

A U S T R A L I A N

Medicine

The national news publication of the Australian Medical Association

Clarity please

It's been six months since the election, p3

INSIDE

Keeping focus on PHI, p4

Rural GP Pathway, p5

Commitment delivery, p7

Payroll tax case, p9

Indigenous health funds, p14

Violence against medics, p29



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

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AMA LEADERSHIP TEAM



President
Dr Tony Bartone



Vice President
Dr Chris Zappala

In this issue

National News 3, 8-13

Health on the Hill 14

Research 24-28

World News 29-35

Columns

- 4 PRESIDENT'S MESSAGE
- 5 VICE PRESIDENT'S MESSAGE
- 7 SECRETARY GENERAL'S MESSAGE
- 15 GENERAL PRACTICE
- 16 PUBLIC HEALTH OPINION
- 18 RURAL HEALTH
- 19 DOCTORS IN TRAINING
- 20 AMSA
- 21 PRIVATE SPECIALIST PRACTICE
- 22 FINANCE AND ECONOMICS
- 23 INDIGENOUS TASKFORCE
- 35 MOTORING
- 36 MEMBER SERVICES

Government must do better

AMA President Dr Tony Bartone is putting the Federal Government on notice, saying it has had long enough since being re-elected in May, to deliver a clear way forward for the nation's health system.

The AMA Federal Council gathered in Canberra on November 15 and 16 to discuss policy and set priorities for the months ahead.

Dr Bartone got the meeting off to a strong start by comparing the high level of advocacy and policy work of the AMA to what he described as a lack of "overarching vision and strategy" from the Government.

"We are now six months post-election," he said.

"Clearly, in that six months there has been an enormous amount of activity that's gone up on the Hill and through the Department... in trying to coordinate a way forward.

"Frenetic activity. Poorly coordinated activity, you might say.

"There are three major taskforces that Health Minister Greg Hunt has convened – one on prevention, one on mental health, and one on primary care. They are all likely to report back in the next 12 months.

"Unfortunately, in all of that activity there is still not a clear sense of direction, and no clear sense of additional funding formula that is going to underpin all of these three missions plus more."

Dr Bartone noted that he was the common denominator on all three taskforces when it came to advocacy representation.

But he added that being asked to sit on a committee or chair a taskforce was not enough of an indication that the Government is committed to delivering outcomes.

"I believe we are being potentially stakeholder managed," Dr Bartone said.

"What do I mean by that? I mean we are being put into all the right places ... but there is no clear sense that all of this activity will lead to meaningful strategic investment and the alignment of policy framework.

"That puts me in a rather difficult situation whereby I have indicated that I am not happy. I'm not happy with the lack of clarity that's coming through and it's obviously going to be a major point of conversation between the Minister and me over the next month."

Dr Bartone said in order for the AMA to increase pressure on



the Government, it needed to be clear about what is needed to improve the health system.

He said a lot of that work had been done with the AMA's reports and advocacy on public hospitals, private health insurance, and aged care, to name just a few issues.

"We need to crystallise what I see is a lack of overarching vision and policy from Government," he said.

"If I'm going to, on your behalf, call out the lack of direction by Government, it is really, I believe, imperative on us to really articulate what we believe is needed."

Dr Bartone said the AMA would be ramping up its advocacy even further very early next year.

He said the election priorities the AMA outlined during the federal election campaign should already be in play.

"I would really like to have that vision in terms of the advocacy we have outlined ... and see some action from the Government early next year," he said.

"What we've got now is a lot of separate problems and some work being done towards solutions, rather than an overarching direction.

"We need an indication of meaningful investment in health."

On aged care specifically, Dr Bartone said: "Something's got to give and give soon, because it's getting worse."

CHRIS JOHNSON



Keeping the focus on PHI until it's fixed

BY AMA PRESIDENT DR TONY BARTONE

Recently, on behalf of the entire AMA, I released our Private Health Insurance Report Card for 2019.

Despite its release on what eventually turned out to be a crowded health news day (the release of the Mental Health Productivity Commission Report and the interim Aged Care Royal Commission report also were released same day), the Report Card was the subject of significant media attention reflecting the fundamentally pivotal timing that is facing one of the key pillars of our health system.

The AMA has recently begun preparing this report every year to try and focus on improving the clarity and transparency required for patients to better understand what is, despite the recent changes, still quite a complex sector. Our Report Card tries to address some of the issues that remain in private health insurance. The Report Card allows insurance products offered to be compared, uniquely providing the cut-through to the complexity of the multiple products on offer.

In this Report Card, I have referred to private health insurance (PHI) as being on a precipice. PHI is on a precipice because of diminishing affordability, diminishing transparency and a lack of clarity.

What we have seen over the last four years is an increasing proportion of the population making the decision to opt out of private health insurance. The large majority of those opting out are young people. That has a twofold effect. Not only does it mean that premiums will continue to increase because the insurance pool becomes smaller, but it also creates a pool of higher risk people to cover – older Australians with more complex and chronic disease, which requires more expensive treatment.

But we need to remember and emphasise the importance of PHI to our overall health system. It is an important point to remember that 60 per cent of elective surgery today occurs in the private health system. And if that private health system is no longer robust and sustainable, it is all going to rebound back onto the public system. The public system is one of the best systems in the world, but it's under stress. It is doing it really tough with insufficient resources, and any further burden on the public system will only create further delays and further impact on access and equity.

We need to address affordability in PHI now. We need to ensure that more people maintain that decision to stay covered. We need to increase the attractiveness of PHI, especially for the young.

When I say we, I am talking about all the stakeholders involved. The insurers have a massive responsibility to ensure that they are providing transparent and value-for-money products. They need to ensure that they return more of the premiums they collect to the members they cover. They need to ensure that less of the premiums they collect are spent on administration and marketing and, for some, excessive returns to shareholders. They haven't been too good at convincing Australians that they are providing that.

The Government has a responsibility to ensure it happens. Governments need to also bring the MBS rebate in line with the cost of providing care. Is it any wonder that consumers are having to pay more for services and for the delivery of care when the MBS and the allied private health insurance rebate aren't contributing to that cost?

Young people make a decision based on the value of the product, the usability of the product, and the cost of the product. At the moment, the cost of PHI is far too excessive in comparison to their perceived need or use. We have a world class public hospital system they can rely on in case of emergency, and they run the risk on their belief that they will not fall ill now.

We need to ensure that insurance affordability is brought back and that can only happen through a suite of Government measures, as well as the private health insurers returning more of members' premiums in the form of payouts. Cost pressures on premiums must continue to abate, rather than increase faster than the rate of inflation.

If this can happen – if the PHI sector does the right thing and if the Government steps up and insists on it – then we can create a future-proofed viable system that allows that symbiotic relationship between public and private to continue to underpin our world class hospital system that we have here in Australia.

Let's see how serious the Government is about fixing this problem. The future of our healthcare system and the health of all Australians depends on getting this right – and very soon.



National Rural GP Pathway is a good part of the maldistribution solution, but more is required

BY AMA VICE PRESIDENT DR CHRIS ZAPPALA

“The appointment and work of rural GPs in hospitals is easy and the remuneration for this work is equivalent to senior medical officer salary for any specialist working in a metropolitan hospital.”

The immense success of the Queensland rural generalist program is noteworthy, particular given its humble and hopeful genesis. People will hopefully be aware that around a decade ago this specific training program commenced, funded by the Queensland Government, that produced rural GPs who have progressively permeated throughout regional/rural Queensland.

Many of the previously mooted disjointed role substitution models and other stresses within the profession relate to attempted compensation for the maldistribution of doctors i.e. they are borne from workforce inadequacies. It is therefore critical we solve this problem. Not only will a more balanced workforce help our patients and improve health outcomes, it can also facilitate doctors to evolve models of care that increase the resilience of the profession.

It is useful to examine why the rural generalist training program in Queensland has been so successful. Of course it is a good program that inherently held appeal for junior doctors. From all reports, the trainees hugely enjoy it. Crucially however, there was a fundamental recognition that rural medicine and hospitals work differently compared to metropolitan or large regional sectors, and that systems and remuneration need to reflect this.

The appointment and work of rural GPs in hospitals is easy and the remuneration for this work is equivalent to senior medical officer salary for any specialist working in a metropolitan hospital. On-call arrangements were appropriate and remunerated to a degree. Doctors have vibrant private practices in their communities that is operated synergistically with their public hospital work. In other words, the industrial and work conditions were good. These important members of our

profession in rural and regional communities were appropriately recognised and reasonably rewarded.

