AUSTRALIAN
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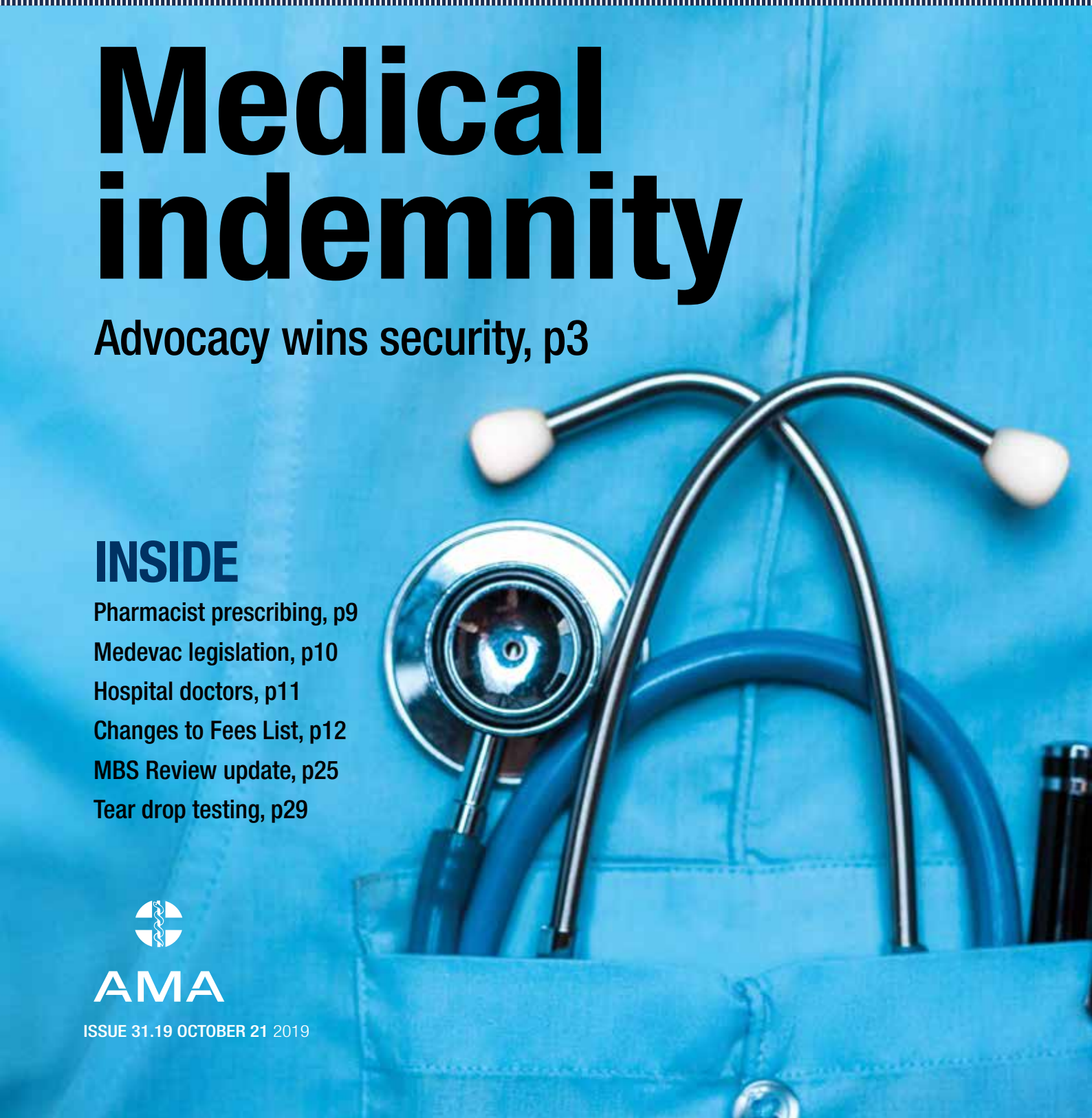
Medical indemnity

Advocacy wins security, p3



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Dr Tony Bartone

Vice President
Dr Chris Zappala

In this issue

Medical indemnity reform wins

Strong advocacy efforts over two years has paid off, with the AMA securing bipartisan political support for medical indemnity stability.

The *Medical and Midwife Indemnity Legislation Amendment Bill 2019* will ensure the AMA's hard-won medical indemnity reforms of 2002 will continue to provide confidence for doctors, their patients, and insurers.

The bill was introduced to Parliament by Health Minister Greg Hunt and found the support of both sides of Parliament.

The ability of doctors to continue to practise medicine securely into the future has been strengthened.

The AMA played a critical role steering two indemnity reviews over the past two years.

AMA President Dr Tony Bartone said bringing the reviews to their conclusions was both challenging and rewarding.

"The AMA has fought hard to maintain the stability of our medical indemnity system and preserve the underwriting from the Commonwealth, which we achieved well over a decade ago," Dr Bartone said.

"In 2016, there was a sudden and substantial cut to medical indemnity schemes, followed by the announcement of the two reviews.

"Concerned about the Government's ongoing commitment to these schemes, the AMA advocated forcefully at each and every consultation, meeting, roundtable, and re-draft of the schemes.

"On behalf of the entire profession, we have worked with indemnity insurers, other peak groups, the Department of Health, the Minister's office, and the Australian Financial Complaints Authority, to name but a few."

Dr Bartone said the AMA had spent considerable time and significant resources on the review process.

He said that was because the AMA knows how critical a stable medical indemnity sector is to every doctors' ability to practise medicine and focus on what really matters – their patients.

"There will be no further cuts to the Commonwealth's funding of these schemes, including but not limited to the High Cost Claims Scheme and the Premium Support Schemes," he said.

"This should ensure that the premium stability we have enjoyed continues."

There will now be a separate scheme for allied health practitioners, meaning they are no longer part of the Medical Indemnity Schemes.

Dr Bartone said that was an important and welcome development for the medical profession.

"It returns us to a fundamental principle for these schemes that was there in the first place – they were designed for medical professionals," he said.

"Improvements have also been made to the schemes, as well as additional monitoring and appeal processes for both indemnity insurers and practitioners.

"The AMA commends the Government for delivering on its promise to use the reviews to demonstrate an understanding of the link between Commonwealth support, affordable indemnity insurance, and cost-efficient stable health care provision.

"We also recognise the contribution of the medical indemnity industry in their collaborative work with the AMA in shaping these reforms.

"In an era of Medicare freezes, funding shortfalls, declining public hospital performance, and shrinking private health insurance membership, it is reassuring that the profession's collaborative hard work has been successful in ensuring stability in this vital area."

In the Minister's Second Reading Speech, Mr Hunt said the improvements would take effect from July next year, allowing insurers ample time to implement necessary changes.

He said the legislation creates a level playing field for medical indemnity insurers.

"The Australian Government decided to subsidise the medical indemnity market to prevent market failure and stabilise the industry after Australia's largest medical indemnity provider, United Medical Protection, was placed in provisional liquidation in May 2002," Mr Hunt said.

"At the time, there was uncertainty as to whether practitioners could access indemnity insurance, coinciding with an increase in claims, costs and premiums. "The Government continues to fund seven professional indemnity schemes to enable privately practising doctors, health practitioners and midwives to access affordable professional indemnity insurance.

"The Government remains committed to guaranteeing that these schemes continue to operate... This bill continues and extends that support but places it on a sustainable and competitive basis going forwards."

JOHN FLANNERY AND CHRIS JOHNSON

Providing leadership to care for older Australians

BY AMA PRESIDENT DR TONY BARTONE

> "This is a very real human tragedy. The victims are our grandparents, mothers and fathers, aunts and uncles, brothers and sisters. These are people who have contributed so much to families, communities, society, and indeed our way of life for many years. They deserve so much better."

There can be no greater responsibility for the Government than to invest in the medical and health care of older Australians as they enter a vulnerable stage of their lives.

The aged care industry in Australia is clearly in crisis. The numerous horror stories of poor standards of care, poor food, and health and hygiene issues are confronting, as is the stunning disbelief that it is happening in our own neighbourhoods.

This is a very real human tragedy. The victims are our grandparents, mothers and fathers, aunts and uncles, brothers and sisters. These are people who have contributed so much to families, communities, society, and indeed our way of life for many years. They deserve so much better.

This crisis was worthy of a Royal Commission. The Commission was announced and has been receiving thousands of submissions and hearing from hundreds of witnesses. The Government recently extended the term of the Commission by another six months, which means it won't report with its recommendations until November 2020. As necessary as this is, it has unfortunately left potential action and redress for older Australians even further delayed.

Let me be clear. The AMA supports the Royal Commission wholeheartedly, and we support the extension of its important work. No doubt more horror stories will emerge over the next year, but **Care Can't Wait** until the end of next year or beyond.

Older people will continue to suffer from lack of appropriate basic care, a lack of nutrition, and inadequate access to quality health and medical care. They are vulnerable, they are lonely, they are scared, and their health and wellbeing will suffer.

As a community, we need to rebel at the way our elderly members are treated. We need to respect and value our older Australians, and not allow them to be notionally discarded into a voiceless minority of lower priority budgetary funding.

Why should older Australians be denied access to the medical care and advice they have enjoyed throughout their productive lives – only to be denied it when they need it most?

The short answer – they shouldn't have to wait. They need better care now. The whole sector needs significant new investment now. It needs leadership!

This is why the AMA has teamed up with the Australian Nursing and Midwifery Federation (ANMF) to push the Government to act immediately to do the right thing by older Australians who need better care, either in residential aged care facilities or in their own homes.

We can't wait for the findings of the Royal Commission to start investing in aged care.

We can't wait while older Australians are being denied the quality of life of life they deserve.

We know that around 120,000 Australians are on a waiting list for a home care package. Home care packages keep older Australians out of aged care facilities. It allows them to be part and parcel of the community that they've grown accustomed to loving and living in, with the support structures, the neighbours, the community health workers, and their local doctors and other allied health professionals who form part of their team.

Last year, 16,000 Australians died while waiting for a home care package. That is a national disgrace. We must stop this happening.

It's important that we allow older Australians to stay in their homes for as long as possible, with the appropriate levels of care for their individual situations.

Looking at the aged care facilities, it is clear that the funding is immeasurably insufficient with what's being required to provide the right environment and right care for the residents - and we're seeing that in the frightening outcomes.

Funding is grossly inadequate to provide the appropriate mix of quality and safety when it comes to the health care team – the

President's message ... continued from p4

vital interactions and communication between doctors, nurses, and allied health professionals.

We know that the lack of appropriate care results in unnecessary and costly emergency department transfers for many residents.

We know that residents lack basic access to the appropriate facilities, timing, and guidance for their medication management. Older Australians are on more than nine medications at one time, on average, so this is a serious concern.

We know, as doctors who make aged care visits, we do not have access to consulting rooms to properly examine patients.

We know that access to the sufficient number of trained registered nurses on a 24/7 basis is lacking.

The aged care system urgently needs a safe and quality skills mix of medical, nursing, and care staff. The increased presence of doctors as part of the care team is vital.

We need to ensure that we put the care back into aged care. Care cannot wait any longer. We need to have that funding discussion now.

Track the AMA aged care campaign on Twitter and Facebook with the hashtag #CareCantWait

Follow the AMA Media on Twitter: http://twitter.com/ama_media

Follow the AMA President on Twitter: http://twitter.com/amapresident

Follow *Australian Medicine* on Twitter: https://twitter.com/amaausmed

Like the AMA on Facebook https://www.facebook.com/AustralianMedicalAssociation

Cut-price health care is on the way with the Government's fees website

BY **AMA VICE PRESIDENT DR CHRIS ZAPPALA**

All would be aware the Commonwealth Government is planning to launch a website to display doctors' fees. We will be asked to voluntarily (at least initially) place our fees on the website. Given approximately 95 per cent of services are provided without a gap or known gap of usually no more than $500, the intent of this seems to be less about revealing out of pocket costs than in managing egregious billers and trying to prevent bill shock. This is an important point because the Government will presumably have to attempt an assessment of whether the website has actually achieved anything in the future (perhaps this is a touchingly quaint hope that Is not being contemplated in any form?).

In the very recent AIHW funding report it was noted that the largest out of pocket expense for patients was non-prescription medicine (31 per cent), dental services the second largest at 20 per cent and medical costs only 13 per cent. From the outset there is therefore immediate conceptual problems with the fees website as doctors are far from the largest cause of out of pocket costs.

