools.

AMSA members attend United Nations climate talks in order to highlight how the importance of mitigating and adapting to climate change is critical to avoid a burgeoning health crisis. AMSA has also developed a sustainability policy for our organisation and the events we run to ensure we are recognising and addressing our own environmental impact as well as engaging all medical students in decisive action against climate change.

From keeping cups, to reusable water bottles, to national policy, medical students are playing their part to preserve the Earth. We are looking towards national leaders and the broader medical community to help solve this problem that affects us all. Last August, alongside many other health organisations, AMSA committed to the fossil fuel divestment. Divestment from fossil fuels is a compelling public message and for medical professionals; it is a broadening of our oath to 'do no harm'. Public policy on climate change by medical professionals should echo those public health initiatives already seen in doctors' separation from other harmful industries, such as tobacco. Now is the time for medical professionals to champion the health benefits of timely climate change mitigation.

In the upcoming federal election, climate change will be front and centre; doctors and medical students hold a unique voice to advocate for patients, public and global health in the face of increasing climate adversity.

AMSA Code Green Coordinator, Keerthi Muvva, attended the climate rally in Sydney where she was inspired by, and able to inspire, other young advocates like her.

"The School 4 Climate Rally was a truly incredible demonstration of youth passion and determination to put climate action on everybody's agenda," Keerthi said.

It is time to put pressure on our nation's leaders. Even if they only see in three-year terms, the impact of climate change is already evident. The upcoming federal election presents an opportunity for our voices to be heard; we need to divest, and invest in climate solutions that incorporate more sustainable living practices into Australian life.

AMSA Code Green is an excellent example of practical action all health professionals can take.

Ms Muvva urged us: "Don't let these strikes be the end of a conversation - make it the beginning."

I would like to thank Code Green Coordinators Keerthi Muvva, Oliver Le Grice and Global Health Vice Chair, Georgia Behrens, for their contributions to advocacy around climate change and health.

The blind men and the elephant

BY DR BERNADETTE WILKS, CO-CHAIR, AMA COUNCIL OF DOCTORS IN TRAINING

The day starts like any other day. You wake up, get ready and head off to work at the Intensive Care Unit at Mount Saint Elsewhere Hospital. You head to morning handover, well rested and ready for the day. The same cannot be said for your other registrar.

Within the space of two days I had the pleasure of attending two events: the National Forum (the 'Forum') on Doctors' Wellness held in Melbourne and run by the Australasian Doctors Health Network, and the AMA's Gender Equity Summit (the 'Summit') held in Sydney, which was the brainchild of Council of Doctors in Training (CDT) Chair Dr Tessa Kennedy.

Both the Forum and the Summit were attended by representatives from various Colleges, key industry players, Directors and CEOs of numerous hospitals; and Presidents of Associations.

During the Forum the parable of the blind men and the elephant was raised as a way of conceptualising why doctors' mental health has taken so long to identify, let alone tackle. Subsequently, during the Summit, I recognised how the parable is equally relevant for the issue of gender equity.

The parable of the blind men and the elephant dates back to 1200BC and has been re-told over the centuries. The crux of the parable is that a group of blind men come to know an elephant by each man touching different parts of the elephant; the tusk, the ears, the hooves. Through this process each man comes to a true conclusion about an aspect of the elephant but a false conclusion of the whole. In some versions of the parable, this leads to violence between the blind men. Attending these conferences enabled me to appreciate the entire elephant that is doctor wellness and gender equity, and not just the parts I knew from my narrow experiences.

I will briefly reflect on the common issues behind, and solutions for, achieving doctor wellness and gender equity that I synthesised from my attendance at the Forum and the Summit.

The Business Case

The business case for improving gender equity and doctors' mental health is well documented. The quadruple aims of improving the experience of the healthcare provider as they achieve the triple aims of optimal patient experience, improved societal health and reduced healthcare costs is a technical version of putting the oxygen mask on one's face first.

For example, in companies with gender equity there is improved productivity, less workplace injuries and reduced operating costs. Even workplaces that accommodate pregnant workers experience minimum costs and increased productivity, retention, recruitment and safety. And likewise, the momentous cost of losing a doctor, even temporarily, from the workplace was estimated by the Lancet in 2009 to be between $211,000 and $420,000. Even the Australian Government thought it important enough to publish Presenting the Business Case for Investment in Health and Wellbeing.

Leadership

Fostering effective leadership helps to redirect and utilise energy otherwise put towards fighting a system. Furthermore, leadership that comes from the top of an organisation is three times as effective. Committed and visible leadership is on par with flexible work models as the most effective means to achieve workplace place equity. And the key barrier to engaging with change is not knowing how to engage, thus leadership is key. But leadership is not only about driving change, it has also been shown to improve employee health and as such should be simultaneously seen as an occupational health factor. Not enough women apply for senior leadership positions and not enough Boards place tangible targets on physician wellness. A tap on the shoulder to encourage a woman to apply can be all that is needed to increase applications. Having a CEO who walks the walk of wellness through wellness KPIs can be all that is needed to reduce burnout.

Flexible Participation

Flexible participation structures and intelligent rostering are crucial scaffolds for equitable workplace engagement and improved clinician mental health. Interestingly, global companies like Yahoo! and Amazon began scaling back flexible work arrangements in 2012-13, driven by the myth that innovation and successful collaboration were best achieved through face time.

Flexible participation includes the use of web-conferences, consideration of time and location of meetings and events, access to breast feeding rooms and plentiful job-sharing. And despite the myth, work flexibility is desired equally by employees without and with children. Furthermore, men and women equally utilise flexible work options throughout their careers.

Intelligent rostering is mindful of an individual's life-events, wellness, training needs, career aspirations, and need for compassionate leave. Such rostering is most successful

A refresher on the who, what and where of recent Government initiatives

BY DR BEVERLEY ROWBOTHAM AO, CHAIR, AMA FEDERAL COUNCIL

There is nothing like an impending federal election to capture the attention of your AMA Federal Council, which met recently in Canberra.