I've heard it said that this program is not applicable to other States and Territories – though it does appear very close to what Professor Paul Worley has suggested as a national approach. Even if this tension is true, there must be several useful foundation components that can be purloined by other jurisdictions. There will be a cost, but without appropriate investment we're not going to solve the crippling maldistribution problem. Use Queensland as an example or work from the National Rural Generalist Training Pathway document. Either way, there is an urgent need to get cracking with it, especially given the \$65million already set aside to start this process.

Having a good training program is one thing, but how do we allow medical students and junior doctors to have sufficiently sustained, positive exposure to rural practice to enthuse them towards non-urban practice? I have long believed we need to create centres of excellence at the centre of care pathways in regional areas to share the burden of hospital-based training and provide augmented regional infrastructure to attract and retain staff that can support training and research.

There is also no doubt (and a large body of evidence that states the obvious) enduring, positive mentorship and sufficient longitudinal practical exposure/work experience to rural medicine do change career choices of pre-vocational doctors (e.g. Stagg P et al Rural Remote Health 2012; 12). This clearly does not occur to the extent it should. It is not just in rural general practice that the evidence exists. For example, 91 per cent of infectious diseases trainees indicated they felt mentorship was influential on career choice (Bonura EM et al, Clin Infect Dis 2016; 63(2)).

The same is true in psychiatry, with acknowledgement that there is a larger stigma hurdle to overcome. I still recall my time as a psychiatry resident with horror, but now look wistfully at my psychiatry colleagues who have unassailable job security, reasonable income and an enviable work-life balance. This rumination is not trivial because there is intuitive evidence that balance between work, family and lifestyle is (most) important in career choices (Grigg M et al, ANZ J Surg 2014; 84(9)).



Vice President's message ... continued

Psychiatry and general practice tick these boxes, but junior doctors and medical students seem less aware of this than they should. There is scope here for positive reform that will cost little.

“Only 13 per cent of a recent cohort of UK graduates ranked general practice as their first-choice career despite having a generally realistic and positive view about the specialty.”

There is helpful evidence that indicates exposure for more than a year is required to change career choice towards rural practice and that interestingly, this exposure should be mixed between regional hospitals and rural general practice, rather than exclusively in either location (O'Sullivan B et al Med Educ 2018; 52(8)). The effect of having a rural background and rural clinical experience is also additive (Kwan MMS et al, PLOS One 2017; 12(7)).

Only 13 per cent of a recent cohort of UK graduates ranked general practice as their first-choice career despite having a generally realistic and positive view about the specialty (Chellappah M London J Prim Care 2014; 6(6)). I would have thought the reason behind this was at least partially obvious as debt and anticipated income are important considerations which shape career choice of junior doctors (Grayson MS et al Med Educ 2012; 46(10)). The chronic, enervating under-funding of general practice for many years now is abundantly obvious to all and Government cannot be surprised that young doctors, often with partners/families, expensive future training pathways and HECS debts, are worried about future income. Rather than trying to conscript doctors into regional/rural areas by whatever means, simply funding general practice, and rural practice in particular (for all doctors) is absolutely required to repair the maldistribution of workforce.

Reflecting on the above evidence it is clear medical schools' curricula should echo this evidence and hospitals/policy makers need to take heed. There is a sense of partial understanding, but still much room for improvement.

The Rural Health Multidisciplinary Training program provides funding support to medical schools that encourage recruitment and retention of rural and remote doctors. RHMT program targets include a requirement for at least 50 per cent of medical CSPs to complete a minimum four consecutive weeks rural clinical training in Australian Statistical Geography Standard-Remoteness Areas-RA (ASGS-RA) 2-5 locations despite knowing this short period of time does not change career choices.

By contrast, only at least 25 per cent are to complete a minimum 12 months rural clinical training in ASGS-RA 2-5 locations – a group must more likely to remain in rural practice. Universities also agree that 25 per cent of their medical enrolments will be drawn from a rural background. In the most recent Medical Schools Outcome Database (MSOD) National Data Report 2019 we find only 22.2 per cent of students have a rural background – which is reduced from the last few years.

In examining the preferred location for future practice among those students from a rural background, it is sobering to note the system seem to have managed to dissuade significant proportion of them against small community/rural practice as follows:

Capital city 31.3 per cent; major urban centre 21.3 per cent; regional city or town 32.1 per cent; smaller town 10.4 per cent; small community 4.9 per cent.

This data indicates we are far from reaching an appropriate experiential and mentoring experience for our students and junior doctors to promote general and rural practice. Universities need to be less concerned with increasing full-fee-paying students who are significantly more likely to choose urban practice (Hays RB et al, MJA 2015; 202(1)) and more concerned with investing in rural training mentorship and pathways that then articulate with rural pre-vocational and vocational training opportunities. This is a clear example of where regulation is needed to constrain the self-interested behaviour of Universities that is significantly exacerbating workforce stressors. Hopefully the much-touted medical force strategy will address these opportunities. The myopic, faintly sardonic assertion that doctor behaviour is to blame for workforce imbalance causes a frustrating loss of focus on true reform opportunities that will make a genuine difference.



Commitment is all in the delivery

BY AMA SECRETARY-GENERAL DR MARTIN LAVERTY

“If the inquiries, taskforces, and reviews are a priority for the Government, work should be underway now to make provision for new spending in next May’s Federal Budget.”

When a government establishes an inquiry, taskforce, or review, it is usually called for good reason. A crisis might need a response, a long running problem might need fixing, or a challenge of the future can be planned for.

If you’ve ever been asked to participate in a taskforce or policy review, you’ll recall being flattered by your first invitation. When a government seeks expertise, it’s nice to be asked.

However, for those who’ve been around government reviews for a while, it is wise to have pragmatic expectations about what an inquiry or taskforce can actually deliver.

I was delighted in 2012 when my book – *Determining the Future: A fair go and health for all* – triggered a Senate Inquiry into why Australia had ignored World Health Organisation recommendations on social determinants of health.

It got even better the following year when, after a several month Inquiry involving effort of many contributors, the Government, Opposition, and Cross Bench Senators issued unanimous recommendations on how to implement the World Health Organisation action plan.

Almost a decade on, the recommendations of that Senate Inquiry sit on a shelf.

The Government today has established multiple inquiries, taskforces, reviews, and two Royal Commissions, all of which are underway at once.

The AMA is formally involved in these multiple reviews, be it the ongoing MBS Review Taskforce, the Primary Health Reform

Steering Group, the expert steering committee for the ten-year national preventive health strategy, or the Residential Aged Care Funding Reform Working Group.

All are important. All can lead to real change. The proposals made to the review processes by the AMA and others alike are informed by desire to improve health outcomes across Australia.

However, implementing the multiple findings of each of these reviews will need significant coordination. Primary health reform must relate to the preventive health strategy, both of which must relate to the MBS review. This coordination is not overly apparent.

More so, implementing multiple findings of multiple reviews will need significant new funding. By gathering together experts, and asking them to come up with solutions, the Commonwealth must simultaneously prepare to find new money to meet the cost of action.

The lead up to Christmas is peak season for Federal Budget preparation in Canberra. Departments are preparing budget submissions, in response to priorities already set by the Government’s Expenditure Review Committee.

If the inquiries, taskforces, and reviews are a priority for the Government, work should be underway now to make provision for new spending in next May’s Federal Budget.

It’s of course not just new health measures that need funding, but also measures already announced but not yet funded.

The last Federal Budget committed \$62.2 million to the National Rural Generalist Pathway. The AMA was a key member of the taskforce that developed the proposal to better recognise rural generalists. The last Budget’s funding was a down payment. Next May’s Budget needs more. I’m worried it’s not going to be funded.

The AMA representatives involved in the many inquiries, taskforces, and reviews currently underway are working hard on behalf of the profession, and ultimately patients everywhere. The AMA has an additional job; to ensure the many reviews deliver.

Say g'day to our new Aussie



An excited Dr Hirowatari waiting to pledge her loyalty to Australia.



Dr Hirowatari with her citizenship certificate and friend, another Canadian GP who now practises in Australia, Dr Susan Douglas.

The AMA's very own rural health champion Dr Sandra Hirowatari is here to stay.

Dr Hirowatari, Chair of the AMA Council of Rural Doctors, has just been made a fully-fledged (and fully pledged) Australian citizen.

Canadian born and raised, Dr Hirowatari answered a recruitment advertisement 12 years ago to practise medicine in Australia. The rest is history.