The AMA strongly believes that all attempts to improve health literacy are worthy and that patients have an immutable right to receive fully informed financial consent. Recognising our responsibility in this regard the AMA developed the recently released Informed Financial Consent document <https://ama.com.au/system/tdf/documents/Informed-Financial-Consent%20resource.pdf?file=1&type=node&id=51042>.

This document sets out in simple terms how fees are compiled and how gaps are generated, with reference to the nefarious hidden effect of variable and insufficient health insurance rebates. This context is important because patients do not realise that out of pocket costs are borne largely from insultingly low rebates (both Medicare and health fund rebates). As soon as the doctor charges over a known gap the health funds receive a partial reprieve for reasons that defy understanding – and their rebate can drop even lower to only 25 per cent of the insufficient MBS benchmark. This then is perceived by the patient as the doctor over-charging – but in fact the root cause is the avaricious behaviour of the insurance funds to preserve handsome profits by offering low rebates and successive Governments in attempting to reduce what they pay for each citizen on healthcare. There is some sense this might be working with a reduction in the proportion of total tax revenue from Australian Governments paid for healthcare from 26.0 per cent (2016-17) to 24.4 per cent (2017-18) and real growth in Australian Government expenditure on Health is noticeably slowing compared to previous years. Over this same time period, expenditure by individuals on health increased by 3.0 per cent.

The undoubted principal driver of both doctors' income and patient gaps are rebates (both Medicare and private health insurance). Together with the knowledge that a very significant proportion of services are provided at no/known gap, it remains unfathomable how any contemplation of a Government fees website could omit detail of the rebates. Moreover, I'm not sure it is at all fair to ask/insist that doctors disclose their fees if the private health insurance funds are not going to also disclose their rebates given the entwined relationship of both. For any patient to truly understand the cost of care and gap they might be requested to pay, all rebate information must be disclosed. This is technically possible using publicly available data of PHI rebates.

Doctors will sometimes adjust their fees to accommodate variation in PHI rebates to insulate the patient from excessive out of pocket costs. This requires discounting to some patients (for the same procedure/service) who are members of funds offering low rebates in order for costs to remain within no/known gap arrangements for that miserly fund. A simple average

Vice President's message ... continued from p6

fee/fee range disclosure website without PHI rebates does not allow vision of this discounting effort by doctors. If a key goal of the fees website is to help people understand reasonable versus egregious billing or their out of pocket costs, as stated by Minister Hunt, it is therefore necessary to highlight the rebates in a central location, rather than on each, disparate health fund website.

> "Quality medicine could easily suffer if discounted services become the principle method to attract patients and earn a living."

Consider when a doctor charges a single, set fee to all patients for a particular service – variable rebates once again create confusion for patients. Similar gold policy holders across funds could each be subject to huge variation in out of pocket costs depending on rebates that can vary several fold. This rebate variation then leads to patient receiving the same service from the same doctor and possibly in the same institution having vastly different costs from no gap, to a known gap under $500 or a large out of pocket cost.

We must appreciate and agree in advance of the proposed Government's fee website, in any competitive service or commodity market in which price is the principle arbiter in choice of purchase, then a high quality product will never be achieved. The incentive to go the extra mile with a patient evaporates under the relentless discounting (and time) pressure that occurs as doctors compete based on price alone. Quality medicine could easily suffer if discounted services become the principle method to attract patients and earn a living.

Let's ponder some other implications of price-based competition in healthcare. Why bother getting an advanced skills diploma/higher research degree or doing a fellowship year to improve your knowledge/skills if it provides no advantage for receiving referrals/patients because people just want to see any doctor as soon as possible for as little money as possible. The only thing patients might see prior to contemplating an appointment with you are your prices compared to everyone else, without appropriate context or meaningful information to allow an assessment of your quality or expertise. Credible comparative information on expertise, skill and quality would be very difficult to reliably gather and portray. Without it however, the Government's fees website becomes much less a genuinely useful tool for patients to make informed choices and more the rudimentary fulfilment of a political promise without proper regard to the unforeseen deleterious consequences.

There has always appropriately been a public service element to medicine – but price competition places this in jeopardy. Why bother doing a telemedicine clinic to an under-serviced regional area because these are administratively more difficult to organise and the remuneration is inferior to a standard face-to-face clinic in your rooms? Forget travelling to a regional or rural location to do a clinic for predominantly pensioners or healthcare card holders as your substantially increased costs in conducting this clinic will not be recognised or recoverable. Taking the little bit of extra time with a patient is unrewarded. When competing on price alone, it becomes much more difficult to sustain marginally profitable aspects of practice regardless of any service element.

I acknowledge we still have significant responsibilities that as a profession we must attend to. The profession does have to emphatically abolish the practice of charging administrative or booking fees. The quid pro quo however for this to occur is insurance funds agreeing to provide rebates up to the AMA fee, in other words, rebates must be appropriate and reflect the true cost of the service being provided. The maintenance of parlous, differential rebates across thousands of health insurance policies must cease, by regulation/law if required. It would also be necessary for the Government to address the hopelessly deficient MBS rebates in key areas – perhaps they could reinvest some of the savings from the MBS review we keep hearing about?

It is impossible to define an egregious fee. We can however place stock in the AMA list of fees. If greater surveillance and scrutiny of medical fees is going to occur one way or another, perhaps we should be confident enough to publish the AMA fee for key items where possible egregious billing is perceived to occur, so patients can have a sense of the approximate fee they could expect to be charged. If a fee is several-fold greater than this then it is not unreasonable for patients to ask why this might be the case and be given the chance to seek a second opinion. The ACSQHC Atlases of Variation go some way in achieving this already.

Helping rein in egregious billing is part of our professional responsibility and only the AMA has the credibility, experience and scope to gently and progressively deal with this enervating problem. Had we been more active and successful at constraining egregious billing several years ago there is a high chance we would not be having this conversation about a Government medical fees website at all and the entire spotlight of discontent would be squarely where it belonged, on the funders of health care.

Care and campaigns can't wait

BY **AMA SECRETARY-GENERAL MARTIN LAVERTY**

"The campaign in one sense has come together quickly, but in reality, it's built on input from AMA members who helped shape the profession's submission lodged with the Royal Commission this month."

Care can't wait. It's a simple line. It fits so many objectives of the AMA.

Care can't wait is the theme our President, Dr Bartone, has adopted in campaigning for more medical and nursing presence in residential aged care services. The new campaign seeks extra medical and nursing care to provide an immediate boost to safety and quality for residential aged care recipients. The Government could choose to provide this safety and quality boast in advance of the 12 to 18 months it will take for the current Royal Commission to finish its essential work, and for the Government to thereafter respond to Commission recommendations.

The *Care Can't Wait* campaign is the first I've been involved with at the AMA. I've observed AMA advocacy for years, but am new to supporting the President and Federal Council in making the medical profession's case to Government. The campaign in one sense has come together quickly, but in reality, it's built on input from AMA members who helped shape the profession's submission lodged with the Royal Commission this month.

Whereas the significant submission to the Royal Commission contains more than forty recommendations, the aged care campaign is narrowly focused. It's not asking too much. Enhancing clinical presence of doctors and nurses in aged care services will result in improved care outcomes, which is what aged care service consumers and the wider public want. The main point of the campaign is for government to act now. To not delay. To not defer improvements in aged care until some point in 2022.

The way in which the AMA has traditionally done advocacy has served it well. Yet the nature of government of has changed. So too must AMA advocacy.

You can expect planned campaigns to become more of a feature of the AMA in coming years. In support of Dr Bartone's priorities of aged care, private health insurance, mental health and the role of general practice in prevention, I've spent my first few weeks at the AMA working with the skilled staff in the Federal Secretariat to structure campaigns around these four imperatives.

Longer term, there is the opportunity for greater AMA member and even wider public participation in health issue campaigns led by the AMA. GetUp! and Change.Org have taken traditional grass roots campaigns into the digital age. The same opportunity exists for the AMA, even if it takes a while to get our digital capacity organised.

In the interim, I'll soon ask Federal Council, it's individual Councils, and the wider AMA membership what longer term issues confronting our nation's health system the Federal Secretariat should target its attention towards. The Secretariat currently focuses on a wide range of issues. Focusing energy on the most important will likely bring members and the wider community greater benefit.

As I go about thinking about how the AMA can best target its campaign capacity, and work through enhancements with the AMA Board and Federal Council, sing out and let me know your own thoughts on what you'd like to campaign about, and how. secgen@ama.com.au

Autonomous pharmacist prescribing ruled out

The AMA has welcomed the Pharmacy Board of Australia's decision not to pursue autonomous prescribing by pharmacists.

The Pharmacy Board recently released its *Position Statement on Pharmacist Prescribing* and said it would not seek to chase a model whereby pharmacists could prescribe medications without medical supervision.

The Pharmacy Board's statement said autonomous prescribing by pharmacists would require additional regulation, changes to State and Territory legislation, and an application to the Ministerial Council, which could only proceed following the development of a registration standard.

The Board said it was not making an application at this time.

Health Minister Greg Hunt has ruled out any changes, despite the Pharmacy Guild of Australia campaigning for them.

AMA President Dr Tony Bartone said the Pharmacy Board had put patient safety first.

Dr Bartone met with the Pharmacy Board before it released its Position Statement. He applauded the Board's position.

"Pharmacists are not doctors, and they should not be allowed to undertake autonomous prescribing," Dr Bartone said.

"The Pharmacy Board has highlighted that significant issues remain with any model of pharmacist prescribing including evidence of need, conflicts of interest, and the importance of separating the prescribing and supply of medicines – all issues that were raised by the AMA."

Dr Bartone said the Pharmacy Board had strongly endorsed the appropriate scope of practice of health professionals. He added that that the AMA highly values the professional role of pharmacists in working with doctors and patients.

The Pharmacy Board's Position Statement was published a day after the AMA released its *10 Minimum Standards for Prescribing* document.

In that document, developed by the AMA Council of General Practice and approved by the AMA Federal Council, the AMA seeks to ensure patient safety and high-quality health care.

The *10 Minimum Standards for Prescribing* are:

- **Standard 1**: Prescribing by non-medical health practitioners should only occur within a medically led and delegated team environment in the interests of patient safety and quality of care.
- **Standard 2:** There must be no pecuniary or non-pecuniary benefit to the prescriber related to the choice of medicines prescribed or the dispensing of those prescribed medicines.
- **Standard 3:** Before prescribing establish a therapeutic relationship with the patient and perform a comprehensive medicines assessment to identify what other medicines, including complementary medicines, the patient is taking and consider any implications to the patient's treatment plan.
- **Standard 4:** Prescribers ensure they:
  - a) consider the necessity and appropriateness of medications in managing the patient's health care needs,
  - b) choose the most suitable and cost-effective medicines when medicines are considered appropriate, taking into account the efficacy, potential for self-harm and the ability of the patient to adhere to the dosage regimen,
  - c) advise patients are aware of the relevant side effects of prescribed medications as well as relevant interactions between medications, and
  - d) report any adverse reactions to the TGA.
- **Standard 5:** Prescribers must maintain clinical independence.
- **Standard 6:** Prescribers must operate only within their scope of practice and comply with state, territory and legislative requirements including restrictions under the Pharmaceutical Benefits Scheme.
- **Standard 7:** Prescribers work in partnership with the patient to set therapeutic goals and with other health professionals as appropriate to select medicines and to tailor and implement a treatment plan.
- **Standard 8:** Prescribers provide clear instructions to delegated prescribers within the health care team and to other health professionals who dispense, supply, or administer the prescribed medicines.
- **Standard 9:** Prescribers with the patient consent communicate with other health professionals within the patients' health care team about the patient's medicines and treatment plan.
- **Standard 10:** Prescribers monitor and review the patient's response to treatment and adjust the treatment plan as appropriate.

JOHN FLANNERY

Medevac is working and should remain

The AMA has joined 11 Medical Colleges in calling on Australian lawmakers to keep intact the Medevac legislation that gives doctors proper say over the health of asylum seekers on Manus and Nauru.

Laws that give doctors more influence over whether asylum seekers should be transferred to the Australian mainland for treatment were passed in February, against the wishes of the Coalition Government.

> "The AMA has strongly supported Medevac and insists the Independent Health Advice Panel (IHAP) process established by the new laws is working well."

But following the May federal election, the Government introduced legislation to repeal the Medevac laws.

The repeal bill passed in the House of Representatives in July, but the Senate referred it to a committee and is due to vote on it in November.

The committee, which is controlled by the Government, has recommended in its report that Medevac be repealed.

The committee, however, did not reach a consensus and has broken down along party lines.

The Opposition, the Greens, and the Centre Alliance each wrote consenting reports saying the Medevac laws should not be repealed.