Elections are always an opportune time in the political cycle to mount a final push for commitments on key health policies, building on the groundwork that is laid over the several months preceding through many meetings with politicians, bureaucrats, and our constant efforts in raising the media profile of issues that matter to members and our patients.

It is no coincidence that, in the days leading up to Federal Council, the AMA President met with the Prime Minister to prosecute the case for improved health funding. This followed a number of productive meetings with the Leader of the Opposition.

Your AMA had already signalled its policy intent when it released its 2019/20 Federal Budget submission in January this year and, at the time of writing, was ready to hit the campaign trail running as soon the election was called. Federal Council settled on a very strong election policy platform that covers a broad range of areas including public hospitals, general practice, rural health, mental health, private health insurance, Medicare, aged care, public health and medical workforce.

Our election policy platform has had strong grassroots input, having been developed over time through the AMA's various Councils and Committees before being presented to Federal Council for finalisation. It is a document that will provide all major parties with a real vision for our health care system.

Although much of our March meeting was devoted to discussing the 2019 election policy and strategy, there was a great deal of other work to review from our Councils and Committees with the approval of seven Position Statements and five policy resolutions.

From supporting pill testing trials and calling for the age of criminal responsibility to be raised, to encouraging generalism and better workforce planning – the broad range of policy outcomes reflected the many different areas of work the AMA undertakes every day as well as the tremendous diversity of our membership. While some members tell me we tackle too many issues, it is this breadth of work the builds our credibility with the community and our level of influence on the Hill.

I am also pleased to say that Federal Council has decided to tackle the issue of gender equity within the AMA. While some of our Councils and Committees have strong female representation, we still have a significant way to go. In supporting the introduction of gender targets for AMA Councils and Committees, Federal Council sent a strong signal that the AMA is very serious about this important issue.

The AMA's Equity, Inclusion and Diversity Committee now has the task of finalising recommendations to Federal Council about what the target(s) should be and how we can achieve them. No doubt these recommendations will take into account the outcomes of the AMA Gender Equity Summit that was held on March 23.

By the time you read this article, the Federal Budget will have been delivered and an election will have been called. Your Federal Council has developed the policies to help keep health front and centre in the election contest and make a long-term difference to the health of the community.

Doctors in training ... continued

when done within a single department and not en masse by a medical workforce unit, as the number of doctors becomes too many to individually tailor rostering to be dynamic and responsive. In fact, one NICU found not only were trainees more supported through intelligent rostering but were more successful at achieving training targets.

We have progressed past ignoring the elephant in the room; and are now transitioning beyond seeing the parts towards a more complete (from incorrect) interpretation of the whole and thereby removing it from the room completely.

Bargaining with our future – climate change and the public hospital medical workplace

BY DR ROD McRAE, CHAIR, AMA COUNCIL OF PUBLIC HOSPITAL DOCTORS

The AMA is a strong advocate for the prevention of further climate harm that is a result of human activity. Through its Position Statements and 2018-2019 Pre-Budget Submission, the AMA acknowledges that human health is ultimately dependant on the health of our planet and its ecosystem, that the health system must be model of sustainability and acknowledges that steps to mitigate and reduce greenhouse gas emissions are clearly necessary. In its submission to the 2017 Senate Inquiry into current and future impacts of climate change, the AMA called for the urgent development of a national strategy for climate change and human health to safeguard the provision of healthcare services in the context of an increasingly volatile climate.

While possibly a surprise to many, CPHD is of the view that climate change related employment conditions implemented through enterprise bargaining have a part to play. The process to agree on such conditions would invariably ensure doctors and their employers, mainly public hospitals, find new ways to work together to promote climate change mitigation. To this end, the AMA's National Bargaining Framework (for the use of both the AMA and the Australian Salaried Medical Officers Federation across jurisdictions) includes a climate change mitigation model clause.

Some academic research into the beneficial nature of climate focused workplace entitlements exists, but nationally, across all sectors, binding conditions through registered agreements have been slow to emerge. CPHD considers there is opportunity through enterprise bargaining for salaried doctors to show leadership and introduce accountabilities and rights to assist public hospitals' management and staff to do their part in confronting this global challenge.

The three features of the AMA model clause are that employers (hospitals) agree, via enforceable clause enterprise agreement conditions, to do the following:

1. harness their status as a community lead to be a champion for the environment. In a practical sense, a hospital could be required to publicise that climate change is real and has implications for community health. Particularly, there would be a requirement to highlight that climate change will increase:
    - heat-related deaths and hospital admissions, particularly among the elderly;
    - concentration of water-borne pathogens though the effect of floods;
    - mental illness because of the commercial and social effect of extreme weather events; and
    - Legionella contaminated cooling towers, vector-borne diseases and respiratory illnesses.
2. establish and resource an environmental committee genuinely capable of organisational influence, open to all employees, and charged with mitigating climate change through recommending organisationally sustainable choices.
3. promote energy and cost savings and reduce waste through continuous improvement strategies including reviewing green initiatives and identifying needs gaps. This is envisaged to include hospital review of workplace behaviours, objectives and policies that may impact on climate change then take practical steps to mitigate negative effects.
    - Review terms of reference would be codified in the agreement and include assessment of: procurement decisions, recycling, waste reduction, energy use, other environment related efficiencies, modifying or utilising capital in an environmentally friendly manner and other practices.
    - Practical steps a hospital could be required to take may include new staff training/skills development (particularly useful for environment committee participation noted above), purchasing carbon credits to offset hospital carbon emissions, installing renewable energy and/or hospital car fleets being hybrid or electric.

This 'industrial' response discussed in my column is obviously a very tiny part of a broad suite of global actions but there is legitimacy in the mantra think global act local! We should question an often-loud assertion that because Australia is such a small carbon emitter in global percentage terms we have no influence to affect change, so should not bother doing anything. Not only is showing leadership important but when all the 'one-percenter' emitters act positively together, '90 percent' of the problem can be turned around.