During a ceremony in Canberra on November 11, Dr Hirowatari pledged her loyalty to Australia and its people and was awarded citizenship.

A fierce campaigner for rural medicine, Dr Hirowatari was clearly thrilled with her new citizenship status, and she immediately reaffirmed her commitment to keep working to improve rural health in Australia.

Dr Hirowatari's latest column on rural health is in the current edition of *Australian Medicine*, and her previous columns can be viewed on the journal's website.

CHRIS JOHNSON

Update on payroll tax – Optical Superstore

We have received some queries about the recent decision in Commissioner of State Revenue v The Optical Superstore Pty Ltd.

“The Victorian Court of Appeal held that payroll tax was payable on payments made to optometrists who operated out of premises at The Optical Superstore.”

The Victorian Court of Appeal held that payroll tax was payable on payments made to optometrists who operated out of premises at The Optical Superstore. The decision has attracted some attention in the medical community because:

- the arrangement was described as a lease;
- there was no employment relationship between the optometrists and The Optical Superstore;
- the patients were the patients of the optometrists;
- the optometrists had directed that Medicare pay amounts for bulk billed services into an account held on trust for the optometrists; and
- payments to the optometrists were made out of this account.

However, it is important to appreciate that the amount paid to the optometrists was based on the number of hours they were available to see patients. The rate assumed 7.6 hours and 21 appointment slots per day, with no adjustments for cancellations or no shows. In other words:

- the optometrists received the same hourly rate regardless of how many patients they saw or how those patients were billed; while
- the net “rent” payable to the “landlord” was variable and

could be negative.

The lower court accepted that, even though the optometrists were not employees, the amounts received were for the performance of work. This meant that the key issue was whether there was a ‘payment’. The lower court held the amounts received could not be ‘payments’ because the optometrists were the beneficiaries of the trust and you cannot pay money to yourself. The Court of Appeal said that the only legislative test was whether there was a ‘payment’ and the fact that the payment was made from a trust for the optometrists was irrelevant.

Consistently with this decision, in Homefront Nursing Pty Ltd v Chief Commissioner of State Revenue the NSW Civil and Administrative Tribunal held that Medicare payments made to contracted GPs were not subject to payroll tax even though the practice collected the payments and remitted 71.5 per cent to the practitioners. By contrast, payroll tax could be payable on top up payments made to GPs. These amounts were payable in the first 13 weeks of engagement and had the effect of guaranteeing a total income of at least \$3,600 per week regardless of patient billings.

Both decisions are a reminder that the Commissioner will look behind the documentation to determine whether practitioners engaged under servicing arrangements are:

- genuinely providing medical services to their own patients and acquiring services from the practice; or are
- actually working in the business of the medical practice, that is, supplying services to the medical practice and/or its patients

This is likely to involve consideration of how the amounts paid to each party (i.e., the doctor and the practice) are calculated and who is taking the risk.

GEORGINA ADAMS
AMA GROUP GENERAL COUNSEL

INFORMATION FOR MEMBERS



AMA

Referring patients to My Aged Care just got easier

GPs can play a key role in supporting patients to access aged care services to suit their needs with referrals to My Aged Care. And these referrals just got easier.

The Australian Government Department of Health together with HealthLink has developed a new e-Referral form allowing GPs to send referrals to My Aged Care directly from their practice management systems.

The e-Referral form responds to feedback from GPs who have found the current referral processes frustrating due to the lack of integration between My Aged Care and their practice management systems. "It was quite time consuming flicking between the patients file to get all of those details that it didn't automatically input," said a participant from the recent e-Referral pilot. "The new e-Referral form just makes it so much easier," they said.

How does My Aged Care e-Referral work?

The e-Referral form is intuitive, easy to use and accessible through the patients' electronic medical record. By pre-populating patient information, the focus is on screening patients, making it the quickest and easiest way to refer your patients to My Aged Care. All GPs need to do is check patient details and add additional information and attachments required to support an assessment of their aged care needs. One pilot participant found the form very easy and user friendly. "The process made it very straight forward and simple," they said.

Once submitted, the e-Referral form is safely and securely sent to My Aged Care. Response from pilot sites has been positive, with feedback highlighting the ease and convenience of the new form.

Testing and feedback

From July 2019, a trial of the e-Referral capability was rolled out to a pilot group of GP practices to get user feedback of

the solution based on real cases. The feedback received from participants helped inform further enhancements, which were implemented during the pilot.

Feedback from pilot participants indicates the enhancements made a great improvement: "I noticed them straight away. It just makes it all run a lot smoother," said one participant.

How to get started

The e-Referral form is now available through MedicalDirector, Best Practice and Genie practice management systems. Quick Start Guides to support transition to this more efficient form are available on the 'For health professionals' page on the My Aged Care website (easily accessed by a link in the footer or search for health professionals).

For user and technical support, contact HealthLink through their customer service email helpdesk@healthlink.net or by calling 1800 125 036.

The existing online 'Make a Referral' web form, fax and phone options will continue to be available. See www.myagedcare.gov.au/health-professionals for details.

Information for patients

A new brochure called *After you've registered with My Aged Care* is also available to support your patients with next steps after they have been referred. You can find the brochure on the My Aged Care website and order it free through National Mailing and Marketing by emailing health@nationalmailing.com.au or calling (02) 6269 1025 and quoting the code 150150.

Feedback on both the e-Referral form and the brochure are welcome to be sent to: myagedcare.hpreferrals@health.gov.au

This information article was provided by the Department of Health.

National Cancer Screening Register to support National Bowel Cancer Screening Program

From November 18, the National Cancer Screening Register (the National Register) will begin supporting the National Bowel Cancer Screening Program (NBCSP).

The Australian Government's National Bowel Cancer Screening Program (NBCSP) is a population-based screening program, that aims to help detect bowel cancer early and reduce the number of Australians who die each year from the disease.

From November 18, 2019, the current NBCSP Register operated by the Department of Human Services, will transition over to the National Register to create a single national record for participants of the NBCSP and the National Cervical Screening Program (NCSP).

The National Register will support the NBCSP by:

- Collecting and storing NBCSP bowel cancer screening data.
- Inviting and reminding eligible people to participate (through integration with the Medicare database).
- Distributing iFOBT kits to eligible participants (a free test kit that can be completed at home and mailed to the contracted pathology laboratory for analysis).
- Providing the State and Territory Participant Follow-Up Function (PFUF) access to the National Register to facilitate their support and follow up of positive iFOBT results.
- Providing information on participants to healthcare providers.
- Providing reporting on key program and operational outcomes for policy makers and key stakeholders to ensure appropriate safety, monitoring and evaluation of the Program.

Additional functionality will be implemented in stages from March 2020, including:

- An online portal which will enable healthcare providers to access patient information and submit data electronically to the NBCSP and the NCSP.
- Integration with primary care Practice Management Software systems.
- Integration with whole-of-government services (e.g. MyGov, My Health Record) which will enable greater self-service options for people to manage their participation in both Programs.

What you need to know:

Migration of NBCSP data will occur over November 15-17 and the National Register will commence operating the NBCSP Register from the morning of Monday, November 18, 2019.

National Register contact details:

From November 18, the National Register can be contacted for both NBCSP and NCSP-related purposes on the following:

- National Register Contact Centre
1800 627 701 (operates Monday to Friday, between 8am and 6pm in all Australian State and Territory time zones)
- Fax
Bowel Screening Fax: 1800 115 062
Cervical Screening Fax: 1800 627 702
- Post
Bowel Screening Post: Reply Paid 90965
Sunshine VIC 3020
Cervical Screening Post: Reply Paid 90964
Sunshine VIC 3020

AMA's Julian Rait joins the Board of Vision Australia



Associate Professor Julian Rait OAM has been appointed to the Board of Vision Australia. One of Australia's most highly respected eye health professionals, Professor Rait is President of the AMA (Victoria) and Chair of the Federal AMA Council of Private Specialist Practice.

He is a strong supporter of Vision Australia and its core mission of supporting people who are blind or have low vision to live the life they choose.

"I have had a long association with Vision Australia and have

much admired and appreciated the support that has been provided to many patients," Professor Rait said.

"I very much look forward to contributing to the further success of this wonderful organisation and its compassionate advocacy for people who are blind or have low vision, along with their families."

Vision Australia CEO Ron Hooton said the organisation was fortunate to have Associate Professor Rait on its Board.

"It's always a positive when you can welcome somebody like Julian to an organisation and his position on our Board is great news for Vision Australia and the wider blind and low vision community," Mr Hooton said.