The AMA has strongly supported Medevac and insists the Independent Health Advice Panel (IHAP) process established by the new laws is working well.

AMA President Dr Tony Bartone said the AMA had repeatedly proposed a body of clinical experts, independent of government, with the power to investigate and advise on the health and welfare of asylum seekers and refugees.

This call was always backed by the Medical Colleges, and with the establishment of IHAP, the AMA and the Colleges have been steadfast in their support.

Eleven Colleges recently called for the Medevac legislation and the IHAP process to be maintained. The AMA backed that call.

Dr Bartone said the united call from the esteemed Medical Colleges was consistent with the long-held AMA position that those who are in the care of the Australian Government have the right to appropriate medical care without discrimination, regardless of citizenship, visa status, or ability to pay.

"Over the last couple of months, I have met Home Affairs Minister Peter Dutton, and the Home Affairs Department Chief Medical Officer Dr Parbodh Gogna, to reiterate the AMA's strong support for Medevac and the ongoing work of IHAP," Dr Bartone said.

"The AMA has a representative on IHAP. IHAP is working as intended and the Parliament should continue to support and properly resource it into the future.

"Asylum seekers and refugees in Australia or in offshore detention, in the care of the Australian Government, should be treated with compassion, respect, and dignity."

With One Nation and independent Senator Cory Bernardi joining with the Government in wanting Medevac repealed, it leaves two major blocs in the Senate with opposing views on the repeal bill.

Independent crossbench Senator Jacqui Lambie appears to have the deciding vote and is yet to reveal her position.

More than 130 asylum seekers have been transferred to mainland Australia from Nauru and Papua New Guinea since Medevac became law.

The 11 Medical Colleges issued a joint statement mid-October saying the process was working well and should be maintained.

The AMA commended the Colleges and added its voice to the call.

CHRIS JOHNSON

AMA gains assurances for hospital doctors

An article in *The Australian* recently suggested that the Commonwealth Government would be seeking to reclaim funds from doctors working in public hospitals, and that State Governments will not accept responsibility for any 'double dipping'.

The article cites Freedom of Information (FOI) documents that suggest that the State and Territory governments want to shift the blame for so-called 'duplicate Medicare payments' to individual doctors in the hospital system.

Of course, the AMA would not stand for State and Territory Governments who may try to blame doctors for any funding issues they are facing under the current Commonwealth-State public hospital funding agreement. Equally, the AMA would not accept the Commonwealth going after doctors to claw back these funds.

We sought urgent clarification. Thankfully, that is not what is occurring.

The AMA has been engaging with the Federal Department of Health regarding their compliance activities, including any future activities under the shared debt recovery powers recently introduced and legislated.

In doing so, the AMA has continually pointed out that in public hospital settings the billing is often managed by the hospital; that, under team arrangements, billing can be complex, particularly in the areas of pathology and diagnostic imaging; and that practitioners do not have line of sight where State Governments also bill an episode of care under Activity Based Funding (ABF).

Furthermore, the AMA has highlighted that, in any attempt to undertake an audit, it will need to be hospitals, not practitioners, that take the lead on looking at the records, as often a practitioner will not hold them all.

The AMA has received assurances from the Department of Health that this is indeed understood, and that the intent is not to pursue individual practitioners for the recovery of funding, where there is identified 'double dipping' alongside an ABF payment.

The AMA position is that State Governments, their bureaucrats, and hospital administrators must take responsibility for the running of their public hospitals and their side of the bargain in the Commonwealth-State agreements.

No doubt there has always been a blame game between the Commonwealth and the States when it comes to public hospital funding. This, in large part, stems from the fact that there is simply not enough funding for our public hospitals.

While it is appropriate that compliance action be undertaken where there is clear wrongdoing, the AMA has continued to advocate that it is the hardworking doctors, nurses, and other health workers who keep the system going amid ongoing and critical funding and resource shortages. As such, they should not be the target of this action. Thankfully, we believe this message has been heard.

The AMA will continue to work with Governments, State and Federal, on this issue, while calling for a greater focus to be put on funding our hospitals to be better, not just busier.

LUKE TOY
AMA DIRECTOR, MEDICAL PRACTICE

Medicare photo ID bill rejected

The AMA welcomes the report tabled recently by the Community Affairs Legislation Committee, following its Inquiry into the *Human Services Amendment (Photographic Identification and Fraud Prevention) Bill 2019*, which recommends that the bill not be passed.

The bill, which has been introduced by Senator Pauline Hansen, proposed requiring photographic identification on the front of Medicare cards.

The AMA was the only medical organisation that made a submission to the Community Affairs Legislation Committee Inquiry and, in rejecting the proposal, highlighted:

- There was no evidence of widespread Medicare card fraud that would warrant such changes to the Act;
- Concerns at the potential for extra red tape and compliance;
- The potential impact on access to care for vulnerable patients;
- Significant improvements to the security and integrity of Medicare following the recommendations of the Independent Review of Health Provider's Access to Medicare Numbers.

The Committee, in its findings, clearly took on board these views and, while recognising the importance of the sustainability and security of Medicare, made the sensible decision to reject the bill.

AMA CHANGES TO AMA FEES ON 1 NOVEMBER 2019

Fee Indexation for 2019

The AMA will be indexing its recommended fees on 1 November 2019 for existing items on Fees List Online in line with CPI and Wage Index increases. To assist with your implementation of these new recommended fees, a preview file has been uploaded to Fees List here: https://feeslist.ama.com.au.

Other Changes to the AMA Fees List on 1 November 2019

In addition to a preview of indexation of the fees, a preview of the significant changes to anaesthesia and colonoscopy items reflecting the Government's MBS review changes have been uploaded to Fees List.

These previews can be found in the turquoise banner on top of the page when you log in to Fees List Online.

If you are an AMA member and have any difficulties with your password or login details, please contact Member Services on: MemberServices@ama.comaum or call 1300 133 655.

For non-member subscribers of the AMA Fees List and AMA members, if you have difficulty accessing these previews, please contact us at: Feeslist@ama.com.au

The Government has made extensive changes to the anaesthesia and colonoscopy suite of MBS items. With a small number of exceptions, the AMA will be reflecting these in the AMA List.

The Government changes include:

Anaesthesia

The revised MBS structure contains 28 amended items, 10 new items, and deletes 31 items.

NB: some services no longer receive Medicare funding.

Colonoscopy

The revised MBS structure is highly prescriptive with new items to distinguish eligible patient cohorts by interval screenings, as recommended by the MBS Review Taskforce.

NB: Some services no longer receive Medicare funding.

A 'Summary of Changes' for November 2019 has been uploaded to Fees List Online as a preview to assist you to implement the considerable number of MBS changes to anaesthesia and colonoscopy.

MBS Changes Not Implemented by the AMA on 1 November 2019

Due to the high volume and complexity of MBS changes and the need to consult with relevant specialist groups and establish new fees, the AMA has not been able to achieve reflection of all of these in the AMA Fees List for 1 November 2019. This will be done as soon as possible after consultation and a Fees List Committee meeting.

You will be advised at a future date of forthcoming changes to implement the MBS changes to:

- Eating disorders – a comprehensive suite of GP, other specialist, and allied health eating disorder items.
- Eligible patients will be able to access up to 40 psychological, medical, consultant psychiatrist, and 20 dietetic services in a 12-month period.

These items are modelled on existing GP mental health care plan items.

- Telehealth –new GP items (2461 -2483) for people living in MMM areas 6-7.
- Diagnostic imaging – new breast MRI items, two new breast PET items, 1 new mobile skeletal x-ray item for residential aged care

Other 'minor' amendments to:

- 2 Sleep studies items.
- 8 spinal surgery items .
- 1 ENT item replaced with a new item for stroboscopy.
- Urology - to restrict Medicare benefits for services connected with ExMI.
- 6 cystic fibrosis gene testing items .
- 1 plastic and reconstructive surgery item to be split into two.

Reducing unnecessary diagnostic imaging requests

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

I recently attended a Department of Health presentation on reducing unnecessary diagnostic imaging requests. The purpose of the presentation was to run through the Department's latest approach to changing provider behaviour. This presentation coming ahead of almost 4,000 of the top 20 per cent of diagnostic requesting GPs being sent a letter aimed at reducing diagnostic testing that may cause unintended harms including overdiagnosis and overtreatment.

As highlighted in a recent article in the *Medical Journal of Australia*, part of the solution in reducing overdiagnosis and its associated harms potentially lies in an enhanced awareness, particularly for referrers and their patients about the evidence for, and the consequences of, overdiagnosis and related overtreatment. Wiser Healthcare, as part of the National Action Plan to Prevent Overdiagnosis and Overtreatment in Australia, is conducting research to this end – its research informing the Department's approach.

As presented, the evidence suggests that the majority of cases for low back pain imaging and specialist referral are unwarranted. With a quarter of patients in Australia who present to GPs with lower back pain receiving some form of imaging there is a need to look at the drivers and potential solutions in order to support appropriate care and cost-effective use of resources. Particularly, given only one to four per cent of patients presenting with lower back pain will have a spinal fracture, and less than one per cent will have some form of underlying malignancy.

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> "GPs who receive a letter are encouraged to contact the Department with any questions or feedback, including suggestions on how you can be better supported with diagnostic imaging requesting."

The AMA is pleased to see that thez Department appears to be taking more of nuanced and nudge approach with this exercise, as opposed to the seemingly more threatening approach they took last year with the opioid letter. An approach, that brought claims of unintended consequences, such as palliative care patients not receiving adequate pain relief as their GPs became fearful of being referred to the Professional Services Review if there was no change in their prescribing rates.

This time around, the Department has taken a more researched and GP tested approach as to how to encourage behavioural change were appropriate within the target group. The Department is looking at how it presents information to GPs to best inform them about their diagnostic imaging referrals and to highlight how they differ from their peers and in what specific areas. The Department also looking into its follow-up approach and what tools may be of assistance to GPs and their patients regarding when and for what conditions imaging is appropriate.

Effectively, the Department's revised approach is an experiment to see what impact the process has in eliciting a change in diagnostic requesting behaviour. The outcomes from this latest letter to be monitored over the next year and a half, to determine if this approach is more effective in stimulating a reduction in unnecessary requesting.

The AMA is concerned that the metrics for determining the target group does not recognise that some GPs may have special interests in sports and musculoskeletal medicine. This was also a problem with the opioid letters which failed to recognise those practitioners providing palliative care. The AMA does not want to see a situation where patients are denied referrals where their presenting condition indicates it is the appropriate course of action. If this were to be the outcome it is likely not only to adversely impact patient outcomes but the costs associated with delayed diagnosis and treatment could be substantial.

Whether a letter is received or not it is always worthwhile for referrers to consider whether their referrals align with appropriate referral pathways and to assist patients in understanding why a referral at any time is warranted or not. As part of that process patients should of course understand the risks associated with any proposed diagnostic imaging, particularly in relation to repetitive exposure to ionising radiation.

GPs, in deciding to request diagnostic imagining, need to look for any red flags that would signal the inappropriateness of a wait and see approach. GPs who receive a letter are encouraged to contact the Department with any questions or feedback, including suggestions on how you can be better supported with diagnostic imaging requesting.

While fear of missing a diagnosis and a desire to keep the patient happy can provide strong motivation for a diagnostic request, our duty of care to the patient, needs to be stronger. As per the AMA's position statement on *The Doctor's Role in Stewardship of Health Care Resources*, effective stewardship positively influences quality of care.

Resources are available to assist GPs with appropriate requesting. These include PHN Pathways, RANZCR's *Education Modules for Appropriate Imaging Referrals*, and the WA Department of Health's *Diagnostic Imaging Pathways*, which is also available via the *AMA GP Desktop Toolkit*.

Information that may be useful for patients can be found at Inside Radiology and includes the Australian Radiation Protection and Nuclear Safety Agency's *Guide For Medical Imaging*.

The AMA will be watching with interest the impact of the Department's latest experiment in behavioural science.

A child shall lead them

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

Swedish climate activist Greta Thunberg arrives in New York for UN climate summit.

Friday, September 20 was a magnificent late summer's day in New York – crystal-blue sky and 28 degrees – like that almost 18 years ago when two early morning-flight passenger jets roared over Manhattan into the twin towers, killing 3,000.

At Battery Park, close to where the twin towers stood, tens of thousands of school children and supporters gathered that Friday to protest and express concern about the threat to human existence posed by global heating. By chance, I was in Manhattan and gained a clear sense of the strong motivation of the students. The seasonal conjunction of the 9/11 anniversary and the children's protest over what they perceive as impending catastrophe did not escape one or two commentators.