Sir David Attenborough said (at the January 2019 World Economic Forum) that the connection between the natural world and urban societies had been "remote and widening" since the industrial revolution. He said humans did not realise the effect their actions have on global ecosystem and that it was "difficult to overstate" the urgency of the environmental crisis we all face. The enterprise bargaining process can have its part to play in responding and shifting a mind-set.

Practising complementary or emerging medicine

BY ASSOCIATE PROFESSOR ANDREW C MILLER, CHAIR, AMA MEDICAL PRACTICE COMMITTEE

The AMA receives both praise and criticism for its policies and positions on the practice of complementary medicine.

When the AMA published its updated *Position Statement on Complementary Medicine* last year, it elicited support from members for its clear support of evidence-based medicine. But it also drew comments from some members who were offended that the term 'complementary' medicine was used to include what they believe is legitimate and medically-indicated treatment. It also drew strong criticism from other members who argued the AMA should oppose any doctors practising complementary medicine.

The complex issue of doctors' involvement in complementary medicine is also concerning the Medical Board of Australia. The Board is seeking public comments on a proposal to strengthen guidelines for medical practitioners who provide complementary medicine and/or unconventional medicine and/or emerging treatments.

In its consultation paper, the Board details a wide range of activities currently being undertaken by medical practitioners such as: providing 'alternative' treatments for cancer in place of conventional therapies; diagnosing and treating Lyme disease in patients who have never left Australia; offering autologous stem cell therapy or providing infusions of platelet rich plasma for conditions where there is little evidence of benefit; and performing 'anti-ageing' cosmetic regenerative procedures.

Under the Health Practitioner Regulation National Law, the definition of professional misconduct includes:

- providing a person with health services of a kind that are excessive, unnecessary or otherwise not reasonably required for the person's well-being;
- referring a person to, or recommending that a person use or consult, another health service provider, health service or health product if the health practitioner has a pecuniary interest in giving that referral or recommendation, unless the practitioner discloses the nature of that interest to the person before or at the time of giving the referral or recommendation.

As all registered medical practitioners must comply with the National Law, there is a clear mechanism for the Medical Board to investigate and take appropriate action against medical practitioners who do not comply.

However, the Board considers that additional guidelines will benefit both medical practitioners and consumers. Medical practitioners will have clear, nationally consistent guidance about the Board's expectations in relation to complementary and unconventional medicine and emerging treatments. Consumers will have improved safeguards and access to better information while still having choice.

The proposed guidelines would also provide additional support to the Board in investigating reported misconduct because under the National Law an approved registration standard, code or guideline is admissible in proceedings against a practitioner as evidence of what constitutes appropriate professional conduct or practice.

The proposed guidelines cover: discussions with patients; knowledge and skills required by medical practitioners; managing conflicts of interest; informed consent; appropriate diagnostic methods and techniques; appropriate treatment; patient management; advertising requirements; and research requirements.

The Medical Practice Committee is currently examining the content of the Board's draft guidelines in detail and will provide advice on the AMA's response. However, overall the draft guidelines are consistent with existing AMA policy. Members views are very welcome and can be forwarded to president@ama.com.au.

Relevant AMA policy can be found in the following position statements and guidelines: Complementary Medicine; Medicines; Advertising and Public Endorsement, Managing Conflicts of Interest; and Doctors' Relationships with Industry.

The AMA will lodge a submission to the Board, but if you would like to make an individual submission you can find the full public consultation paper and information on how to make a submission at: https://www.medicalboard.gov.au/news/current-consultations.aspx

Position on conscientious objection updated

BY DR CHRIS MOY, CHAIR, AMA ETHICS AND MEDICO-LEGAL COMMITTEE

The AMA has now approved an updated *Position Statement on Conscientious Objection 2019* (which replaces the position statement from 2013). In an ethics column I wrote on this issue last August, I informed members that the AMA's Ethics and Medico-Legal Committee (EMLC) was specifically going to examine whether the AMA should have an explicit policy on 'effective referral'.

An effective referral is where a doctor with a conscientious objection to participating in a certain treatment or procedure (e.g. abortion, voluntary assisted dying) has an obligation to refer the patient to another doctor who the practitioner reasonably believes does not have a conscientious objection to providing that treatment or procedure. This does not necessarily mean that the other doctor supports the treatment or procedure, but that they have a balanced view and can provide the patient with relevant health care.

However, some doctors consider that an effective referral implies that they must refer the patient to a doctor who would specifically 'do what they would not do' – and therefore feel that such a requirement, by extension, effectively compels them to participate in a treatment or procedure to which they conscientiously object.

Among doctors (as well as the wider community), there are wide, and often strong, differences of opinion on whether doctors have a duty to effectively refer a patient in cases of conscientious objection. These were clearly expressed by members when State and Territory AMA offices were consulted to engage their views on whether the AMA should have an explicit policy on effective referral.

Members had divergent views sometimes dependent on the type and urgency of the treatment being considered, and the general expectations of the medical and wider community in these circumstances. For example, the view that doctors should effectively refer if they conscientiously object to termination of pregnancy was much stronger than that for voluntary assisted dying.

The majority view of AMA State and Territory offices was to retain the current position of not having an explicit policy on effective referral but to continue to emphasise that patient's access to care should not be impeded.

As such, Federal Council agreed not to move to include an explicit position on effective referral in this Position Statement on conscientious objection because of its overarching nature. They supported the view of several State and Territory AMAs, however, that an explicit position on effective referral may be considered when revising individual, context-specific position statements such as those on reproductive medicine (which includes termination of pregnancy, contraception, surrogacy, IVF, pre-implantation genetic diagnosis) and euthanasia and physician assisted suicide.