"Medical professionals play an important role in people who are blind or have low vision receiving the support they need. Julian's knowledge of this field and eye health will be an asset to Vision Australia and help ensure we are working effectively alongside primary health providers to ensure people are receiving the best possible support."

Associate Professor Rait is a specialist Ophthalmologist and has been practising for more than 30 years.

In 2018, he was awarded the Medal of the Order of Australia for service to Ophthalmology and to the development of overseas aid.

CHRIS JOHNSON

Health Star Rating works, says Choice

Consumer advocacy group Choice has found that the Health Star Rating on food labels is having a positive impact. It now wants the labelling advice compulsory on all packaged products.

Choice's research survey tested community perceptions of products with and without the Health Star Rating.

"It's clear to us that Health Stars make it far easier for people to pick healthy foods," said Choice's food policy expert, Linda Przhedetsky.

"Our survey found that without Health Stars, two-thirds of people

rely on marketing material to decide if something is a healthy choice. Too many food brands still try to trick us into buying their unhealthy products with misleading images and claims. A compulsory Health Star Rating system will help disrupt the food industry's tricks."

Choice has written to all Health Ministers asking that the Health Star Ratings be made compulsory for all packaged food products.

The full report can be viewed at: <https://www.dropbox.com/sh/o2vv61xr6uxs76r/AABFWuGzLzkNQdDanzp3xxZpa?dl=0>



AMA

Indigenous Medical Scholarship 2020

Applications are now being sought for the 2020 Australian Medical Association (AMA) Indigenous Medical Scholarship. Applicants must be of Aboriginal and/or Torres Strait Islander background.

Applicants must be currently enrolled full-time at an Australian medical school and at least in their first year of medicine. Preference will be given to applicants who do not already hold any other scholarship or bursary.

The Scholarship will be awarded on the recommendation of a selection panel appointed by the AMA. The value of the Scholarship for 2020 will be \$10,000 per annum. This amount will be paid in a lump sum for each year of study.

The duration of the Scholarship will be for the full course of a medical degree, however this is subject to review.

Applications close 31 January 2020.

To receive further information on how to apply, please contact Sandra Riley, Administration Officer, AMA on (02) 6270 5400 or email indigenousscholarship@ama.com.au. An application package can be also downloaded from the AMA website www.ama.com.au/indigenous-medical-scholarship-2020.

The Indigenous Peoples' Medical Scholarship Trust Fund was established in 1994 with a contribution from the Australian Government. In 2016, the Trust Fund became The AMA Indigenous Medical Scholarship Foundation. The Foundation is administered by AMA Pty Ltd.

The AMA would like to acknowledge the contributions of the following donors: Reuben Pelerman Benevolent Foundation; the late Beryl Jamieson's wishes for donations towards the Indigenous Medical Scholarship; Deakin University; The Anna Wearne Fund and B B & A Miller Fund, sub-funds of the Australian Communities Foundation.



Health on the Hill

POLITICAL NEWS FROM THE NATION'S CAPITAL

Funding boost and new model for Aboriginal health services



Health Minister Greg Hunt and NACCHO Chair Donnella Mills.

The Federal Government is investing an additional \$90 million over three years in the Indigenous Australians' Health Programme (IAHP), to further support the delivery of culturally appropriate, comprehensive primary health care.

A new way of funding primary health care has also been introduced for Aboriginal Community Controlled Health Services (ACCHS).

From July 1 next year, major changes to the way the Government distributes funding to ACCHS for primary health care under the IAHP will begin.

The Government has partnered with key stakeholders including the AMA and the National Aboriginal Community Controlled Health Organisation (NACCHO) to develop a revised funding model.

AMA President Dr Tony Bartone described the new funding model as positive recognition for the critical role Aboriginal health services play in the nation's overall health system.

"The AMA welcomes Minister Hunt's announcement. This funding will ensure that ACCHSs continue to receive the funding they need to provide quality, comprehensive, and culturally safe primary health care," Dr Bartone said.

"We know that Indigenous people have a greater chance of improved health outcomes when they are treated by Indigenous doctors and health professionals. They are more likely to make and keep appointments when they are confident that they will be treated by someone who understands their culture, their language, and their unique circumstances."

Health Minister Greg Hunt welcomed the partnership and said the implementation of the funding model will deliver real benefits on several fronts. "Streamlined processes and three-year funding agreements will provide certainty around health workforce continuity and planning, and reduce the administrative burden on the sector," Mr Hunt said.

"Importantly, no service will lose funding under the new funding model. Funding levels will be maintained in real terms."

In addition, all services will receive annual wage indexation increases. Funding distribution will be based on activity levels, the cost of delivering services, and the relative health needs of locations.

"Finalising the model is a significant achievement that has been made possible as a result of our ongoing collaboration and shared commitment to Closing the Gap," Mr Hunt said.

NACCHO Acting Chair Donnella Mills welcomed the announcement, saying it provided greater certainty over the next three years.

"The new funding arrangement will allow our community controlled health services to have certainty on their funding for the next three years," Ms Mills said. "In particular we are pleased that an additional \$90 million over three years will be provided to the sector and will support services. Of course, more funding is still needed and we will continue to work with Government in this regard."



Practice Nurses

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

As general practice contemplates a future that involves an ageing population, an increasing incidence of chronic disease, the drive for patient-centred care and different funding models to support new models of care, it is worthwhile contemplating what that future would look like without practice nurses.

According to the *Health of the Nation 2019 Report*, 92 per cent of GP respondents indicated their practice employed a practice nurse and the average number employed in a practice is 3.1. With about 14,000 nurses working in general practice across the country, they are an essential part of general practice as we know it in Australia.

They support GPs in providing a comprehensive range of services, yet in many instances are underutilised. Data from the Australian Primary Health Care Nurses Association (APNA) Workforce Survey 2018, indicates that of the nearly 50 per cent of primary healthcare nurses who suggested to their employer they could be undertaking more complex activities within their scope of practice, less than half were permitted to do so. Reasons cited for this by APNA's President in a recent *MJA InSight+* article include lack of support by the broad healthcare team, and financial and resourcing challenges.

Practice nurses have clearly contributed to the success of general practice as one of the most cost-effective and efficient sectors within the Australian healthcare system. Over the last 20 years there has been steady growth in the number of practices employing practice nurses. The Government has recognised the importance of the role and put in place financial arrangement to support practices in building their teams and expanding the services they provide. General practice nurses are involved in the delivery of comprehensive care including care coordination, patient education, immunisations, health assessments, supporting chronic disease management and the management of the clinical environment.

Satisfaction levels amongst primary care nurses are reported to be high, particularly regarding being a valued member of the team, working collaboratively and effectively within the team and contributing to patient satisfaction and positive health outcomes. However, nurses also commonly reported that lack of time and financial remuneration affected their ability to perform their roles. Twenty-five per cent reported they had never been

offered a pay increase.

As valued members of the healthcare team, it is important that practice nurses have opportunity for career development, to work to their full scope of practice, and are appropriately remunerated for their contribution to general practice. Current financing arrangements make this difficult and this needs to be addressed as part of our advocacy for a strong, effective and viable general practice now and in the years ahead.

Worryingly, estimates suggest that with an ageing workforce and no clear career pathway, there will be a significant workforce shortage of full-time equivalent practice nurses by 2025.

It is good that the Government is focused on developing a new Primary Care Strategy and has announced some additional funding for general practice that is now starting to flow. However, if we want a high performing primary care model that delivers better access and outcomes for patients, we cannot allow this to be jeopardised by ignoring the future of our practice nurse workforce.

Improving employment opportunities, recruitment and retention of nurses in primary health care settings will be essential if our plans for the future of general practice are to be realised. To that end, I would encourage you to engage with your practice nurses on how their skills and experience could be put to better use. To look into what career supports are available through their professional organisation to help them upskill where required and to support them when transitioning into general practice.

The AMA has recognised this and is working hard to improve the level of financial support that is available to practices that employ or want to employ practice nurses. We are targeting the Workforce Incentive Program and calling for annual indexation as well as a lift in the cap on the level of subsidy that is available.

General practice has embraced team-based care and moving forward means that policy settings need to keep pace with change. The old approach of providing a subsidy and then letting it be steadily eroded is limiting how much more we can progress, and it is time that the Government move to address this and set up durable and sustainable funding arrangements for our practice nurse workforce.