The focal point in the New York protest was an address from Swedish 16-year-old Greta Thunberg, who arrived in New York harbor from Plymouth, England, on Wednesday August 28 aboard the *Malizia II*, an 18-metre racing yacht that uses solar panels and underwater generator turbines to avoid producing carbon emissions. She self-identifies as having Asperger's syndrome. She avoids air travel because of its pollution. She is taking a sabbatical year from school. Her personal crusade started with a "School Strike for Climate" outside her national parliament in Stockholm in August last year. (Google 'Thunberg TED talk' to hear her.) *The Guardian* wrote:

> For the first time since the school strikes for climate began last year, young people called on adults to join them – and they were heard. Trade unions representing hundreds of millions of people around the world mobilised in support,

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employees left their workplaces, doctors and nurses marched and workers at firms like Amazon, Google and Facebook walked out to join the climate strikes.

In the estimated 185 countries where demonstrations took place, the protests often had their individual targets; from rising sea levels in the Solomon Islands, toxic waste in South Africa, to air pollution and plastic waste in India and coal expansion in Australia.

But the overall message was unified – a powerful demand for an urgent step-change in action to cut emissions and stabilise the climate.

The week following the student strike and protest march, the United Nations General Assembly in NYC devoted time and attention to the same subject. Greta addressed the United Nations Climate Action Summit, hosted by Secretary General António Guterres on September 23 – and not attended by Donald Trump or Scott Morrison – this time calling in extremely strong emotional terms for action.

The science of climate change is ultra-complex. Those who maintain a negative view about the reality of global heating can legitimately claim that all that we would like to know is not yet known and that the sheer complexity of the science makes it inaccessible to critical appraisal. This matters. Leading Harvard environmental economist Martin Weitzman, 77, who died in August this year by suicide, considered that there were major limitations imposed on economic models of the effects of climate change because, as *The Economist* tells it, 'the sensitivity of global surface temperature of atmospheric carbon dioxide remains uncertain' so that even if we might cope with steady rises in temperature, 'a cataclysmic event, such as global warming over six degrees Centigrade remains worryingly possible.'

Those who maintain that fluctuating global temperature is natural and not man-made have an uphill battle to establish their case when the observational data about temperature trends are examined and the upward movement revealed in secular trends of principal indicators such as atmospheric concentrations of carbon dioxide and ambient temperature.

Strong advocates call for urgent action because of the rising levels of greenhouse gases that diminish the ability of the planet to return reflected sunlight and locally-produced heat into space. Bill McKibben, an American environmental author and activist, quotes his latest book, *Falter*, from climate scientists in asserting that

> The extra heat that we trap near the planet because of the [extra] carbon dioxide we spew out is equivalent to the heat from 400,000 Hiroshima-sized bombs each day, or four each second.

What to do? The socially-embedded nature of the industrial processes that generate greenhouse gases, like the social determinants of health more generally, limits the actions. As with achieving an accurate understanding of why obesity is such a global problem, we need to dig deep into what motivates society and what moral and economic distortions make society obesogenic – and susceptible to heating. The contribution of greed and economic gluttony to the changing climate is immense.

Because these causes lie so deep in society, to change the behaviours that underpin global warming is a gargantuan task. Making one ton of concrete releases one ton of carbon dioxide. McKibben claims that social science research shows that peaceful protest, however, has double the chance of achieving change compared to violent protest except during civil war.

Humanity is amazingly resilient and human history may yet accommodate a chapter on what we did to recover from global heating. Carbon capture may yet turn cement manufacture into a climate friend. Perhaps a seemingly miraculous technological fix will emerge – a kind of environmental statin. *The New Yorker* carried an entertaining essay in its September 30 issue about multibillion-dollar efforts underway to develop hamburger substitutes made from vegetables. Perhaps nuclear generation of electricity will be achieved cheaply and safely at scale and displace fossil fuel. Storage of electricity generated by wind, water or sun may become cheap and accessible. While most of these efforts are directed at reduced greenhouse gas emissions, the risks of catastrophic disruptions, as Weitzman argued, remain.

But for those of us in medicine, we must plan our health services for a hotter, less hospitable world. Alongside such realistic preparation we can support the peaceful efforts of those who advocate for greater environmental sensitivity, accountability, and humility.

Road safety and quad bikes

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

Quad bikes are part of the rural landscape – they have been present in every rural setting I can remember. They seem innocent and useful, rounding up stock, travelling to the next off-road location, helping with all sorts of rural chores.

> "We support implementing ACCC recommendations on mandatory roll protection on all quad bikes to prevent more deaths on Australian farms."

But they are associated with huge numbers of injuries and fatalities. Rural doctors, you know that chill up your spine when the ambulance service radios in a quad bike trauma.

In July 2019, the National Farmers' Federation (NFF), Cattle Council and Rural Doctors Association questioned why legislation requiring all quad bikes to be fitted out with roll bars had not been passed by the Government.

Our AMA Council of Rural Doctors discussed the issue. We support implementing ACCC recommendations on mandatory roll protection on all quad bikes to prevent more deaths on Australian farms.

Since 2001, more than 230 Australians have died in quad bike related accidents, and in the period 2011 to 2018 there were more than 126 deaths from quad bike accidents, an average of 16 people killed per year. Most deaths occurred on farms.

Tragically, many of these victims are children. In the eight years from January 1, 2011 to December 31, 2018 there were 128 fatalities, about 11 per cent (14 fatalities) were children aged 11 years of age or under. These numbers need more attention. In comparison, for the same time period, there were two deaths from button batteries. Some are now calling for age restrictions on the use of quad bikes to be introduced

The safety problem with these off-road vehicles is that they roll and the occupant typically dies from crushing-related injuries or asphyxiation.

Data provided by the NFF shows that each year there are more than 650 hospitalisations as a result of quad bike accidents. Every day, an estimated six people present at an emergency department for a quad bike related injury.

There is no available data on exactly what types of injuries present, but from our discussions with the NFF we understand that a significant proportion would result in permanent disability, including quadriplegia and paraplegia.

Australia's regulator, the ACCC, have estimated the cost of quad-related deaths and injuries to the national economy at more than $200 million.

In March this year, the ACCC issued a report following an 18-month enquiry, concluding that new safety standards should be introduced requiring all new quad bikes to:

- Meet the specified requirements of the US or EU quad bike Standards;
- Be tested for lateral static stability test;
- Display the angle at which it tips on to two wheels on a hang tag at the point of sale;
- Have a label affixed alerting the rider to rollover risk;
- Include rollover safety information in the owner's manual: and
- Meet minimum requirements for stability.

So why aren't these standards being adopted? It seems that quad bike manufacturers have threatened to withdraw from selling these vehicles here if roll bars are mandated.

These bullying tactics are disappointing. These devices save lives. The AMA supports the requirement for mandatory installation of "operator protection devices" to save lives and reduce trauma.

Although there are urban quad bike injuries and fatalities, this is a rural issue. There is more off-road travel, the vast distances to get medical help is our hidden terror, and these quad bikes are part of the armamentarium for our rural and remote communities.

I hope you can join the AMA in advocating for this life saving policy.

Climate change is a health issue

BY JESSICA YANG, PRESIDENT, AUSTRALIAN MEDICAL STUDENTS' ASSOCIATION

On Friday, September 20, medical students from around the country joined more than 300,000 people at the Global Climate Strikes to draw attention to the potential adverse health consequences of climate change. Representatives from all of Australia's 22 medical schools unanimously voted to include "working collaboratively to minimise the health impacts of climate change" as a national advocacy priority for the Australian Medical Students' Association (AMSA).

> "It would be a disservice to Australians not to use our voice to call attention to a health issue that affects our future patients."

For some, it may seem that climate change and human health are two separate issues; it is easy to assume that the health of the environment is not an area in which medical students or doctors should be invested. However, the evidence is clear that climate change negatively affects health.

Beyond the science and data of climate change, we see its repercussions in our day-to-day lives; emergency room visits spiking during increasingly frequent and severe weather events, droughts affecting crop yields threatening our nation's food supplies, and heat-waves becoming hotter and longer. Australia is particularly susceptible to climate change which is why Australia's future doctors pushing for more to be done. Australia's ageing population is more vulnerable to extreme temperatures, our agricultural industries are threatened by water scarcity, and we have a high population density in flood zones, and located along the coasts. The climate change fall-out disproportionately affects rural and remote locations where resources, personnel and nearby support are already stretched too thinly, and may not be sufficiently adaptable to manage the climate crisis.

It would be a disservice to Australians not to use our voice to call attention to a health issue that affects our future patients.

AMSA is in good company advocating on this issue; in September, the Australian Medical Association declared climate change as a health emergency. In April 2019, we joined an open letter to all political parties, including Doctors for the Environment Australia, the Climate and Health Alliance, and the Royal Australian College of Physicians, emphasising the "significant and profound impacts climate change has on the health of people and our health system".

Being a doctor is more than diagnosing and treating illness: it is also about prevention. Medical students are taught from day one that prevention is better than cure. Climate change is a public health issue just like antibiotic resistance, smoking, or vaccination programs and the same preventive stance should be taken to limit further detrimental health effects of climate change.

AMSA has been advocating on climate change and its impact on health since 2014, as part of the AMSA Code Green advocacy project. Our advocacy extends far beyond calls to action and skipping classes to go to a march: we have partnered with *The Lancet* and made policy submissions to both Federal and State governments on climate change-related health effects.

In his statement to *The Australian*, Federal Education Minister Dan Tehan said: "What I'd like to see is medical students striking on a weekend about getting more doctors into remote Indigenous communities and rural and regional Australia".

Climate change and rural health are interlinked issues: the changing health landscape, including in response to water scarcity and major weather events, hit rural communities first, and worst.

Serendipitously, medical students did actually "strike on a weekend" for rural and regional Australia, at AMSA's annual Rural Health Summit (RHS) in Cairns on September 21-22. RHS actively celebrated the unique nature of medicine in rural Australia and supports medical students to pursue a career in this area. Medical students advocate on a plethora of issues in health and medical education. While I thank Minister Tehan for keeping rural health at the forefront of our minds, advocacy on one issue does not mean we can ignore another.

We are not only the future generation of doctors, but we are part of the future generation of Australians too. We call upon the Australian Government to seriously consider what tangible action they are going to take to mitigate climate-related health effects, and what they are willing to be held accountable for.

Clinical advocate or serving another master? (The lot of the public hospital Chief Medical Officer)

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

Before you read on, I want to be clear that I am not seeking to have an easy free kick, and I note not one size fits all: it's a big country. All of us employed to practice medicine in public hospitals understand the organisational complexity and the essentially guaranteed inadequacy of government funding support. In this context, I respect the truth that the Chief Medical Officer (CMO) community participate in those decisions which influence the deemed appropriate distribution of resources, improving general hospital performance and with the rest of us, striving for the delivery of the highest quality care for our patients.

> "I acknowledge here that to be successful, a CMO needs to build credibility on the administrative side to have sufficient influence for the benefit of patients and doctors."

But, and now the but, I do not want to experience a trend where CMOs cease to practice proper leadership of medical staff by no longer working collaboratively with other doctors about solutions and deciding direction. One becomes increasingly concerned if CMOs direct junior medical staff at orientation sessions not to apply for employment entitlements of overtime payments as compensation for such work in direct contravention of employment entitlements.

Academic literature has regularly published findings that the best performing hospitals have leaders who are doctors. I acknowledge here that to be successful, a CMO needs to build credibility on the administrative side to have sufficient influence for the benefit of patients and doctors. It is less clear that an administrative qualification per se is necessary or required for a CMO, as opposed to a CEO. When a doctor (with the right competencies and skill) is on the hospital's senior management team we all benefit from having a professional who 'gets' both sides of the equation and operates as an effective liaison between the two.

However, there are studies that show CMOs are now spending most of their time on the managerial aspects of their job, which greatly limits their time spent on clinical practice, teaching and/or research. While the CMO generally has some extent of a clinical background, offering opportunity for them to build trust and support among their medical colleagues, the role itself has a tendency to push the CMOs orientation away from being a clinical advocate to instead being a supporter or even agent of the hospital's 'party line'.

In my view, there is a degree of incompatibility between the CMO's need to maintain trust with medical staff and their (at least perceived) need to be a persuasive backer of managerial 'bean-counter' decisions. I don't suggest our CMOs have lost sight of the responsibility to patients and community. It just must be challenging to, on the one hand, be charged with implementation of public hospital priorities decided, often unilaterally, by our administrative masters and on the other, act as clinically independent public health and doctor advocate (however they learn of the hospital medical staff's view). I fear this tension is often resolved through the prism that we cannot expect optimum outcomes because we are in resource-poor public health. That is wrong; we always must press for the optimum!