On a matter where there are sometimes intense sensitivities with regard to the rights of individual doctors weighed against the potential for patient care to be affected, the tone and emphasis of the statement has shifted. Instead of taking a prescriptive 'thou shalt not' approach which might be counterproductive by being confrontational, the Position Statement takes a reflective approach where a doctor is asked to focus on what really should matter the most: the impact of their decisions on the patient in front of them. For example, Paragraph 2.4 of the statement advises the following:

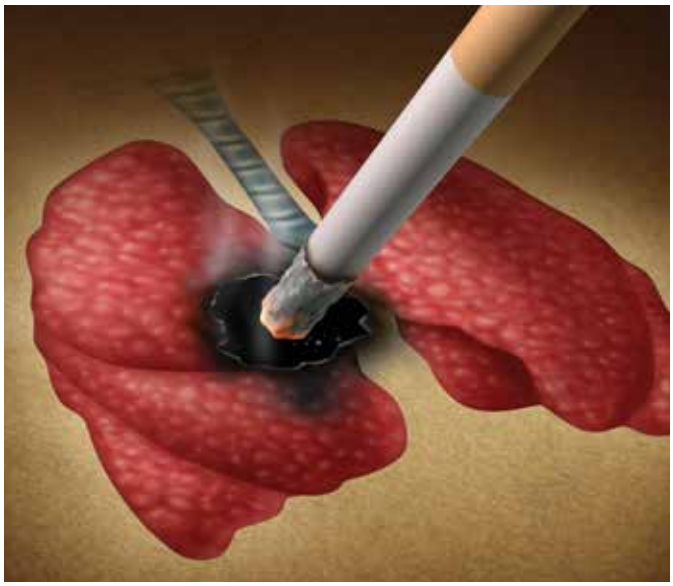
> *2.4 The impact of a delay in treatment, and whether it might constitute a significant impediment, should be considered by a doctor if they conscientiously object, and is determined by the clinical context, and the urgency of the specific treatment or procedure. For example, termination of pregnancy services are time critical whereas other services require less urgency (such as IVF services).*

If you have any questions in relation to the *Position Statement on Conscientious Objection 2019*, please send them through to ethics@ama.com.au. The Position Statement is accessible on the AMA website at https://ama.com.au/position-statement/conscientious-objection-2019 .

Research

BY CHRIS JOHNSON

Latest research into lung cancer deaths and smoking



New research from the Cancer Council suggests 100,000 lung cancer deaths could be avoided this century if smoking rates are reduced to 10 per cent by 2025.

Currently, more than 12 per cent of Australians are daily smokers. An additional three per cent smoke less frequently.

Cancer Council NSW research shows that if the smoking rates for all smokers could be reduced to 10 per cent by 2025, a total of 97,432 lung cancer deaths could be avoided by 2100.

If smoking rates are reduced to five per cent, more than 200,000 lung cancer deaths would be prevented. Recent Australian data, however, shows the decline in smoking rates has slowed.

Cancer Council Australia is calling for a national comprehensive tobacco control strategy that includes:

- Set targets to achieve declines in smoking prevalence;
- Renewed and significant national investment in hard-hitting anti-tobacco ads like the '*every cigarette is doing you damage*' campaign; and
- New laws to regulate product design and ingredients to stop the tobacco industry finding new ways to entice new young smokers.

Anita Dessaix, Chair of Cancer Council Australia's Public Health Committee, said while not all lung cancers are caused by smoking, tobacco remained the biggest preventable factor behind Australia's number one cancer killer.

"Smoking doesn't just cause most lung cancers, it also causes many other cancer types, as well as cardiovascular disease, emphysema and multiple other chronic and fatal conditions," she said.

"Around 2.5 million Australians still smoke and two in three of them will die prematurely from smoking if they don't quit.

"This study just shows the tip of the iceberg in terms of the potential number of lives the next Australian Government, in fact all state and territory governments, could save if tobacco control was made a priority again.

"With an election campaign imminent, federal MPs and candidates have an ideal opportunity to show their commitment to reducing smoking in our communities based on doing more of what works."

The latest research findings also coincide with an Australian Government review of tobacco legislation.

Professor Karen Canfell, Director of Research at Cancer Council NSW, said the good news was the new study estimated that previous tobacco control measures introduced since 1956 had already saved almost 79,000 people from dying from a preventable lung cancer.

"Smoking rates halved over the past 25 years. This study highlights the amazing impact of previous measures such as tobacco taxation, plain packaging, smoke-free legislation, mass media campaigns and restrictions on advertising, as well as greater awareness about the benefits of quitting smoking," Professor Canfell said.

"The indications are that tobacco control measures have put us on a trajectory to potentially save almost two million lives from lung cancer alone by 2100.

"To ultimately reach this goal we need to ensure that the

Research

Government commitment to tobacco control continues. We must ensure Australians remain motivated to quit."

Lung cancer mortality in Australia in the twenty-first century: how many lives can be saved with effective tobacco control? is a study by Cancer Council NSW researchers published in *Lung Cancer.*

The aim of this study was to estimate the number of past and future lung cancer deaths that have already been averted by tobacco control initiatives in Australia, and to estimate the number of additional deaths that could be averted under various smoking scenarios.

Researchers predicted lung cancer mortality rates and numbers of deaths to 2100 using a previously validated generalised linear model based on age, birth cohort and population cigarette smoking exposure. They estimated the impact of various tobacco control scenarios: 'actual tobacco control' (incorporating changing smoking behaviours including those related to the aggregate effect of past and current taxation, plain packaging, mass media campaigns and other initiatives) and scenarios where 10 per cent, 5 per cent and 0 per cent smoking prevalence was achieved by 2025, all of which were compared to a counterfactual scenario with the highest historical smoking consumption level continuing into the future as if no tobacco control initiatives had been implemented.

Without behaviour change and the contribution of tobacco control, there would have been an estimated 392,116 lung cancer deaths over the period 1956-2015; of these 20 per cent (78,925 deaths; 75,839 males, 3,086 females) have been averted due to tobacco control. However, if past and current measures continue to have the expected effect and behavioural trends continue, an estimated 1.9 million deaths (1,579,515 males, 320,856 females; 67 per cent of future lung cancer deaths) will be averted in 2016-2100. If smoking prevalence is reduced to 10 per cent, 5 per cent or 0 per cent by 2025, an additional 97,432, 208,714 or 360,557 deaths could be averted from 2016 to 2100, respectively.