The difficult challenge of medical indemnity

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

In this golden age of 'magic bullet' medicine, doctors and patients alike hope that things will always go right – perhaps not with the certainty of air travel, but we do expect top-quality care. Of course, seriously ill patients die and we doctors recognise that we have much to learn in caring and curing those with cancer, dementia and end-stage organ failure. But...

“Court awards blew out so much in the 1990s that the Federal Government intervened with support which, following recent negotiations with the AMA, will continue.”

When the outcome is unsatisfying, it is natural to seek a reason. Patients may settle on someone to blame and punish. They might seek compensation. Through that portal, we enter the conflicted world of medical litigation and defence built on a combative relationship between medicine and the law. Court awards blew out so much in the 1990s that the Federal Government intervened with support which, following recent negotiations with the AMA, will continue.

Paul Niselle (a general practitioner and expert in medical indemnity, who has worked with medical defence funds in Australia and the UK for 20 years) wrote in 2011 about the complexities. <https://insightplus.mja.com.au/2011/9/paul-niselle-expert-witnesses-have-duty-care-too/>

Any doctor acting as an expert witness must know that their responsibility is to the court, not the person who has commissioned their report and testimony, but some doctors still slip into the role of medical advocate.

Whether it is a treating doctor asked to provide a report because the patient is making a compensation claim, or an independent expert commissioned by one of the parties to an action to provide a report, the doctor has a duty first to ensure they remain within their areas of demonstrable competence, and second, to write a completely dispassionate report, free of any bias.

The Australian Institute for Health and Welfare (AIHW), charged with keeping track of health and health care, provides data about claims. These arise 'from allegations of negligence of breach of duty of care by healthcare practitioners'. Claims can be 'closed' by a court decision, by a negotiated settlement between claimant and insurer, or by dropping the case. <https://www.aihw.gov.au/reports/hospitals/medical-indemnity-claims-2012-13/contents/table-of-contents>

That report covered financial years 2008-09 and 2012-13. How claims are managed varies from State to State. Nearly 1,000 new public sector claims arose in the 2012-2013 – 120 from emergency departments and 114 from general surgery. The figures fluctuate from year to year, showing no trends. The annual number of closed public sector claims was about 1,500. New claims in the private sector were about 3,300 and closed cases (after increasing annually) were 3,800 (The most up-to-date figures available).

The process of litigation can make a public elective surgery waiting list look trivial. "For claims [relating to events in 2001-02] closed for \$500,000 or more, the proportion was less than one per cent of claims up to five years after the incident, after which it rose very gradually to [about] five per cent of claims." About 25 per cent of claims closed for \$10K or less were settled in two years, but 50 per cent remained open after ten years.

Drawn-out stress, if not agony, ensues for claimant and practitioner alike. This reaches well beyond monetary considerations. Regrettably for the practitioner, the media will often prominently feature the allegation, but not any exculpation.

The lack of overlap of legal concern with professional behaviour and that of the clinical guardians of the quality of clinical care can be substantial. It is not always clear whether an adverse deviation from customary practice is a quality or a legal concern.

When errors occur, there is often an element of individual responsibility (one should not practise if overtired, drunk or otherwise impaired), but there are strong social and physical forces which predispose to mishaps. Bad or insufficient equipment, erratic rostering, inadequate arrangements to cover colleagues absent on vacation, at a conference or ill, all predispose to error. Who or what is really to blame? As in poor



Public health opinion ... continued

human health, there are social determinants of poor medical outcomes.

Because every patient is different, problems arise at law when clinical practice guidelines are used as unequivocal statements of best practice for the individual patient. The guidelines are derived from standardised aggregated data whereas the individual is exactly that.

Although evidence-based medicine was originally defined as ‘the conscientious, explicit and judicious use of current best evidence in making decisions about the care of individual patients’, the latter half of the definition is often overlooked in the court room.

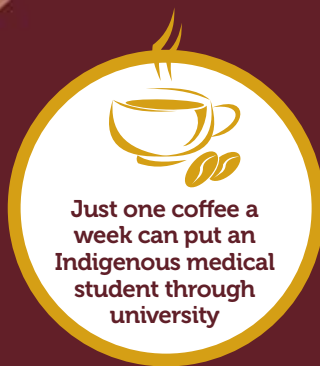
Guidelines are used as legal proclamations of the only acceptable practice against which the behaviour of a clinician

might be held to be faulty. Yet the history of medicine is rife with new ideas being disparaged until they could no longer be denied. We have our own example in Barry Marshall and Robin Warren and their disputed theory of an infectious cause for peptic ulcers. Sometimes tenacity is needed to go against the tide of popular opinion in pursuit of best care.

A doctor’s duty of care, Nisselle argues,

extends beyond just those people seen as “patients” to include all people who could be affected by the exercise of professional judgement, whether in clinical practice or ... in court.

[I gratefully acknowledge the help of Dr Peter Arnold OAM in writing this article.]



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Working together to improve rural health

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

My regular readers will know that I believe conferences are important for rural doctors. They allow us to come together to discuss the big issues and to form connections we can call on when we return to our often isolated communities. In October, I attended RMA19, along with about 1,000 other rural doctors.

The nature and personality of this conference is unique. It reflects us. We are opinionated, passionate and we fight for what we believe in. We are a culturally diverse, family oriented, gender diverse just bunch of doctors who do not take the easy path.

So, the event reflects us.

A strong spousal and family program is a key element in RMA. It reflects what we need to keep us rural – our families.

A big focus on women's health and women in our medical workforce. This is so refreshing when other conferences have difficulty getting panelists who represent us.

A unique keynote speaker from Chinese presented on an unpleasant concept – the 'nobody' GP.

Another highlight every year is the Presidents' breakfast where presidents from major players in rural medicine share the stage to discuss rural health. This year, the AMA was represented by our well-spoken Vice President Dr Chris Zappala, in a broad ranging discussion on systems and structures that drive quality in health care.

Despite a sometimes hostile audience, Dr Zappala spoke eloquently and passionately about the importance of strengthening rural primary care. In fact, one of the more negative moments of the conference led to one of the most positive statements from our Vice President: collegiality is what is needed now, not stone throwing.

This became more apparent as the discussion moved to the challenges ahead for the National Rural Generalist Pathway (NRGP). There are many hurdles to a fully realised NRG, but one the AMA is increasingly concerned about is the lack of a standardisation of credentialing requirements. This is a crucial component of the NRG but there has been virtually no discussion about it from the Government or the Department of Health.

One of the challenges noted by the panel was interprofessional disagreement about the requirements for professional qualifications, access to non-GP MBS rebates for accredited additional skills, and determining scope of practice. Again, Dr Zappala rose above the squabbling and blaming to make the point that this is an issue for the entire medical profession. We as doctors need to resolve this – no one else is going to do it for us.

The good news is that the work has started. Earlier this year, RDAA released their position statement *Credentialing and defining the scope of practice of Rural Generalists*. The position statement calls for the development of national guidelines for determining the scope of practice and the credentialing, nationally consistent processes for collecting documentation, and ensuring continued and meaningful involvement of rural doctors in the development and review processes.

The AMA supports this position statement and we want the Federal and State/Territory Departments of Health, the Colleges, and the other organisations to start working towards the achieving nationally consistent credentialing processes and scope of practice definitions.

To achieve this, we need to start working together. It helps nobody when we try to divide the profession by the letters after our names. We need to work together because our rural communities are suffering.

A final highlight for me was the Great Debate, a comical debate about what works better to encourage doctors to go rural – carrots or sticks. The debate ended spectacularly with Dr John Hall physically carried off the stage by a fellow rural doctor as he over ran his allotted debate time.

RMA19 also saw the same Dr John Hall assume the role of President of RDAA for the next two years. John has been a strong AMA advocate, so our AMA President, Vice President and the Council of Rural Doctors are looking forward to working collaboratively with him and RDAA.

I am also looking forward to seeing him carried off stage again at RMA20.



Vulnerable leadership

BY DR TESSA KENNEDY, CHAIR, AMA COUNCIL OF DOCTORS IN TRAINING

Omniscient. Unwavering. In control.

Many traditional ideas about medical leaders evoke the stoic hero. Always decisive, never tiring, unperturbed by the suffering and grief around them.

Over the last near decade as a doctor, I like to think I've been pretty good at managing that balance of compassion and empathy that defends against emotional exhaustion. Acknowledging the stresses of the job and the experience of patients and families but generally being able to leave it at the front door.

Everything changed when I returned to work after the birth of my son, to the paediatric intensive care no less. Suddenly every distressed or unmoving child wheeled through our doors was re-imagined as my own. Vivid and intrusive, like a flashback to a trauma I'd never lived.