So, rather than hospital executive teams requiring a CMO to show loyalty by choosing their (wrong?) side, I think we need to instead encourage CEOs to embrace their CMO's unique positioning and allow their CMO to properly balance their duties. This encouragement comes from how the CMO's freedoms and expectations are set by their employing hospital.

I recommend a good start is for a CMO's KPIs to centralise having both the express freedom to fearlessly advise their executive on medical workforce planning, clinical innovation and service development, and the clear expectation that they will always bring the voice of and fiercely advocate for their clinical colleagues at the table.

Preventing the CMO from becoming isolated and embracing their engagement with us will not only break down resistance to implementing necessary and useful change, but will contribute to not only improved performance (budget and patient related), and most importantly staff morale. Whatever we do, CMOs cannot be allowed to slip into apologists for managerial obstructionism.

Offering financial payment services

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

The AMA's Ethics and Medico-Legal Committee (EMLC) recently discussed whether it is ethically appropriate for a doctor to offer Afterpay (or similar) financial payment services in their medical practices.

Afterpay[1] is a payment service promoted as an alternative to credit. It charges retailers to offer customers interest-free instalment plans by splitting a purchase amount over four fortnightly instalments. The service is free to customers who pay on time, with no interest and no contracts. Unlike other payment products, Afterpay does not require customers to enter into a loan or credit facility or pay any upfront fees or interest.

Concerns have been raised that Afterpay (and similar services) derives much of its income from late payment penalties, largely driven by the fact it does not undertake credit checks and is generally used by younger people that may have limited financial literacy or capacity to pay.

The AMA contacted the Medical Board to obtain their views on doctors offering payment services such as Afterpay. In its guidance on financing schemes for doctors who provide cosmetic medical and surgical procedures, the Board states that doctors should not offer financing schemes to patients (other than credit card facilities), either directly or through a third party, such as loans, as part of the cosmetic medical or surgical services.[2,3]

The Board advises, however, that patients can use 'buy now, pay later' services such as Afterpay, Zip Pay, Openpay and ZipMoney as accepted payment methods for cosmetic medical and surgical procedures. So long as the doctor does not promote these products to patients, they can inform patients about funding options and accepted payment methods.

There is extensive uptake of payment services such as Afterpay which are driven by consumer demand – they are convenient and easy to access, and patients may increasingly expect their doctor to offer them.

But just because patients may want such a service, is it appropriate for doctors to offer it, knowing that there could be serious financial implications for some individuals, particularly those with poor financial literacy or who are otherwise unable to meet their repayments?

While such services are similar to offering credit card facilities, these services do not have the same checks and balances during application (which is likely part of their appeal) thus making them particularly attractive for those who do not wish, or are unable, to use a credit service.

But is it really a doctor's role to judge how a patient chooses to pay for their medical services? On the one hand the AMA is moving towards acknowledging that it is the right, and responsibility, of the community and governments to determine its positions over other ethical matters. On matters such as euthanasia and abortion, the weight of community sentiment is toward 'let us decide'. But with choice comes the burden of consequence. Is it then reasonable for the community to place the responsibility onto doctors to have a contrasting paternalistic role on matters such as this, and to take on the burden of blame, in matters relating to the financial independence of individuals, except where a doctor is knowingly complicit in situations where vulnerable patients are taken advantage of?

Certainly financial regulators, as instruments of government and therefore the community, must have a central role here.

So what can a doctor do to support patients in making decisions involving payment of medical services?

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New Chair of Medical Practice Committee

BY AMA VICE PRESIDENT DR CHRIS ZAPPALA

In my first article as the Chair of the Medical Practice Committee (MPC), I would like to focus on the recent developments in aged care. Aged care is one of MPC's primary areas of focus.

Unfortunately, the situation in the aged care sector has been deteriorating for several years. The current effort by the Government and others to restore a high level of care and dignified living for older Australians need not however wait for the Royal Commission report. There is much we can implement without delay.

The Royal Commission into Aged Care Quality and Safety was established by the Government in October 2018, with a mandate to look into the quality and safety of services provided to older Australians. This includes the systemic failures in the provision of services, mistreatment or abuse, dementia care, the role of government and aged care service providers in ensuring high quality care, and the sustainability of aged care into the future.

The Royal Commission has so far held a number of hearings, as well as community forums, attempting to obtain insights from the community, recipients of aged care services and their family members, aged care service providers and the Department of Health officials on the workings of the sector. The AMA has made extensive written and verbal submissions to the Commission.

The Commission has thus far uncovered systemic failures in care provision for our oldest and most vulnerable people. As the Commission's hearings were unfolding, additional evidence of those failures came from some of the cases reported by the media. Firstly, there was the case of closure of a residential facility in the Gold Coast, the Earl Heaven Retirement Village, which left 70 people stranded. A number of the frailest residents required transfer to hospital because no other suitable accommodation could be found.

Few could forget the cases of maggots being found in the ear and a head wound of elderly residents in BUPA facilities in Queensland and New South Wales, respectively. It is an astonishing disgrace that 43 non-compliance notices have been issued by the Aged Care Quality and Safety Commission to one of the largest for profit providers in Australia.

When I reflect on the experience of my grandmother in a residential aged care facility, I recall spartan nursing resources causing difficulties with medication timing and accuracy. The built facility was however very lovely and peaceful.

For a long time the AMA has been arguing that the health and aged care systems in Australia have been suffering from a lack of government support and resources, to the detriment of our older Australians. A growing ageing population with multiple complex chronic diseases, coupled with reductions in funding for aged care, have led to the almost daily failures we are witnessing as practitioners. This, when combined with low Medicare rebates for GPs working in residential facilities, and the declining number of registered nurses in aged care has conspired with other forces to allow standards of care to diminish and basic compassion be lost in some circumstances. Beginning down this pathway of inquiry few would have predicted the true extent of the isolation and travails being borne by some senior Australians. The Commission was clearly overdue.

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Along with our advocacy activities, AMA has been engaging with the Australian Aged Care Quality and Safety Commission, working on the development of the new clinical governance in aged care resources. We have argued for improved communication between doctors and residential aged care facility (RACF) staff, and for establishment of protocols with visiting practitioners around clinical responsibility. We have also strongly argued for greater accountability of aged care providers for failures in clinical care provision.

AMA has also been engaging with the Department of Health and Chief Medical Officer Professor Brendan Murphy around the appropriate use of restraints in aged care. The AMA maintains that the prime purpose of restraint should be the safety, wellbeing and dignity of the patient – it should only be prescribed when the potential risk of the patient not being restrained is higher than the harm caused by the restraint itself. It is our view that use of restraints in aged care could be further minimised by having sufficient numbers of trained staff available, and by having registered nurses available in RACFs 24/7. Introduction of a mandated (adequately-trained) staff-resident ratio would be an appropriate step in that direction. To that end, the AMA welcomed the recent announcement by the Queensland Government.

The MPC held its face to face meeting on 21 September. Significant portion of that meeting was dedicated to devising our future policy in aged care, including our future engagement with the Aged Care Quality and Safety Commission, optimisation of use of medicines for older Australians and the AMA's position on innovation needed in aged care to ensure its future sustainability and safety. Dr Melanie Wroth, Chief Clinical Advisor of the Aged Care Quality and Safety Commission presented at the meeting and discussed the Commission's work and expectation of future AMA involvement in the Commission's processes. It is worth noting that AMA was one of the strongest advocates for introduction of the Chief Clinical Advisor role with the Commission. Strong, enlightened medical leadership is a pre-requisite for any significant program of change in healthcare, as will hopefully occur in this sector.

As hard as the situation in aged care may be at the moment, I look forward to chairing the MPC through these challenging times for the sector. The AMA and the Medical Practice Committee have an important role to play in ensuring that the rights of older Australians are respected and that they enjoy the standard of living and compassionate clinical care they deserve. Older Australians have the right to age with dignity and to have services they require tailored to their needs. This also involves care provided by a general practitioner being appropriately remunerated to attend RACF. In my next column I look forward to talking to you about the other work stemming from our recent meeting, including AHPRA engagement, medication changes and of course the MBS Review.

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A doctor has a responsibility for ensuring that their patient is aware of his or her fees (which must be fair and reasonable) and for encouraging open discussion with their patients about health care costs. The doctor (or the doctor's representative such as practice staff) must facilitate informed financial consent to ensure patients understand and consent to the potential fees for medical services (there may be exceptions in emergency situations).[4] Where patients are concerned with their out-of-pocket costs for the medical service, they can discuss their concerns directly with their treating practitioner.[5]

And what about offering specific payment services? Doctors should not enter into an agreement with any financial service which creates a financial incentive to sell medical treatments or procedures. So long as a doctor does not use a financial service to take advantage of, coerce or induce patients to accepting treatments and procedures, the EMLC considers that a doctor should be able to decide for themselves what payment services they offer to patients.

What do you think? Send your views to ethics@ama.com.au

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1 Afterpay. How it Works. https://www.afterpay.com/en-AU/how-it-works

2 Medical Board of Australia. Information Sheet. *Cosmetic medical and surgical procedures – guidance on financing schemes, 13 May 2019.*

3 Medical Board of Australia. FAQs – Guidelines for Registered Medical Practitioners who perform cosmetic medical and surgical procedures https://www.medicalboard.gov.au/Codes-Guidelines-Policies/FAQ/FAQ-guidelines-for-cosmetic-procedures.aspx

4 *AMA Position Statement on Informed Financial Consent 2015.*

5 *AMA Position Statement on Setting Medical Fees and Billing Practices 2017.*

What makes DiTs satisfied at work?

BY DR HASHIM ADBEEN, DEPUTY CHAIR, AMA COUNCIL OF DOCTORS IN TRAINING

"The physical stress of a gruelling schedule combined with the knowledge that some hospitals do not rehire failed candidates, low exam frequency, and the financial costs, all contribute to huge stress that translate to mental exhaustion."

Being a Doctor in Training (DiT) in 2019 provides many exciting learning opportunities and can be a lot of fun. The ground-breaking technologies and treatments we have today lead to the improvement — and sometimes even cure — of our patients' ailments. The amazing feeling when a patient or family member is genuinely thankful ought to give us great job satisfaction and put a smile on our faces. But with the increasing external and internal job pressures, it is becoming harder to achieve fulfilment and maintain one's passion for medicine.

At a recent academic conference I attended, there was a break-out session on the all too familiar topic of Doctor Wellbeing. As the session went on, people listed the familiar perceived contributing factors: long work hours, rostering, exams, selection pathways, poor work life balance, bullying and harassment, and what I believe to be largely a deflection of systemic responsibility – personal resilience. While these are all important risk factors, I couldn't help but feel that the comments were just listing the problems.

In this article, I have taken a few of these issues and presented my thoughts and some simple solutions.

Doctors in training ... continued from p23

1. Exams

I sat my physician exams only this year. As we banded together in misery, I was acutely aware of my colleagues' wellbeing (or lack thereof) in the lead up. I saw first-hand how difficult it was for some people to secure normal shifts before the big day: some worked long nights, others busy rotations with excessive overtime. This meant barely a minute to study. Some had significant commitments outside of their working lives, such as looking after children. In the end, some of my colleagues failed, most passed, but all of us were left burnt out to some degree.

I question why it is so hard to get exam or professional development leave. Is it not more sensible to roster exam takers with reasonable and consistent shifts so that your body clock is not totally out of whack? The physical stress of a gruelling schedule combined with the knowledge that some hospitals do not rehire failed candidates, low exam frequency, and the financial costs, all contribute to huge stress that translate to mental exhaustion.

2. Selection into Training

Since about the second year of medical school, I have been well informed of the 'training pipeline bottleneck' and the 'medical student tsunami'. I was advised that I would have to work hard to get onto a training program. For many of us, this challenge is something we are willing to accept, after all we are not strangers to competitive processes.

More than the bottleneck itself, it is the parameters around the selection of candidates that is the real source of stress. For me, these parameters are the opaque selection processes with no or minimal feedback to unsuccessful candidates; marking criteria with disproportionate weight placed on non-clinical CV criteria that has little or no correlation to what makes a good clinician; the 'pre-interviews' that bias members of the selection panel; gender and family planning discrimination; and the new trend to limit the number of application attempts.

These selection processes lack uniform oversight and should be reviewed as part of the College accreditation process, which must also include the speciality Societies, to assure some level of standardisation and accountability.

3. Long work hours

I think most people who enter medical school expect long work hours to some degree. Medical television shows drum into us the life of a busy doctor – not that it is anywhere near as glamorous in reality.