Tobacco control in Australia has had a dramatic impact on the number of people dying from lung cancer. Several hundred thousand more lung cancer deaths could be averted over the course of the century if close-to-zero smoking prevalence could be achieved in the next decade.

Concern over negative test results for flesh-eating ulcer

Buruli ulcer is endemic in the coastal regions of Victoria and northern Queensland, and the incidence is increasing annually.

Correct swabbing technique and caution when interpreting negative results are needed when testing for the presence of *Mycobacterium ulcerans*, the bacteria which causes the flesh-eating disease Buruli ulcer, according to the authors of a research letter published in the *Medical Journal of Australia*.

Led by Associate Professor Daniel O'Brien, infectious diseases specialist at University Hospital Geelong, the study found that early diagnosis of Buruli ulcer is 'vital for good outcomes,' but problems with false negatives can cause diagnostic delay or misdiagnosis.

"The most important diagnostic method for Buruli ulcer in terms of accuracy, speed, and ease of performance is the polymerase chain reaction (PCR) assay of lesion tissue for the DNA insertion element IS2404," Professor O'Brien and colleagues wrote.

"In Australia, the sensitivity and specificity of the assay are each reported to be 100 per cent. However, some often unrecognised pitfalls can lead to missed diagnoses and serious adverse outcomes."

The authors analysed data from 551 patients at Barwon Health in Victoria, with prospectively confirmed *M. ulcerans* disease diagnosed between March 25, 1998 and February 13, 2018.

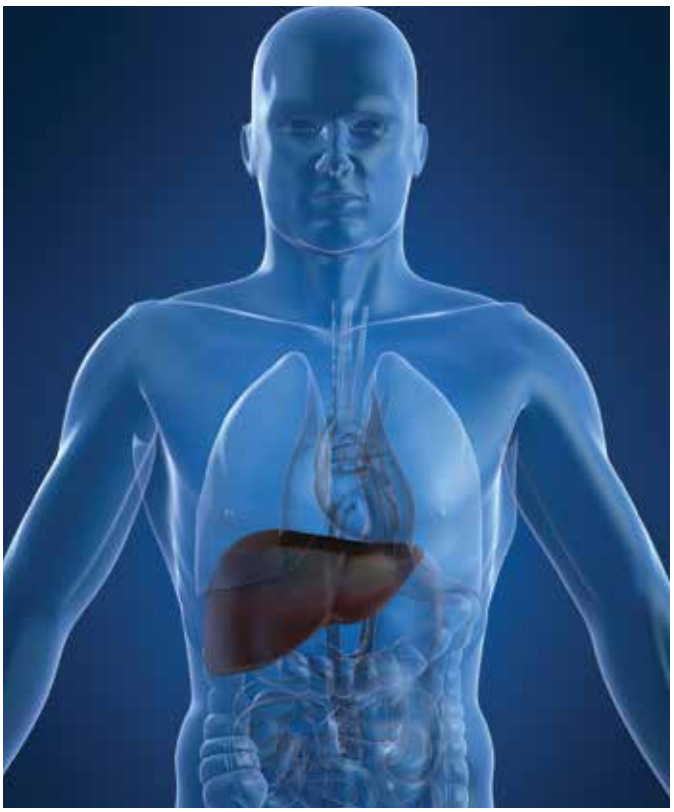
"The PCR result for the initial swab specimen was negative in 34 cases (6.2 per cent), but PCR results for repeat samples were positive (biopsy samples, 15; swab specimens, 19). The initial negative test led to a diagnostic delay of as long as 74 days," they wrote.

"Health practitioners should be cautious when interpreting negative PCR results from people with lesions suggestive of *M. ulcerans* disease, especially when testing early lesions or children. If suspicious, repeat the PCR test, ideally on a punch biopsy specimen. Non-ulcerative lesions require a biopsy to obtain fresh tissue for the PCR test.

"Incorrect swabbing technique probably explains most negative initial PCR results, with insufficient clinical material collected for detecting bacteria. It is imperative that swab samples are taken by circling the entire undermined edge of a lesion, and checking that clinical material from the lesion is visible on the swab surface."

Research

Research project to help reduce liver disease deaths



Life-threatening liver disease is skyrocketing in Australia, with alcohol and hepatitis C and now obesity-related fatty liver disease on the rise.

Australia's National Health and Medical Research Commission (NHMRC) has announced major funding for researchers at Flinders University and their partners at several major South Australian and Western Australian public hospitals to develop a model of care to improve outcomes for these at-risk patients.

"With the average age of death of these patients in their mid-50s, this represents a huge loss for individuals, their families and for the community," said Flinders University Associate Professor Alan Wigg, the lead investigator in the $900,000 combined partnership grant.

"The program we're developing will aim to address the elephant in the room, that is the economic and health system cost of these patients and their devastating disease," he says.

"It will help to address the multiple and complex barriers that prevent health systems from being able implement many of the highly effective treatments that currently exist."

Nationally, more than six million Australians suffer from chronic liver disease with more than 7000 deaths a year – all part of the effects of chronic conditions such as alcohol, hepatitis C, and non-alcoholic fatty liver disease (NAFLD).

A previous Deloitte study indicates the cost of managing the rising tide of chronic liver disease – including lost productivity – now exceeds $50 billion a year in Australia alone.

A previous trial by Flinders University, Flinders Medical Centre and other SA Health researchers showed that patients managed under a chronic liver failure program supervised by liver specialists within a coordinated care model had a 48 per cent lower rate of liver-related emergency readmissions and significantly improved (67.7 per cent versus 37.2 per cent, p=0.009) three-year survival than patients managed with standard care.

Not being managed in the hospital with a coordinated care model was independently associated with a 2.5-fold higher risk of mortality.

In an influential small randomised pilot trial, the research team previously demonstrated some important clinical benefits of managing this patient group with a different style of care. The 'co-ordinated care model' was associated with improvement in quality of care and encouraging trends towards less emergency admissions and lower mortality.