It has faded a little as I've recalibrated my sense of normalcy, re-immersed myself of the emotionally monotone science of it all, and reframed disease and injury as problems to be solved again. But it doesn't take much to scratch the surface.

It seems maintaining good psychological hygiene will be a topic of continued learning – especially in the face of hunger, fatigue, shift number six and trackwork. What has helped the most is realising that I am not alone in the struggle. And importantly, that it's not just other doctors in training, but highly experienced, respected, senior consultants who have and continue to struggle too.

I have previously been very sceptical of hospital 'wellbeing' initiatives (that usually score low on a scale of yoga to paying my un-rostered overtime), but I'll admit I could be a convert.

It started with a regularly scheduled meditation session. Uptake hadn't been great as it was the middle of winter chaos, no one was terribly sure what to expect, and frankly the critical mass required to ensure peer pressure favoured attendance over avoidance hadn't been reached.

But I was not terribly busy and hadn't thought of an excuse, so I went.

The essential oil diffuser was going, and three consultants and I sat in the room with the facilitator. Half an hour of meditation

was promised, preceded by an exercise where we would pick a card naming an emotion, followed by an art card which spoke to our experience of this emotion, to be discussed in the group. Oh good. This sounds... confronting to say the least.

One of the consultants began. They picked one card, then the other, and spoke softly about their experiences. Of anxieties, difficulties, hopes, and reflections across the span of their career. Not seeking to impart any divine wisdom, but simply offering up their thoughts and a little window into their self, as a person like any other. With struggles like any other. When my turn came it required a small leap of faith to abandon the hierarchy and speak freely, but I was so grateful for my senior colleagues' willingness to do just that.

Since then I've tried to go whenever I can.

The meditation is nice. But it's the sense of community and culture that is fostered that is the real game changer. This protected time for the clinical team to sit together as equals, sharing and reflecting on different aspects of our emotional existence – building great trust, respect and humility.

Having discussion guided by an external facilitator disarms the usual hierarchy and reveals omniscient consultants as imperfect humans among the rest of us. In this little pocket of calm so hard to find in a windowless room lit by fluorescent strip lights and beeping screens, we were offered connection, and I was struck by the power of introducing a little vulnerability, of earnest imperfect humanity into interactions as a leader, a supervisor, a teacher.

Sometimes it feels in this medico-political world of the AMA that it's all doom and gloom. Bullying, harassment and discrimination remain rife in the profession. The intern tsunami is now trying to push into the specialty training pipeline with a gross mismatch between trainees and the places available to them. So, CV buffing has taken over Friday nights drinks as the primary focus of residency. And the pharmacists keep trying to prescribe things, which is all that seems to separate some of us from secretaries...

But actually after five years of shining lights into the dark corners of our culture, of facing some painful home truths, there are signs of change. The conversation is moving from the whether and why, to the how: how to ensure kindness and humanity are emphasised in a system that tries to squeeze it out of us as an efficiency dividend. How to ensure work and life outside it can co-exist,





Continuing the conversation on mandatory reporting: from a medical student seeking help

BY JESSICA YANG, PRESIDENT, AUSTRALIAN MEDICAL STUDENTS' ASSOCIATION

In February, medical students were disappointed to see the Queensland Parliament reject recommendations to the Health Practitioner Regulation National Law which would reflect the WA model of exempting treating practitioners from mandatory reporting. While the adopted changes were a step in the right direction, I would like to reflect on a personal experience which reminded me of the reality for vulnerable medical students and doctors attempting to seek help.

Several months ago, I relocated to a new area in Sydney. New suburb, new GP, same old medical history. While I still have a regular GP, now about half an hour away, a practice down the road from my new abode was too convenient to turn down. The consultation was friendly enough and conversation flowed easily as we bonded over our experiences in the medical field (albeit mine being far earlier in the path than hers).

During my long-winded history, I recounted my experience with (what I still assume was) stress-induced fatigue last year during a particularly brutal rotation which required a reasonable 35 hours per week of clinical contact. Then, I added the 20 hours per week studying for the end-of-placement exam, and the 20 hours I worked part-time on weekends to support myself. Taking days off, even for illness, would mean having to remediate those hours on a weekend and having to forgo my weekly income.

To make matters worse, I was placed at a satellite hospital an hour commute away, with only one staff member of our medical school trying their hardest to support the dozen students on the rotation.

A month into this placement, I went to the only local GP available after hours. I was convinced I had developed narcolepsy as I frequently found myself on the verge of falling asleep throughout the day, most worryingly during my hour-long drive to and from the hospital. I never had the time to go back to confirm a

diagnosis, or the money to follow up with the sleep physician he referred me to. By the end of the rotation, I had developed acid reflux symptoms, daily headaches and sleep paralysis.

I recounted this to the new GP, partially to vent my frustrations to someone who had certainly gone through the same experiences during their medical schooling, but also seeking some sort of retrospective medical validation for a level of fatigue that profoundly impacted me during that time.

Instead, the GP scolded me: "You should have followed up. If I had seen you last year and you were as fatigued as you say, I would have been required to report you, you know!"

I cannot fully describe the incredulous mix of emotions I felt when she said this – surprise, anger and mostly, shame. I thought I had been forming a rapport with a new GP, lamenting over the barriers of time, money and social pressures which stop many medical students from seeking help. Instead, this GP put up another barrier for Me – fear.

Just a month before I had seen this GP, AMSA had sent a focus group to consult with AHPRA to identify the best way to positively communicate to medical students that they are able to seek help without fear following the mandatory reporting reform. I remember leaving this focus group feeling positive and ready to encourage my peers to reach out when they needed to.

Despite feeling significantly more deflated following my consultation, I reflect on this experience with a hopeful outlook which requires action. While this positive communication from the top is vitally important, it is just as important to educate those who will be interacting with vulnerable medical students and doctors on their reporting obligations. All the positive messaging in the world is for naught if vulnerable medical students, so early on in the medical careers, are being turned away when they seek help due to ignorance.

Doctors in training ... continued

realising the benefit of perspective they each bring to the other. How to spread the things that work and leave behind the things that don't. How to fit our oxygen masks before assisting others.

At the Australia and New Zealand Prevocational Medical Education Conference in Canberra recently, a colleague from WA presented on her research surveying doctors who had

considered leaving or left medicine. The most commonly cited suggestion to improve retention? Better morale and culture.

To anyone who has felt this way. I hope you find yourself in a quiet room with some colleagues, and ideally an oil diffuser, where you too can find the value in shared reflection and vulnerable leadership.



2019 AMA Private Health Insurance Report Card

BY ASSOCIATE PROFESSOR JULIAN RAIT OAM, CHAIR, AMA COUNCIL FOR PRIVATE

Australia needs a strong and viable private health sector to maintain the reputation of our health system as one of the world's best. Improving the value of private health insurance for consumers is vital for the continuation of private health care in Australia.

Purchasing private health insurance is a significant financial commitment for many consumers and achieving value for money is extremely important. Private health insurance should offer Australians greater choice in their doctors and location of their treatment and should deliver shorter waiting times for services.

However, private health insurance is one of the most complex forms of insurance and the current complexity of product offerings has led many consumers to report that they do not understand when they are covered, what they are covered for and why they have significant out-of-pocket costs but still pay thousands of dollars every year.

In the absence of quality information for our patients provided elsewhere, the AMA continues to provide leadership in health literacy, including financial literacy.

Our annual Private Health Insurance Report Card is a key component of this work. Through our report cards we strive to provide patients and consumers with clear, simple information about how health insurance really works.

The 2019 AMA Private Health Insurance Report Card explains what insurance may cover, what the Medicare Benefits Schedule (MBS) covers, and what an out-of-pocket fee can be under different scenarios. We also highlight the frustrating fact that what insurers pay varies significantly from across insurers, but even more concerningly from State to State within the same insurance fund.

To help consumers better understand what they are buying, we set out the percentage of hospital charges covered by State and insurer, and the percentage of services with no gap, State by State. The Report Card shows that some insurers perform well overall, and some only perform well for certain conditions.

Out-of-pocket costs are becoming a major issue for people contemplating either purchasing a policy for the first time or whether to relinquish their current insurance. Consequentially

explaining how out-of-pocket costs arise in our health system is a major focus for this year's Report Card.

The 2019 Report Card shows each insurer sets the rebate amount that they are willing to pay. If the insurer's rebate is low, the out-of-pocket cost to their customer will be high. These insurer-caused out-of-pocket costs can vary by thousands of dollars.