The deeper I get in the medical muddle, however, the more I realise that it is not entirely the long hours themselves that are the issue – it's the drivers behind them. Where Dr Meredith Grey's day might be filled with patient contact exclusively, in my day it is the administrative burden that delays my clinical decision making; it is the inefficient processes that cause me to make more than five phone calls to organise a simple task; it is the battle between several specialties and facilities to organise a transfer for a patient desperately in need of service; it is the countless hours spent navigating multiple computer systems and software that do not communicate with each other; and it is the never-ending relearning of these different systems across units, hospitals, and health services. The absence of a simple thank you from hospital administration makes those long hours all the less bearable.

4. Rostering

We have all heard about that person who couldn't go to their close friend's or relative's wedding due to work (not to mention the stress of knowing if you can even attend your own!). For shift workers, rosters are released two weeks in advance. For me, that's not enough time to plan my life, whether it be for a wedding or just a day at the beach. The uncertainty takes a toll. While I deeply appreciate that rostering is no easy feat, I think it is one of the main contributors to job dissatisfaction.

To me, these systemic roster issues are extremely obvious. The magnitude of early roster release cannot be understated. Redundancy is necessary so that we can encourage DiTs to call in sick if they need to, or even take a mental health day. It is the first step in challenging our current toxic culture of 'presenteeism' at all costs.

DiT wellbeing has been a topic of discussion for over two decades. In my view, the answers have been in front of us for too long.

A rocky road ahead for the health system

Moving from the MBS review to implementation and insurer fee setting – what could possibly go wrong?

An MBS Review Forum organised by the AMA

As members would know, the AMA supported the concept of the Medicare Benefits Schedule (MBS) Review, provided it was clinician-led, because we believe in a system that reflects contemporary best practice.

Of course, like the rest of the profession, we wanted a contemporary system that provides for the innovations and improvements that have been made in medicine, and the opportunities that technological advancements can offer.

As we have repeatedly stated, any review must be one that is based on robust research and a strong evidence base. It also needs to be one that provides adequate patient rebates, so that we don't end up with a two-tier system – those who can afford treatment and those who can't.

The MBS Review – A recap

Back in 2015, the medical profession made a commitment to work with the MBS Review and the many Clinical Committees and Working Groups working under the Review Taskforce.

The medical professionals on the Clinical Committees and Working Groups provided considerable time, and expertise, to the promised task of modernising the MBS.

Throughout the Review, the AMA called for a review process that is transparent throughout its full lifespan. This included consultation and feedback on proposed implementation plans, consideration of the overall impacts on health funding, and an understanding of viable service delivery.

The AMA also called for the inclusion of clinicians who have the right experience – those who work with, and use, the MBS daily in private practice. The AMA continued to remind the Government that the MBS was an insurance scheme, not a mechanism to control the clinical judgement and the decision making of highly educated practitioners.

We called for the Review not to be a savings exercise, and for the establishment of a 'reinvestment fund' to ensure that every cent taken out of the MBS Review is reinvested in new and improved items. You can read about this in our budget submission and Federal Election campaign document.

A rocky road ahead for the health system

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Keeping an Eye on the Review

The AMA has also played a critical role in bringing together the profession to respond to the MBS Review. We held a meeting of all the Colleges, Associations, and Societies to discuss the MBS Review, including bringing Professor Bruce Robinson to present to us in Canberra.

We have published regular updates in *Australian Medicine*, and AMA communication channels, as well as a dedicated website, https://ama.com.au/mbs-reviews where you will find every one of the AMA's responses to the dozens of clinical committees.

Most recently, you will recall the President wrote to all Colleges, Associations, and Societies, and many members, calling for responses to the Specialist and Consultant Physician report.

This was in addition to a survey of our members on their views of the proposed changes.

Despite this extensive advocacy on behalf of, and with, the profession, there is no doubt that some of the decisions taken by the Government will be unpopular and appear to be designed with a focus of savings or compliance in mind. In discussing these publicly, either as an organisation or as individuals, it is important to understand ultimately, despite the efforts of the many clinicians on the many committees, the final decision on each change rests with the Government.

Better Communication

The MBS Review Taskforce recently sent a newsletter updating the profession about its activities. The September 2019 newsletter was the first since June 2017 – over a two-year gap. It's one of the 'asks' that the AMA has been calling for, for quite some time – more regular communications making transparent the work of the Taskforce.

Separate to that, the AMA has called for better fact sheets and education on the forthcoming MBS changes – pleasingly, the Department has now involved NPS MedicineWise to assist with this work. These materials are being refined, line by line, with feedback from the AMA.

There will now be a clearer explanation of what items are being deleted, what are being amended and what are new, and we hope soon an explanation of how the new fees relate to the old structure. They should also start to include examples of claiming, a quick reference guide, and far-easier-to-navigate formats and designs.

Implementation issues on the horizon

As with all important policy development, implementation is critical.

While actively participating in the MBS Review, the AMA has been lobbying the Minister and the Department about implementation concerns. We have repeatedly argued there needs to be adequate lead time for consultation with private health insurers, the relevant profession/s, peak bodies, and various compensation schemes.

This advocacy was rooted in real world experience. The AMA, as members know, has its own Fees List. When, last November, it came time to adapt to the new spinal MBS items (stemming from the Review) three things became apparent – firstly, that the changes were complex; secondly, practitioners, hospitals, and the insurance industry didn't have the information they needed to implement the fee and descriptor changes; and third, there was simply not enough time to adapt to them.

As a result, no insurer was ready at 1 November with their rebates. Practices and patients could not access rebates. Informed financial consent could not be carried out. The AMA, for its part, couldn't release its Fees List.

Equally troubling, it was not immediately apparent, based on the information released by the Department, how the old items and their fees relate to the new items and their schedule fees.

It is clear in talking to those involved with the MBS Review that there was deep, considered thought on how the old items should be streamlined and combined into new items. There was a clear methodology for how fees should be transitioned from old items (including taking into account the multiple services rule) to the new item structure. But none of this was publicly available to those who generate or set benefit schedules for the private

A rocky road ahead for the health system

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health system, nor to the AMA.

As a result, it is unsurprising that none of this was reflected in some insurers' rebates. Unsurprisingly with this confusion, cuts were made to some private health insurance rebates under the new structure, even where there was not a corresponding MBS cut.

It meant the careful deliberations of the MBS Review were not being realised, due to the difference in insurer fee setting responses. The MBS Review determined that some procedures are worth less, while others more. But this wasn't reflected in the real-world outcomes via insurer schedules.

The AMA Response

Since late 2018, the AMA has undertaken a sustained behind the scenes advocacy campaign.

The AMA wrote to, and met with, the Minister and his office on many occasions, as well as the Secretary of Health and the Department's Senior Executive Service. We called for the MBS and the PHI areas of the Department to come together to hold a forum for insurers, and for the Chair of the relevant Clinical Committee to spend the day going through the MBS changes. This was necessary so that insurers, practitioners, and hospitals could glean the information they need to translate the changes to their systems.

The most recent forum, held in September 2019, was the first time that such information has been conveyed by the Department as part of a new implementation and communication strategy.

While it was still too late to ensure we avoid all difficulties with the 1 November changes on the horizon, it is a step in the right direction.

Our advocacy will continue to call for this communication approach to be improved, before any more items are released. Without it, we risk confusion, inconsistent responses across the industry, increases and greater variation in out-of-pocket costs for our patients, and the carefully thought out design of the MBS Review being undermined.

It is for this reason have asked for a formal agreement between the AMA and the Department, outlining the information and timing we need to successfully implement wholescale MBS changes.

For our members, this additional information and time is critical in carrying out Informed Financial Consent, as per our guide.

Interestingly, it is one of the occasions where we have the support from the Private Health Insurers, and State and Territory workers compensation providers who are in the same predicament as the profession.

At the time of writing, the Government has not responded in agreeing to the new process. We are hopeful a response will be provided soon.

AMA Fees List Changes

While the AMA has been relentless in our pursuit of the right information at the right time to ensure that the AMA Fees List is ready at the same time as the new MBS item takes effect, we continue to be reliant upon the timelines set by the Department of Health.

We will work to have the AMA Fees List ready as soon as is possible after the MBS items take effect – but it is unlikely it will all be loaded by 1 November 2019. There is a significant volume of changed MBS items expected in anaesthesia, gastroenterology, diagnostic imaging, a new suite of eating disorder items for GPs, specialists and allied health providers, GP telehealth, and several other minor changes.

To better prepare the AMA for the tight timelines, and the considerable volume and expected complexity of the changes, the AMA has undertaken an extensive review of our AMA Fees List processes.

Over many meetings and with Federal Council approval, we have put in place a new Fees List Committee to provide governance of a rigorous, but streamlined, approval process and a new methodology for adaptation of the AMA Fees List.

The AMA has a deep knowledge of the Department's ongoing and increasingly comprehensive compliance activities targeted at those who may utilise MBS items outside of an item's descriptor, notes, or intent. The last thing we want is practitioners to breach MBS compliance rules by relying on an AMA item descriptor that differs from an MBS item one.

Because of this, the AMA Fees List, in an attempt to better inform members of these limitations within the MBS, will more closely align item descriptors, along with warning notes where we have identified restrictions in the corresponding MBS items with which we may disagree.

The AMA List will also try as far as possible to reflect the changes in the MBS item structure and fee relativities – while still setting a fair and independent fee suggestion via a robust methodology.

A rocky road ahead for the health system

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We are very aware that members find great value in the AMA Fees List providing a guide on what a fair fee to charge is for any particular MBS item – failure to adapt the AMA Fees List to a new MBS structure will make life harder for our members, something we wish to avoid.

At the same time, we will continue to ensure that the AMA Fees List represents a fair fee, without leading to excessive fee suggestions, noting the current prolonged media debate about medical fees.

Some MBS changes may not be reflected in the AMA list, and will be clearly marked, to indicate that the AMA does not support the change, and there may be some AMA items retained where there is now no corresponding MBS item.

Our move to an online platform two years ago means that we are now prepared to adapt the AMA Fees List as MBS Review changes roll out – the previous process of printing a physical book once a year would have rendered adapting to the constantly changing MBS a near impossibility.

Finally, in considering any changes to the AMA Fees List we will continue to engage with the relevant Society or Association before our Fees List Committee considers any change.

For the 1 November changes, we have been working closely with representatives from the Australian Society of Anaesthetists (ASA) and the Gastroenterological Society of Australia (GESA) to ensure that we have the anaesthetic and colonoscopy changes ready as close to 1 November as is possible.

Other speciality groups will be consulted on the other expected 1 November changes, including eating disorders, diagnostic imaging, sleep study, further spinal changes, ENT, reconstructive, urology, and cystic fibrosis.

However, these changes will not be able to be reflected in the AMA List in November and will follow anaesthesia and colonoscopy as closely as possible before the end of the year. Of course, our annual fee indexation will occur, ready for 1 November.

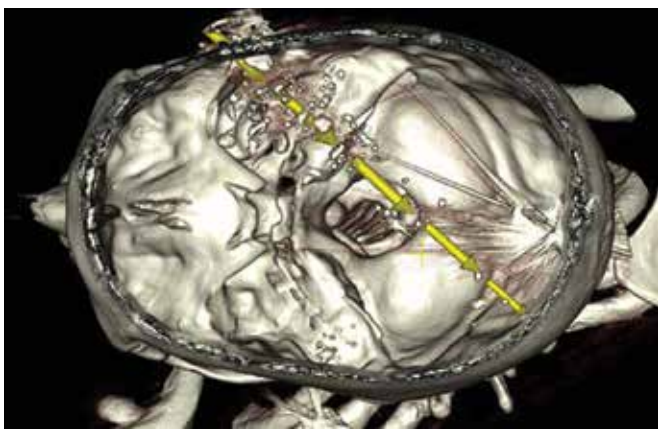
There is no doubt the next few years will be interesting ones as we seek to bed down this significant change.

LUKE TOY
AMA DIRECTOR MEDICAL PRACTICE

Research

WITH CHRIS JOHNSON

Forensic medicine research looks at ballistics



Monash University researchers are working on new technology using machine learning and augmented reality that could one day help forensic investigators track bullet paths in shooting victims.

If successful, it could fundamentally transform ballistics investigations in Australia and globally.

Monash University and the Victorian Institute of Forensic Medicine (VIFM) are collaborating with the State Coroner to develop this technology.

The project aims to use machine learning to create a digital 3D model of the human anatomy, including entry and exit wounds. This will allow investigators to record the trajectory of the projectile through the body, identify and localise projectile fragments, and may one day be able to assist in determination of projectile calibre and the range from which the projectile was fired.