"We argue that some simple measures, including regular contact with specially trained nurses, can greatly improve outcomes for this chronic condition, which sometimes is poorly understood and mismanaged by patients and their medical and nursing systems," said Professor Wigg.

The NHMRC Partnership Project maximises the impact of research funding through key collaborations that ensure rapid translation of research to the benefit of patients and healthcare systems.

Research

The new project aims to reduce emergency department admissions, improve mortality rates, give patients more nursing support following discharge and more health information and better general quality of care. It is hoped that benefits will also be reduced overall cost to the health system.

Cirrhosis is a very serious and complex form of liver disease which is often not well managed.

"Non-alcoholic fatty liver disease (NAFLD) affects one in four Australian adults and has been increasing in parallel with the rising prevalence of obesity and diabetes in the community," said Associate Professor Leon Adams from the Sir Charles Gardiner Hospital in Perth, which is one of the four Australian hospitals involved in the latest research.

"A minority of people develop cirrhosis, however this appears increasingly common with NAFLD cirrhosis the fastest growing indication for liver transplantation in Australia and New Zealand."

Rapid flu tests getting results

The 2017 introduction of faster testing for influenza and respiratory viruses in emergency department patients has seen a decrease in hospital admissions, faster test turnarounds and quicker feedback to patients, according to the authors of research published in the *Medical Journal of Australia.*

Rapid polymerase chain reaction (PCR) testing for influenza and respiratory syncytial viruses (RSV) was introduced in New South Wales in July 2017, but until now its impact on outcomes for emergency department (ED) patients had not been assessed.

Led by Dr Nasir Wabe, a Research Fellow at the Centre for Health Systems and Safety Research, Australian Institute of Health Innovation, Macquarie University, a large group of researchers analysed the data from 1491 consecutive patients tested by standard multiplex PCR during July–December 2016, and 2250 tested by rapid PCR during July–December 2017, in four metropolitan emergency departments in NSW.

"Compared with those tested by standard PCR, fewer patients tested by rapid PCR were admitted to hospital (73.3 per cent v 77.7 per cent) and more received their test results before leaving the ED (67.4 per cent v 1.3 per cent); the median test turnaround time was also shorter (2.4 hours v 26.7 hours)," the authors wrote.

"The proportion of patients admitted to hospital was also lower in the rapid PCR group for both children under 18 (50.6 per cent v 66.6 per cent) and patients over 60 years of age (84.3 per cent v 91.8 per cent). Significantly fewer blood culture, blood gas, sputum culture, and respiratory bacterial and viral serology tests were ordered for patients tested by rapid PCR."

There was no significant difference in hospital length of stay between the two groups.

"Rapid PCR testing for influenza virus and RSV infections in patients attending EDs was associated with significant improvements in a range of patient and laboratory outcomes, suggesting potential benefits for both the patients and the health care system.

"A cost–benefit analysis could examine the impact of rapid PCR testing on bed management and antimicrobial drug prescribing."

BY CHRIS JOHNSON

World push for no vested interests in defining who is sick

An international group of leading doctors and researchers has launched a reform proposal to change the rules for defining disease and setting thresholds for medical diagnoses.

Published in *BMJ Evidence-Based Medicine*, the proposal calls for a new process to be led by family doctors or GPs, with strong engagement from consumer or citizen groups, and entirely free of ties to drug companies or other vested interests.

Lead author Dr Ray Moynihan, an Assistant Professor at Bond University in Australia, said the proposal is a response to the problem of expanding disease definitions which are: "Causing too many people to be diagnosed and treated unnecessarily, producing harm and waste, and posing a major threat to human health and the sustainability of health systems."

Co-author Dr Anna Stavdal, President-elect of the World Organisation of Family Doctors, said: "The aspiration is to see diagnoses offered to those who will benefit from them, rather than those for whom they may cause more harm than good."

Examples of the problem of inappropriately expanded definitions of disease mentioned in the proposal include:

- The controversial definition of Chronic Kidney Disease, which labels many older people who will never experience related symptoms, and was launched at a meeting sponsored by a drug company
- A vastly expanded definition of Gestational Diabetes, which may now label up to one in five pregnant women, despite a lack of good evidence that the newly labelled women or their babies will gain meaningful benefits that outweigh potential harms
- A proposal to expand the definition of High Blood Pressure, which would label one in every two adults in the US, but has been rejected by a family doctor organisation and others over concerns it may cause more harm than good to many people
- The creation of 'pre-diseases' such as pre-osteoporosis, or pre-diabetes, which classify healthy people who are essentially 'at risk of being at risk'.

As the *BMJ Evidence Based Medicine* analysis article points out, in general disease definitions are currently set by panels which are led by disease-specialists – including those with ties to drug companies – and these panels often tend to expand definitions and label more healthy people as sick.

The new proposal recommends replacing existing panels with much more multi-disciplinary panels, with representatives from consumer/citizen organisations, led by generalists, with all members free of financial ties to pharmaceutical or other interested companies.

The authors conclude: "The human person can no longer be treated as an ever-expanding marketplace of diseases, benefitting professional and commercial interests, while bringing great harm to those unnecessarily diagnosed."

The 13 authors of the reform proposal come from Europe, Latin America and Australia, and include doctors working at a senior level within the World Organisation of Family Doctors. The proposal arises from the Preventing Overdiagnosis conference series, which is supported by the *BMJ*, and will take place this year in Sydney, December 5-7, co-sponsored by the World Health Organisation.

Cholera vaccination ramps up in Mozambique following cyclone

An oral cholera vaccination campaign to protect survivors of Cyclone Idai has begun in Beira, Mozambique. Funded by Gavi, the Vaccine Alliance, the campaign will be carried out by the Mozambique Ministry of Health, with support from the World Health Organisation, UNICEF, the Red Cross, Médecins Sans Frontières, and Save the Children.

There has already been one reported cholera death and almost 1500 reported cases following the cyclone, which caused severe flooding in Mozambique, Zimbabwe, Malawi and Madagascar after making landfall in March. Nine cholera treatment centres, with 500-bed capacity, are already admitting patients.