The Report Card demonstrates how the same doctor performing the same procedure can be paid significantly different rates by each fund, this is often the untold story behind patient out-of-pocket costs, despite there being high levels of no gap and known gap billing statistics.

Following two years of deliberation by the Private Health Ministerial Advisory Committee, 2019 saw the Government implementation of the full suite of its reforms to private health insurance. Reforms that: developed clearer consumer communication; introduced standardised clinical definitions; and brought in the Gold, Silver, Bronze and Basic tiers of insurance.

Our Report Card this year includes a guide for patients about what the recent government reforms mean for them – how the reforms have impacted on their policies, their choices.

The complexity of private health insurance reduces the value to patients, through reducing transparency of benefit coverage, and choice of practitioner and timing of treatment.

Through this report, and in conjunction with our recently released guide – *Informed Financial Consent: A Collaboration Between Doctors and Patients*, the AMA aims to empower patients with important information to help them navigate their private health insurance policies, understand medical costs, and give them confidence to discuss and question fees with their health insurers and their doctors.





Private Health Insurance reform – the policy vacuum and the opinions

BY DR OMAR KHORSHID, CHAIR, HEALTH FINANCING AND ECONOMICS COMMITTEE

There is no disagreement private health insurance (PHI) sustainability is at a crossroads. Without reform, the private health insurance as we know it, is on a trajectory to oblivion. While some might cheer, those of us who work across the public and private hospital sectors know this outcome will hurt public patients the most. The already stretched public hospitals with unacceptable elective surgery treatment waiting times, are not at all well placed to absorb the nearly three million (2.7m) episodes of private hospital elective surgery episodes undertaken in private hospital beds and financed by PHI.

“The AMA has been methodically developing our own options for reform which will be announced when the time is right.”

The Prime Minister has stated his Government will listen to all suggestions to arrest the slide in private health insurance. The AMA has been methodically developing our own options for reform which will be announced when the time is right. In the meantime, Private Healthcare Australia recommends restoring the 30 per cent base rebate for young people under 40 and for the same group, introducing a fringe benefits tax exemption for PHI premiums. Private Healthcare Australia also want a targeted PHI promotion campaign to increase awareness and understanding of the existing, recently implemented, age-based premium discount and the Lifetime Health Cover penalties for delayed PHI purchase. Individual insurers have been in the media promoting their own preferred solutions including the abolition of Medicare and community rating that protects patients from premium price discrimination on the basis of health status, PHI claims history and genetics etc.

The Medical Technology Association of Australia (MTAA) is advocating for change to improve the efficiency of private healthcare delivery, largely within the existing PHI policy parameters, including premium restraint from the most profitable insurers. The Australian Dental Association suggests

PHI needs a full scale review. They also favour replacing PHI with government Health Savings Accounts (HSA) similar to the Singapore model.

Actuaries Australia offers a number of solutions that include: the promotion of out of pocket doctor's fees linked to patient outcomes; creating a role for independent care coordinators to guide patients in medical practitioner selection along their health care pathway using evidence of outcomes and fees; a prospective PHI re-insurance scheme to encourage insurers to more actively manage the health costs of high cost members, including the adoption of outcome based PHI benefit payments; and more effective PHI promotion.

With all of these stakeholder suggestions for PHI reform, the jockeying for influence amongst stakeholders is gaining pace. Meanwhile, the Government is holding its cards close to its chest. With the Federal Budget due to be announced in May 2020, any new spending in the health portfolio will likely need to be offset at least in part by portfolio savings if the Government wants to maintain its commitment to a budget surplus. No wonder, the Health Minister is so keen to rush through Parliament a Data Matching Bill, designed to increase MBS & PBS compliance in the hope of generating savings.

The Minister's priorities for spending these savings won't be publicly known until Budget night. The not yet fully agreed public version of the 2020-25 National Health Reform Agreement makes it pretty clear any new health sector money in the 2020 Budget is unlikely to be spent on public hospitals other than by virtue of the existing funding formula.

The AMA will be doing all that it can to ensure the PHI solutions that get implemented are genuine, address the underlying cause of young people dropping out of PHI, maintain PHI equity, protect doctors from PHI interference in clinical decision making and hold private health insurers to account. It is vital new government investment is not commandeered by health insurers for profits or PHI administrative budgets – budgets that are already running at around nine per cent of premium revenue per annum.



Improve access to safe drinking water to improve Indigenous health

BY AMA PRESIDENT DR TONY BARTONE, CHAIR OF AMA INDIGENOUS TASKFORCE

“It is devastating that some communities are currently at risk of losing their water supplies, but it is even more disturbing that many Indigenous communities live without safe drinking water on a daily basis.”

Having access to safe drinking water is a human right. Water is a critical issue for many communities across Australia, particularly those experiencing the effects of the current drought. It is devastating that some communities are currently at risk of losing their water supplies, but it is even more disturbing that many Indigenous communities live without safe drinking water on a daily basis.

In prosperous countries such as Australia, it is often assumed that safe drinking water is accessible to everyone – but it is not. In many remote or very remote communities bore water is often the primary source of drinking and household water – it is often contaminated and fails to meet the standards of the Australian Drinking Water Guidelines. In a 2015 report from the Western Australia (WA) Office of the Auditor General, between 2012 to 2014, 80 per cent of the State’s remote Aboriginal communities failed to meet quality standard testing. Furthermore, water contamination is causing alarming rates of disease in Indigenous communities, where toxicity from nitrates is much higher than that of non-Indigenous Australians.

The burden of inequity in terms of access to safe drinking water in Australia disproportionately affects remote areas, and these areas often have a larger population of Aboriginal and Torres Strait Islander people. The fact that Indigenous people live without safe drinking water is unacceptable and it should not be the case that people in remote communities are out of sight, therefore, out of mind. Aboriginal and Torres Strait Islander people in remote communities represent an important part of Australia’s heritage and local, state, territory and federal governments must take urgent action to address the water crisis facing many remote communities.

Not only is access to safe drinking water a human rights issue, it is also an important public health issue. The lack of water and affordable healthy food in rural and remote communities is strongly linked to the epidemic levels of diabetes and renal disease among Aboriginal and Torres Strait Islander people. Sugary drinks are more readily available than low sugar drinks, and in some communities, they are more accessible than running water. In a study published by the Australian National University earlier this year, concerns about the safety and quality of drinking water in rural and remote areas have led residents to avoid tap water and instead buy bottled water, cordial or other sugary drinks.

It is unfathomable that in Australia, communities do not have access to safe drinking water – this is essential for good health and wellbeing. While the majority of us enjoy free, safe drinking water from the tap, those who can least afford it often have to pay just to ensure they are not drinking water sourced from rivers, streams, rivers, cisterns, poorly constructed wells, or water from an unsafe catchment. It is an issue that demands immediate attention and action by all levels of government – without it, the health gap Aboriginal and Torres Strait Islander people and their non-Indigenous peers will remain wide and intractable.

Access to safe drinking water is an important policy issue for the AMA and is something that we will continue to advocate for. Governments must invest in infrastructure, such as proper treatment facilities, water storage facilities and distribution systems to meet the demands of communities.

All Australians have to right to have permanent and free access to safe drinking water regardless of where they live.



Research

WITH CHRIS JOHNSON

Aussie health at risk due to climate change inaction



Australia remains at significant risk of declines in health due to climate change because of a lack of national policy to address it, say authors of research published in the *Medical Journal of Australia*.

The 2019 *MJA-Lancet* Countdown report calls for substantial and sustained national action on climate change, and specifically in the context of health.

“In a year marked by an Australian federal election in which climate change featured prominently, we find mixed progress on health and climate change in this country,” said lead author Associate Professor Paul Beggs, from Macquarie University.

“There has been progress in renewable energy generation, including substantial employment increases in this sector. There has also been some progress at State and local government level.

“However, there continues to be no engagement on health and climate change in the Australian Federal Parliament, and Australia performs poorly across many of the indicators in comparison to other developed countries; for example, it is one of the world’s largest net exporters of coal and its electricity generation from low carbon sources is low.

“We also find significantly increasing exposure of Australians to heatwaves and, in most states and territories, continuing elevated suicide rates at higher temperatures.”





The 2019 update tracked progress on health and climate change in Australia across the same five broad domains and many of the same indicators as in 2018. A number of new indicators were introduced this year, including one focused on wildfire exposure, and another on engagement in health and climate change in the corporate sector.