With further development and industry support, it could also help investigators determine the type of gun used, and if the wounds were self-inflicted or resulting from attempted homicide.

"Ballistics in forensic medicine has traditionally involved fairly basic analytic techniques, which have not changed for a century," Associate Professor Richard Bassed, the Deputy Director of VIFM, said.

"Before we had CT imaging, we were using x-rays to produce a 2D view of someone's body, which made localising projectiles and fragments difficult without conducting an internal examination. Trajectory was determined using basic techniques such as long probes to determine a projectile's path.

"Current imaging techniques can't differentiate between bullet fragments and foreign metal objects, such as a pacemaker or dental fillings.

"This technology will allow us to make a 3D digital reconstruction of a shooting victim that we can then slice in multiple planes and directions using advanced computer graphics, including the use of augmented reality. We can then apply machine learning to determine trajectory and projectile fragmentation, and create a 3D-printed model that can potentially be used as evidence in a court of law."

Information technology and biomedical research company Leidos has contributed $150,000 to the project. This contribution was made possible through the Monash Institute of Medical Engineering.

Tear drop testing might help diabetics

Tear samples might be the next screening method used for diabetic peripheral neuropathy, new research from UNSW Sydney suggests.

The study, recently published in *The Ocular Surface*, is the first to show that peripheral nerve damage – often the earliest sign of the condition – can be traced in tear film.

Diabetic peripheral neuropathy is a debilitating condition that affects people with diabetes. It is the most common complication of diabetes and affects almost 50 per cent of diabetics. It occurs when chronically high blood sugar damages the nerves connecting the brain and spinal cord to the rest of the body.

Symptoms include pain, numbness, imbalance, weakness, pins and needles, and recurring foot ulcers.

"We found that people with type 1 diabetic peripheral neuropathy – which can result in recurring ulcers of the feet and in severe cases require amputation – have reduced levels of a protein known as 'substance P' in their tear film," said Dr Maria Markoulli, senior author of the study.

Research

"Peripheral neuropathy is notoriously difficult to detect early on and requires specialty training.

"What we're proposing with this method is something that will be done quickly, non-invasively, and potentially could be done even by a non-specialist."

The researchers tested the concentration of two proteins (called neuropeptides) in the tear film of people with type 1 and type 2 diabetes compared to control groups. The study consisted of almost 100 participants.

While the researchers found that those with type 1 diabetic peripheral neuropathy had less 'substance P' protein in their tear film, the results did not suggest that type 2 diabetes have the same biomarkers.

While the results are promising for those with type 1 diabetes, further study is required before tear testing becomes available clinically. In particular, the researchers hope to study substance P loss over time according to varying severities of peripheral neuropathy.

Sea sponge in the fight against TB

An Australian sea sponge could hold the key to successfully combatting the deadly disease tuberculosis (TB), a new study from the Centenary Institute and the University of Sydney suggests.

Reported in the journal *Nature Scientific Reports*, the sea sponge was found to contain an exceptionally potent anti-bacterial agent able to inhibit *Mycobacterium tuberculosis*–the bacteria that causes TB in humans.

Every year more than 10 million people fall ill with TB and 1.8 million die from the disease. The new finding has the potential to open-up a new avenue of research to target what is the world's top infectious disease killer.

"TB is a major global health problem and our battle against this resilient and deadly disease is incredibly difficult," said the study's lead author Dr Diana Quan.

"Effective antibiotics for TB are difficult to develop, there are constant issues with new drug-resistant TB strains and our current treatment approach for TB is both lengthy and complicated," she said.

"There is an urgent need for new drugs and antibiotics which can shorten and simplify TB treatment in order to combat this burgeoning TB pandemic."

Photo credit: Australian Institute of Marine Science

Marine samples being collected

In the reported study, a sea sponge from the Tedaniidae family was examined by Dr Quan and found to yield compounds that displayed strong inhibitory potency against TB and also importantly, against drug-resistant strains of the disease. Following analysis, the active component from the sponge was identified as bengamide B which was also found to be non-toxic when tested against human cell lines.

"This is an extremely exciting finding," said Dr Quan.

"Bengamide B shows significant potential as a new class of compound for the treatment of tuberculosis and also importantly, for the treatment of drug-resistant TB which is an ever increasing obstacle to TB eradication around the world."

The sea sponge was harvested off the Queensland coast and was one of approximately 1,500 different marine samples tested by Dr Quan for possible effectiveness against TB over the course of a three-year program.

"Throughout history, the vast majority of antibiotics have been sourced from nature. In the search for new TB drugs, the marine environment offers a promising and largely untapped source of potential targets due to its amazingly potent biodiversity," said Dr Quan.

World News

WITH CHRIS JOHNSON

WHO Regional Committee gathers in the Philippines

Health ministers and senior officials representing 37 countries and areas across Asia and the Pacific met in Manila during the first week of October to agree on priorities for the work of the World Health Organisation (WHO) in the Western Pacific Region.

They agreed the priorities for WHO's work in the region over the coming five years should have the goal of making the Western Pacific the world's healthiest and safest region.

The WHO Regional Committee for the Western Pacific today endorsed *For the Future: Towards the Healthiest and Safest Region* – a policy paper developed by Regional Director Dr Takeshi Kasai and his team, in extensive consultations with Member States, partners and WHO staff, to respond to current and future health challenges in the Region.

The 70th session of the WHO Regional Committee for the Western Pacific is the first under the leadership of Regional Director Dr Takeshi Kasai, who started a five-year term in February this year.

Delegates discussed and endorsed For the Future: Towards the Healthiest and Safest Region – a policy paper developed by Dr Kasai and his team, in extensive consultations with member States, partners and WHO staff, to respond to current and future health challenges in the Region.

"Some of the challenges we face are significant, but they are not insurmountable. I truly believe that by embracing new possibilities, and acting today to address the problems of tomorrow, we can turn challenges into shared opportunities," Dr Kasai said.

"I look forward to working with all of you, to make the Western Pacific the healthiest and safest region in the world."

"In the many conversations I've had since February with leaders, partners, health workers, and people in communities across the region, three key messages have emerged. First, while we should continue what we are doing well, we cannot stand still. Our region is extremely dynamic, and rapidly changing. To stay relevant and valuable, WHO must also keep changing, and stay ahead of the curve.

"Second, member States greatly value the direct, tailored support WHO provides. While countries have many challenges in common, each is unique. We are committed to continuing to provide support to every country for their specific priorities.

"Third, it's clear that we need to focus on the most pressing health challenges of the future. We will work with countries to 'future-proof' their health systems. This requires new thinking and new ways of working."

Delegates also reached decisions on: protecting children from the harmful impact of food marketing; action to fight antimicrobial resistance; tobacco control; and promoting well-being into older age.

In addition, the Regional Committee discussed progress in a number of regional programs, including health security, noncommunicable diseases and mental health, and climate change. Progress on efforts towards the elimination of measles and rubella, combating HIV, viral hepatitis and sexually transmitted infections, ending tuberculosis' and reducing newborn deaths in the region was also gauged.

WHO Director-General Dr Tedros Adhanom Ghebreyesus also addressed the gathering.

"Your region is incredibly diverse, and so is the range of challenges you face," he said.

"WHO is committed – and I am personally committed – to working with each country, rich and poor, small and large, to promote health, keep your people safe, and serve the vulnerable. Every country matters, because every person matters."

World News

Tiny Pacific nation eliminates lymphatic filariasis

Kiribati has eliminated lymphatic filariasis as a public health problem. The Pacific island nation joins 11 other countries and areas in the World Health Organisation (WHO) Western Pacific Region to have defeated the disfiguring tropical disease.

WHO Regional Director for the Western Pacific Dr Takeshi Kasai presented a plaque and certificate to Kiribati Minister of Health and Medical Services Mr Tauanei Marea.

"Congratulations to Kiribati on eliminating lymphatic filariasis as a public health problem," said Dr Kasai.

"Years of effort by the Kiribati Ministry of Health and Medical Services, supported by the Japan International Cooperation Agency (JICA), the Korea Centers for Disease Control and Prevention (KCDC), the Pacific Community (SPC) and WHO, as well as donations of medicines from pharmaceutical partners, have made this landmark achievement possible."

Lymphatic filariasis is a mosquito-borne, parasitic disease that can affect the lymphatic system and lead to abnormal enlargement of body parts. It can cause pain and lead to permanent disfigurement and severe disability, often resulting in people losing their livelihood and suffering from stigma, anxiety and depression.

Lymphatic filariasis is one of 15 neglected tropical diseases that are endemic in the WHO Western Pacific Region. It is spread when mosquitoes bite an infected person, then transmit the parasite to other people through subsequent bites. When lymphatic filariasis develops into a chronic condition, it can cause lymphedema (tissue swelling) or elephantiasis (skin/tissue thickening) of the limbs and, in men, hydrocele (scrotal swelling).

Stopping the spread of the infection is the only way to eliminate lymphatic filariasis. This is done by mass administration of medicines – giving an annual dose to the entire at-risk population.

Kiribati is made up of 32 atolls and one raised coral island scattered over 3.5 million square kilometres in the Pacific Ocean. The geographical challenges did not dampen Kiribati's desire to eliminate lymphatic filariasis. With support from international development and pharmaceutical partners, the country began robust disease surveillance and mass drug administration in 2000.

Alongside prevention and elimination efforts, Kiribati has been working to ensure all people already living with lymphatic filariasis receive the medical care they need. By establishing a national morbidity register, the country was able to manage patient records. Kiribati also promoted home-based care whereby patients are empowered to manage their illness with the help of trained health workers, so chronic lymphedema is properly treated. All men with hydrocele received consultation and surgery if warranted.

"This is a success story for health in Kiribati," said Minister Marea.

"This great achievement was only possible with collective efforts of dedicated health workers together with support from WHO and other partners. We will look after the few remaining patients who unfortunately acquired the disease before we started our preventive treatment campaign, and we will never allow filariasis to regain a foothold in the country."

World News

Rubella offer being ignored in Japan

The Japanese government is in the middle of a concerted effort to raise awareness of a rubella outbreak in the country, and is offering free antibody tests for the most vulnerable demographic.

Yet despite this push, the test offer is being largely ignored.

Japan's Health, Labor and Welfare Ministry has made tests for rubella antibodies and the rubella vaccination free to men aged between 40 and 57, the most likely to be infected group.

But, according to reports in the *Japan Times*, only about eight per cent of the first group of these targeted men (40-47) have taken up the offer. The coupons the men could use for three years are barely being used, despite having all been distributed.

According to data published in the *Times*, the number of rubella cases in Japan declined for four consecutive years to a low of 91 in 2017. In 2018, however, the number of cases jumped to 2,946. To date this year, there were 2,196 cases nationwide. Most of the patients are men in their 30s to 50s who did not receive vaccinations as children.

Only 8.4 per cent of the targeted men, or 544,315 people, have undergone testing, while about 1.5 per cent, or 97,265 people, received shots between April and July.

The offer is set to expire at the end of the 2021 fiscal year.

"The hurdle remains high because the men in the targeted age range are prime-age workers, so it is difficult for them to find time to do it," ministry official Takuma Kato is reported as saying.

The government is urging companies to include the antibody test using the coupons in their regular workplace medical examinations. The aim of the government is to eliminate the infections by the end of fiscal year 2020. It is working to further increase awareness through a highly visible campaign.

No-deal Brexit prospect a worry for UK doctors

The British Medical Association has responded to the UK Government's No-Deal Readiness Report, which outlines what will change should no Brexit agreement be reached by October 31.

BMA council chair Dr Chaand Nagpaul, said that with very little time until 'Brexit Day" there were many questions left unanswered.

"There's no sign of who is going to provide an emergency transport service for critical medicines and medical supplies, or extra freight capacity to guarantee that patients can continue to get the drugs they need in the event of a no-deal," Dr Nagpaul said.

"Overall, this document underlines the sheer scale of the task at hand, with almost no area of industry and society unaffected, not least the NHS and the health of the United Kingdom.

"More worryingly, there are still many unanswered questions over the Government's no-deal immigration plans for EU citizens and those who employ them – including the NHS.

"Hundreds of thousands of Britons who receive healthcare in the EU also face ongoing uncertainty about how, or even if, their healthcare costs will be covered after a no-deal Brexit, leaving the real risk of large numbers returning to use the NHS just as it braces for winter.

"And in Northern Ireland, the ongoing lack of clarity over border arrangements means there's still no certainty for doctors or patients both there and in the Republic of Ireland.