"Cyclone Idai's trail of devastation has left the city of Beira's water and sanitation infrastructure in ruins, providing the perfect conditions for cholera to spread," said Gavi CEO, Dr Seth Berkley.

"This cyclone has already caused enough devastation and misery across south east Africa; we have to hope these vaccines will help stop a potentially major outbreak and prevent yet more suffering."

Dr Tedros Adhanom Ghebreyesus, WHO Director-General, sad hundreds of thousands of people were living in terrible conditions in temporary settlements without safe drinking water and sanitation, putting them at serious risk of cholera and other diseases.

"The key thing is to make sure that people can access rapid treatment and clean water and sanitation. The oral cholera vaccine is a vital emergency measure that will help save lives and stop the spread of this horrible disease," he said.

Cholera is endemic to Mozambique, which has had regular outbreaks over the past five years. About 2000 people were infected in the last outbreak, which ended in February 2018.

The 884,953 doses of oral cholera vaccine arrived in Mozambique in early April. They were taken from the global cholera vaccine stockpile, which is fully-funded by Gavi. Gavi is also supporting operational costs of the campaign.

Since the stockpile was launched in 2013, millions of doses every year have helped tackle outbreaks across the globe. In the 15 years between 1997 and 2012, just 1.5 million doses of oral cholera vaccine were used worldwide. In 2018 alone, the stockpile provided 17 million of doses to 22 different countries.

Since the beginning of 2019, more than six million doses have already been shipped to respond to outbreaks or address endemic cholera in many countries including Democratic Republic of the Congo, Nigeria, Somalia and Zimbabwe.

US Senators target e-cig company

United States Senators have fired off an angry letter to an e-cigarette company accusing it of trying get children addicted to smoking.

Eleven US Senators wrote to Juul Labs early in April demanding answers over the company's relationship with tobacco giant Altria.

The letter accused Juul being part of a vaping "epidemic" in America and of shrouding its company practices in "immense secrecy".

According to a CNN report, Altria invested almost $13 billion in Juul last year.

"Altria has a long and sordid history of spending billions to entice children to smoke through targeted campaigns that intentionally lied about the science and health effects from cigarettes," the letter says.

The letter accused Juul of being "more interested in padding its profit margins than protecting our nation's children" and requested information about its plans to keep targeting American youth.

The Senators want detailed information on Juul's sales and advertising spending and a complete list of what they describe as "social media influencers" paid by Juul.

The Senators are taking the issue up with the nation's Federal Trade Commission.

The Senators want a response from Juul by April 25.

The company has issued an emailed statement saying: "We welcome the opportunity to share information regarding Juul Labs'commitment to curbing underage use of our products while fulfilling our mission to eliminate combustible cigarettes."

WHO's world health stats separated by gender for first time

Women outlive men everywhere in the world – particularly in wealthy countries. The *World Health Statistics 2019* – disaggregated by sex for the first time – explains why.

"Breaking down data by age, sex and income group is vital for understanding who is being left behind and why," said Dr Tedros Adhanom Ghebreyesus, WHO Director-General.

"Behind every number in the World Health Statistics is a person, a family, a community or a nation. Our task is to use these data to make evidence-based policy decisions that move us closer to a healthier, safer, fairer world for everyone."

The gap between men's and women's life expectancy is narrowest where women lack access to health services. In low-income countries, where services are scarcer, one in 41 women dies from a maternal cause, compared with one in 3300 in high-income countries. In more than 90 per cent of low-income countries, there are fewer than four nursing and midwifery personnel per 1000 people.

Attitudes to health care differ. Where men and women face the same disease, men often seek health care less than women. In countries with generalised HIV epidemics, for example, men are less likely than women to take an HIV test, less likely to access antiretroviral therapy and more likely to die of AIDS-related illnesses than women. Similarly, male TB patients appear to be less likely to seek care than female TB patients.

The report also highlights the difference in causes of death between men and women – some biological, some influenced by environmental and societal factors, and some impacted by availability of and uptake of health services.

Of the 40 leading causes of death, 33 causes contribute more to reduced life expectancy in men than in women. In 2016, the probability of a 30-year-old dying from a noncommunicable disease before 70 years of age was 44 per cent higher in men than women.

Global suicide mortality rates were 75 per cent higher in men than in women in 2016. Death rates from road injury are more than twice as high in men than in women from age 15, and mortality rates due to homicide are four times higher in men than in women.

Published to coincide with World Health Day on April 7, which this year focused on primary health care as the foundation of universal health coverage, the new WHO statistics highlight the need to improve access to primary health care worldwide and to increase uptake.

"One of WHO's triple billion goals is for one billion more people to have universal health coverage by 2023," said Dr. Tedros.

"This means improving access to services, especially at community level, and making sure those services are accessible, affordable, and effective for everyone – regardless of their gender."

Between 2000 and 2016, global life-expectancy at birth increased by 5.5 years, from 66.5 to 72.0 years. Healthy life expectancy at birth – the number of years one can expect to live in full health – increased from 58.5 years in 2000 to 63.3 years in 2016.

Life expectancy remains strongly affected by income. In low-income countries, life expectancy is 18.1 years lower than in high-income countries. One child in every 14 born in a low-income country will die before their fifth birthday.

For the first time, this year, WHO's Global Health Statistics have been disaggregated by sex. This new analysis has provided insights into the health and needs of people around the world. But many countries still struggle to provide gender disaggregated information.

The WHO's *World Health Statistics 2019* can be found at: https://apps.who.int/iris/bitstream/handle/10665/311696/WHO-DAD-2019.1-eng.pdf

Mary Poppins and soot

BY **DR CLIVE FRASER**

In 1964, Walt Disney created a magical movie about a London governess named Mary Poppins.

I was six years old when I first saw the movie and immediately fell into its spell as I was roughly the same age as the two children in Ms Poppins' care.

The movie also featured a television actor called Dick Van Dyke who played the part of Bert.

He was of course the chimney sweep, but through song and dance he would join Ms Poppins in the mesmerizing action.

But when he wasn't a singing, dancing, one-man-band, he had the dirty job of cleaning out chimney pipes.

Burning coal in Edwardian fire-places produced a lot of soot.

Left unchecked it would gradually build up and choke the chimney, and at worst, catch fire.

Soot is that black stuff that also pours out of car exhausts, particularly those with diesel engines.

It is made up of carbon particles smaller than 1000Å or 0.1µm.

Any particle smaller than 10µm is respirable and penetrates to the gas exchange region of the lung beyond the reach of the muco-ciliary escalator.

Breathing soot-laden air is undoubtedly deleterious to health.

In 2001 many countries started to mandate that the soot should be extracted from the exhaust using a device called a diesel particulate filter (DPF).

And it was an error message about my DPF that seemed to be keeping my car in limp-home mode.

When working properly layers of a substance called Cordierite (aka magnesium iron aluminium cyclosilicate) filters out the soot particles

But like any filter doing its job the DPF will eventually fill up and clog.

Most diesel cars have a sensor which measures the pressure difference between the intake and output sides of the DPF.

A rising pressure difference means it's time to clean the DPF.

In my car that means burning off the soot at 500°C by converting the carbon into, wait for it, CO_2.

Unfortunately for those of us worried about the environment, this process is the complete opposite of photosynthesis.

The combustion of the soot occurs when my car detects that the DPF is becoming clogged.

This is particularly an issue for diesel cars mostly driven around town as my car is programmed to inject fuel into the exhaust only at high speed.

Failure to regenerate the DPF when needed can lead to a costly $4,000 replacement of the part.

So was it my sensor, or more expensively was it my filter that was at fault?

As the sensor is a delicate piece of electronics exposed to hot exhaust gases and is significantly less expensive than the filter, I opted to replace it first.

A genuine DPF sensor was $250 from my dealer, but the sensor is made by Bosch and can also be sourced as an after-market part for $100.

For those of us who are into cloning eBay also sells a Chinese version of the sensor for $13 including delivery.

I am told by my procedural colleagues that key-hole surgery requires great skill.

But the mechanic who replaced my sensor had more dexterity than a neurosurgeon as he was working in a tiny space between the firewall and an engine that was still very hot.

So it was with great anticipation that I started my car to again be met with the check engine light still illuminated.

In the Mary Poppins movie, Ms Andrews would need to pull a hat stand from her duffle bag to get my car going again.

Cor blimey!

Safe motoring,

Doctor Clive Fraser

doctorclivefraser@hotmail.com

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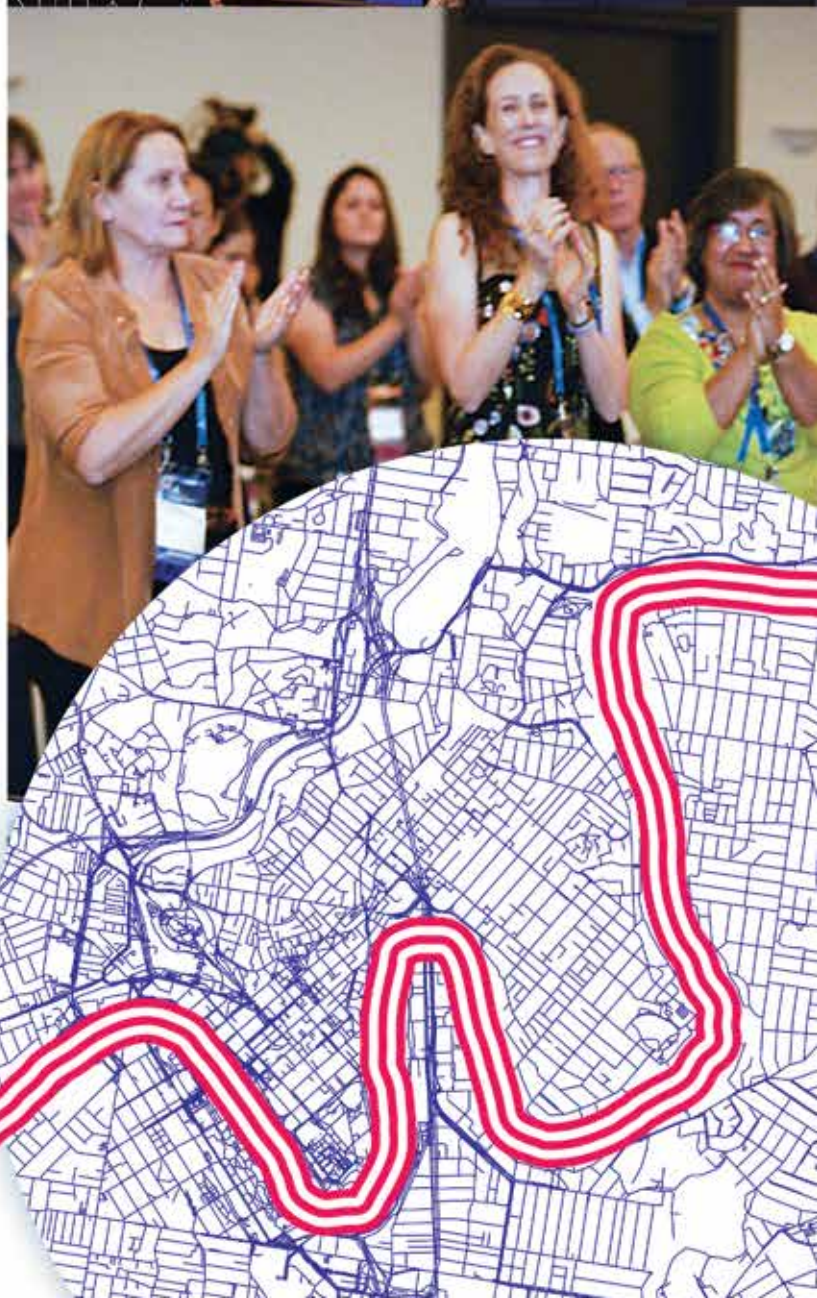

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