"Given what's at stake, no-deal must be avoided to protect the nation's health."

World News

American doctors talk vaping with e-commerce owners

The American Medical Association has sent letters to the chief executive officers of five of the US's leading social media and e-commerce sites, urging them to help keep illicit vaping products off their platforms.

Through the letter, the Association called on these companies to remain vigilant against the sale of items used to create counterfeit vaping products, such as empty vaping cartridges. The letter was sent to the CEOs of Amazon, Facebook, Instagram, LinkedIn, and Microsoft.

"It is time for e-commerce companies to take action to ban the sale of materials fueling the counterfeit vaping crisis. We urge you to actively enforce your existing policies to keep illicit products off the market and out of the hands of people who are, often unwittingly, putting their lives at risk. Given the pace at which vaping-related lung illness is expanding, there is no time to waste," said the Association's CEO and Executive Vice President James L. Madara, M.D.

The letter states that amid growing concern over serious lung injuries linked to vaping, the American Medical Association (AMA) believes those who maintain the nation's leading e-commerce sites must vigorously enforce their existing policies to keep illicit vaping products off their platforms.

"At the same time, we urge you to remain vigilant against the sale of items used to create counterfeit vaping products, such as empty vaping cartridges," Dr Madara wrote.

"The rapid growth of vaping-related lung illness is frightening in scope and unexplained in nature. The U.S. Centers for Disease Control and Prevention (CDC) states that, as of Oct. 1, 1,080 confirmed and probable cases have been reported in 48 states, along with 18 deaths. Clearly, the problem is escalating.

"While the search for a definitive cause continues, the AMA believes steps must be taken now to rein in this problem. As documented recently in the Wall Street Journal, the internet is an abundant source for illicit, and in some cases illegal, vaping materials and devices. Multiple e-commerce sites also offer packaging for fill-your-own vaping cartridges that are nearly indistinguishable from legitimate products manufactured by established companies.

"We urge you, as leaders of large technology platforms, to ensure that existing policies that ban the sale or transfer of illicit items (such as vaping products that contain THC) are enforced."

World News

Mistreatment during childbirth in some countries

New evidence from a World Health Organisation study published in the *Lancet* shows that more than one-third of women in four lower-income countries experienced mistreatment during childbirth in health facilities.

Younger, less-educated women were found to be the most at risk of mistreatment, which can include physical and verbal abuse, stigmatisation and discrimination, medical procedures conducted without their consent, use of force during procedures, and abandonment or neglect by health care workers.

The study, carried out in Ghana, Guinea, Myanmar and Nigeria, found that 838 (42 per cent) of 2,016 women experienced physical or verbal abuse, stigma or discrimination. Fourteen per cent experienced physical abuse – most commonly being slapped, hit or punched. There were also high rates of non-consensual caesarean sections, episiotomies and vaginal examinations.

WHO guidelines promote respectful maternity care for all women, which is care that maintains 'dignity, privacy and confidentiality, ensures freedom from harm and mistreatment, and enables informed choice and continuous support during labour and childbirth'.

The study observed 2,016 women during labour and childbirth in Ghana, Guinea, Myanmar. Interviews were also conducted with 2,672 women after the birth, finding similar levels of mistreatment to the direct observations.

Among the 2016 women observed by the researchers, 35 (13 per cent) caesarean births were conducted without the woman's consent, as were 190 of 253 episiotomies (75 per cent). Vaginal examinations occurred without consent in 59 per cent of cases (2611 of 4393 exams).

In addition to physical abuse, 752 (38 per cent) of the 2016 women were observed to experience high levels of verbal abuse – most often, being shouted at, scolded and mocked. Eleven women experienced stigma or discrimination, typically regarding their race or ethnicity.

WHO has called on professional associations to collaborate to ensure that mistreatment during childbirth is consistently identified and reported, and that locally appropriate measures are implemented.

World News

Too many people worldwide needlessly living with vision problems

More than one billion people worldwide are living with vision impairment because they do not get the care they need for conditions like short and far sightedness, glaucoma and cataract, according to the first world report on vision issued by the World Health Organisation.

The report, launched ahead of World Sight Day on October 10, found that ageing populations, changing lifestyles and limited access to eye care, particularly in low- and middle-income countries, are among the main drivers of the rising numbers of people living with vision impairment.

"Eye conditions and vision impairment are widespread, and far too often they still go untreated," said WHO Director-General Dr Tedros Adhanom Ghebreyesus.

"People who need eye care must be able to receive quality interventions without suffering financial hardship. Including eye care in national health plans and essential packages of care is an important part of every country's journey towards universal health coverage.

World News

Too many people living with vision problems ... continued from p32

"It is unacceptable that 65 million people are blind or have impaired sight when their vision could have been corrected overnight with a cataract operation, or that over 800 million struggle in everyday activities because they lack access to a pair of glasses."

Globally, at least 2.2 billion people have a vision impairment or blindness, of whom at least 1 billion have a vision impairment that could have been prevented or has yet to be addressed.

Other main findings of the report include:

- The burden of eye conditions and vision impairment is not borne equally: it is often far greater in people living in rural areas, those with low incomes, women, older people, people with disabilities, ethnic minorities and indigenous populations.
- The unmet need of distance vision impairment in low- and middle-income regions is estimated to be four times higher than in high-income regions.
- Low- and middle-income regions of western and eastern sub-Saharan Africa and South Asia have rates of blindness that are eight times higher than in all high-income countries. Rates of cataract and trachomatous trichiasis are higher among women, particularly in low- and middle-income countries.
- US$14.3 billion is needed to address the backlog of one billion people living with vision impairment or blindness due to short and far sightedness, and cataracts.

Eye conditions that can cause vision impairment and blindness – such as cataract, trachoma and refractive error – are the main focus of most countries' national prevention and other eye care strategies. But eye conditions that do not typically impair vision, including dry eye and conjunctivitis, must not be overlooked as they are among the main reasons for people to seek eye health care services in all countries, the report states.

The combination of a growing and ageing population will significantly increase the total number of people with eye conditions and vision impairment, since prevalence increases with age.

Other main drivers of the most common eye conditions include:

- Myopia (near-sightedness): Increased time spent indoors and increased "near work" activities are leading to more people suffering from myopia. Increased outdoor time can reduce this risk.
- Diabetic retinopathy: increasing numbers of people are living with diabetes, particularly Type 2, which can impact vision if not detected and treated. Nearly all people with diabetes will have some form of retinopathy in their lifetimes. Routine eye checks and good diabetes control can protect people's vision from this condition.
- Late detection: Due to weak or poorly integrated eye care services, many people lack access to routine checks that can detect conditions and lead to the delivery of appropriate preventive care or treatment.

Stronger integration of eye care is needed within national health services, including at primary health care level, to ensure that the eye care needs of more people are addressed, including through prevention, early detection, treatment and rehabilitation, the report found.

The report states that all people living with blindness and severe vision impairment who cannot be treated are still able to lead independent lives if they access rehabilitation services. Options include optical magnifiers and reading use Braille, to smartphone wayfinders and orientation and mobility training with white canes.

The full report can be found at:

https://apps.who.int/iris/bitstream/handle/10665/328717/9789241516570-eng.pdf

World News

Overseas transplants come with complications

More than a quarter of patients returning to Australia after receiving an organ transplantation overseas will experience complications, including bacterial and viral infections, according to research published in the *Medical Journal of Australia*.

Until now, data about Australians going overseas for organ transplantation has been hard to come by, according to the authors of the research, led by Professor Toby Coates, Professor of Medicine-Transplantation at the University of Adelaide's Royal Adelaide Hospital campus.

"In contrast to transplantations performed in Australia, there is no systematic registration of Australian patients who have received a transplant overseas and no specific mechanism for collecting data on such patients," Professor Coates and colleagues wrote.

The authors distributed a survey to all 540 registered Australian nephrologists and transplant physicians and surgeons through the Transplantation Society of Australia and New Zealand (TSANZ) and the Australia and New Zealand Society of Nephrology (ANZSN).

They asked for information about patients who had considered or actually travelled overseas for transplantation (kidney or other organ). Secondary outcomes included their characteristics, subsequent medical complications, and a comparison of our data with data on overseas transplantations in the Australia and New Zealand Dialysis and Transplant Registry (ANZDATA) registry.

"Most responders (133, or 68 per cent) reported having discussed overseas travel for transplantation with at least one patient, and 105 (53 per cent) had cared for at least one patient after an overseas transplantation," Professor Coates said.

"For the 129 reported overseas transplantations (including 121 kidney transplantations) during 1980–2018, China (40, or 31 per cent), India (10, 16 per cent), and Pakistan (11, 9 per cent) were the most frequent destinations.

Most organ recipients were born in countries other than Australia (119, 93 per cent); 50 were transplanted in their countries of birth (39 per cent).

"Complications following overseas transplantation were frequent, including bacterial and viral infections (33 patients, 26 per cent)."

The authors pointed out that people who travel overseas for organ transplantation may acquire organs by gaining access to local waiting lists for organs from deceased donors, by receiving an organ from a related or unrelated living donor, or through illegal organ trading.

"International travel for transplantation sometimes involves illegal activities, such as trafficking in organs or trafficking in humans for organ removal," they wrote.

"Our findings suggest that routine reporting of these events needs to be improved in order to collect detailed data on factors that influence such activity and facilitate international travel for obtaining organ transplants, as well as about the choice of destination and the outcomes of overseas transplantation.

"More systematic data collection could provide information for informing strategies that support clinicians and patients when making decisions about overseas travel for organ transplantation and care for people who intend to or have travelled abroad for this purpose."

The 2019 Mitsubishi Pajero

BY DR CLIVE FRASER

In 1983, Mitsubishi released in Australia its yet-to-be-iconic Pajero.

Named after a South American Pampas cat, there were unfortunate Spanish translations of the word Pajero which did lead to it being known as a Montero in Spanish speaking markets, including the US.

The first version was powered by the same 2.6 litre four-cylinder motor found in my 1980 GH Chrysler Sigma and there was also a 2.3 litre turbo charged diesel.

Initially all Pajeros had only a 5-speed manual transmission.

The durability of the Pajero was highlighted by its competitiveness in the Paris to Dakar Rally with a first place in 1985 and 11 more first places thereafter.

Incremental improvements over the next three generations have produced a vehicle with exceptional reliability.

I've heard of Pajeros with 400,000 kilometres on the clock with original running gear which are still going strong.

The current Fourth Generation Pajero has been around since 2006 which does leave it looking a little long in the tooth.

That doesn't seem to bother fans who see its unchanging nature as a positive.

Mitsubishi developed its Super-Select four-wheel drive system with four modes selectable by a lever next to the gear shift.

Firstly there's 2H which disconnects drive from the front axle essentially making the vehicle rear-wheel drive.

Drive train noise is reduced and fuel economy is improved in this mode.

Next there is 4H which connects the front axle via a viscous-coupled centre differential.

Traction improves in this mode which can be selected on-the-fly if needed.

Then there is 4HLc which locks the centre differential and 4LLc which offers low-range for traditional four-wheel drive capability.

My 1990s experience of Super-Select did leave me with that binding feeling which isn't detectable in the current model.

Whilst smaller than a Toyota Land Cruiser and a Nissan Patrol the Mitsubishi Pajero is still rated to tow up to 3,000kg which is exactly why my colleague bought it.

You see he has a tinny that weighs 1,500kg and the Pajero is perfectly suited to pulling that sort of weight up a slippery boat ramp.

When towing Mitsubishi does recommend fourth gear and 4H.

I did notice things went better if I manually down-shifted into third on steep inclines and I do wonder how things would fare with double the load.

That all reminds me that when choosing a towing vehicle it is much better to avoid being at the vehicle's limit particularly as fuel and other gear invariably increases the weight of the load.

Mitsubishi was caught out in 2016 falsifying fuel economy figures.

They admitted they'd be doing this for 25 years.

The Pajero is rated at 9 L/100km on the combined cycle, but I can produce a verified fuel economy figure of 19.3 L/100km with the aforementioned boat under tow on the highway from Hervey Bay to the Sunshine Coast.

Whilst I'd like the rear parking sensors on the GLS I feel that I can manage without the automatic headlights, rain-sensing wipers, sub-woofer, chrome door handles, and electric heated front seats which add $7,000 to its price.

At $49,990 the 2019 Pajero GLX is well-priced, robust and competent.

If you shop around you can expect to take at least another $7,000 off that price by buying a demo with very few kilometres.

I think the Pajero will be around for a while.

Safe motoring,

Doctor Clive Fraser

doctorclivefraser@hotmail.com

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