“The lack of Australian national policy to address threats of climate change to health – and the consequent failure to realise the enormous opportunities that doing so would afford our nation – is disappointing to say the least,” Professor Beggs and colleagues said.

“This work is urgent and should be undertaken within a complex systems thinking framework. As a direct result of this failure, we conclude that Australia remains at significant risk of declines in health due to climate change, and that substantial and sustained national action is urgently required in order to prevent this.”

Daytime drowsiness linked to diet

High intakes of saturated fats and carbohydrates increase the risk of excessive daytime sleepiness, according to a study that has sought to understand the condition.

Excessive daytime sleepiness affects about 15 per cent of Australia’s general population and is associated with health and societal consequences – from increased risk of work-related errors and injuries, to cardiovascular diseases and mortality.

Flinders University researcher Dr Yohannes Adama Melaku said the findings had been inspired by diet-related excessive feeling of sleepiness observations that had previously been identified in much smaller studies.

This research is part of the expansive North West Adelaide Health Study (NWAHS), which has examined data of 4,033 participants aged 18 to 90 years between 1999-2000 and 2018.

“We saw a great opportunity to examine daytime sleepiness outcomes within a much larger sample size,” Dr Melaku said.

“It was taking a theory out of the laboratory and seeing if it applied in the general population. And we found that it has.

“Unique to this study, we applied advance methods to



investigate the substitution effect of one macronutrient by other macronutrients. In other words, we looked at the effect of changing nutrients in the diet without changing the amount of calories consumed, allowing us to demystify the interplay and complex interaction among macronutrients in predicting daytime sleepiness.”

The study shows that saturated fat intake was positively associated with feeling sleepy during the day, with a modest similar association of carbohydrate intake.

Professor Adams, who is Medical Director of the Adelaide Institute for Sleep Health at Flinders University, said more research needs to be done about whether replacing high saturated fats and carbohydrates with more protein in a diet will remedy excessive daytime sleepiness problems in patients.





Research

"This study highlights the important role of diet in predicting risk of daytime sleepiness among adults," Prof Adams said.

"People who have sleep related disorders (such as Obstructive Sleep Apnea patients) and disturbed circadian rhythm, such as shift-workers, could benefit from dietary interventions to alleviate excessive daytime sleepiness.

"In addition, the findings of this study have significant implications for alertness and concentration, which would be of particular concern to workers in certain industries.

"Our findings can assist in the design of trials involving substitution of food types in populations with excessive daytime sleepiness."

The paper, *Association between macronutrient intake and excessive daytime sleepiness: an iso-caloric substitution analysis from the North West Adelaide Health Study*, has been published in the journal *Nutrients*.

Study reveals doctor conflicts over ACDs

A new Australian study has shed light on why doctors sometimes struggle to comply with patient choices documented in Advance Care Directives.

An Advance Care Directive (ACD) is a written record of patient preferences for future care. The directive can record values, life goals and preferred outcomes, or directions about care and treatments. ACD can also formally appoint a substitute decision-maker.

They are often used to plan for future health care and a time when patients may be longer able to communicate decisions for themselves.

The study, published in *BMJ Open*, uncovers the complexity and difficulty experienced by doctors when enacting ACDs, and the deep conflict in weighing up whether to follow a patient directive.

The findings challenge the widely-held assumption that personal autonomy and choice trumps all in medical treatment decision making.

The qualitative research led by Advance Care Planning Australia, presented 21 doctors from a Melbourne hospital with real-life scenarios to explore how doctors use ACDs to guide medical

treatment decision making, when faced with different patients and circumstances.

Interestingly, the study found that overall, doctors appeared more motivated to act in what they considered to be the patient's best interest, rather than upholding the individual's autonomy or following a legally-binding directive, which potentially puts doctors and health services at risk.

Doctors were more likely to rely on their own judgement and override patient choice when:

- ACDs are not current, were too vague or incoherent;
- ACDs were not easily accessible at the point of care;
- they encounter family opposition; and
- faced with a patient with a condition the doctor deemed to be potentially reversible.

The study found that doctors sometimes doubted the validity of ACDs, questioning how well equipped non-medically trained people were to make nuanced and complex medical decisions and whether a person could make such important decisions and informed choices in advance.

"The findings suggest that more work needs to be done to support doctors in what can be very ethically and legally complex, challenging and time-pressured decision-making," said Linda Nolte, Program Director of Advance Care Planning Australia.

"We can't underestimate the real-world dilemmas doctors' sometimes face in enacting Advance Care Directives, but equally we can't lose sight of the fact that Advance Care Directives are legally-binding documents. Competent adults have the right to make decisions in advance as to how they wish to be cared for. And quite rightfully they expect that everyone involved in their care will do their utmost to respect their choices.

"The study also highlights the need for people to ensure their advance care planning documents are accurate, up-to-date, complete and easily accessible, otherwise the treating doctor may not be able to comply with the directive."

Advance Care Planning Australia offers a free national advisory service for health professionals and the public on phone number 1300 208 582.





Research

New European guidelines on dyslipidaemias highlights research in Australia

The Australian LDL cholesterol (LDL-C) targets in secondary prevention patients are being revisited in studies, following the recent publication of the European Society of Cardiology (ESC) and European Atherosclerosis Society (EAS) guidelines on dyslipidaemias.

For very-high risk patients in secondary prevention, the guidelines recommend a new LDL-C goal of <1.4 mmol/L and an LDL-C reduction of at least 50 per cent from baseline. For those with recurrent events within two years while taking maximally tolerated statin therapy, a goal of <1.0 mmol/L for LDL-C may be considered.

According to an article published in *MJA Insight* by clinical cardiologist and Professor of Medicine at Flinders University, Professor Philip Aylward, the Australian LDL-C targets for patients at high risk of cardiovascular events, should be revised to <1.4 mmol/L to match the European guidelines.

“In Australia, various guidelines suggest a target of <1.8 mmol/L for LDL-C for secondary prevention patients. However, the new target for patients post an ACS or otherwise at very high risk should be <1.4 mmol/L,” Prof Aylward said.

“Mendelian randomisation studies have confirmed the critical role of LDL-C in atherosclerotic plaque formation and related subsequent cardiovascular events. Lowering LDL-C reduces cardiovascular events, including death, myocardial infarction (MI) and stroke.

“To achieve an LDL-C target of <1.4 mmol/L many patients will require not only high intensity statin and ezetimibe, but additional therapies. Currently an effective additional therapy is a PCSK9 inhibitor.”

One of the main updates since the 2016 European guidelines on dyslipidaemias, is the Class IA recommendation of PCSK9i therapy as secondary prevention. This recommendation is for patients at very high risk not achieving their LDL-C goal after 4-6 weeks of maximum tolerated dose of a statin and ezetimibe.

“The new European clinical guidelines represent a significant step forward in comparison to the previous guidelines,” Professor Aylward said.

The new guidelines are supported by data from Odyssey Outcomes, a multicentre, randomised, double-blind, placebo-controlled, treat-to-target trial assessing the effect of alirocumab versus placebo in 18,924 patients who had an acute coronary syndrome (ACS) 1 to 12 months (median 2.6 months) before randomisation.

Binges and diets affect quality of life



Eating disorders have similar quality of life impacts to other common mental health disorders like anxiety, depression and schizophrenia, according to new Deakin University research.

The research from Deakin’s Institute for Health Transformation showed that even those who experience infrequent binge eating episodes or enforce restrictive diets – typically considered below the eating disorder ‘threshold’ – still reported significantly lower quality of life than peers in the general population.

Representative data from more than 5,000 people was studied, with researchers finding that 18 per cent of the sample showed symptoms associated with an eating disorder, consistent with estimated national prevalence rates.

Lead researcher Dr Long Le, from the Institute’s Deakin Health Economics team, said this insight was critical in understanding the full burden of eating disorders, as well as identifying those who needed help.





Research

"The bulk of this number, 15 of the 18 per cent, were designated as having 'sub-threshold' eating disorders," Dr Le said.

If these behaviours continued, they could become more severe and evolve into 'threshold' eating disorders.

The relationship between binge eating, obesity and quality of life also needed to be more fully explored.

"We found that people with high BMI had a lower quality of life relative to those of a healthy weight, whether or not they had an eating disorder," Dr Le said.

"This is important, as the prevalence of both obesity and binge eating has been increasing significantly during the past 20 years."

Burden and Health State Utility Values of Eating Disorders: Results from a population-based survey was published in the *Psychological Medicine Journal*.

Suggestions we are overestimating lifetime cancer risks

Researchers have found current estimates of lifetime risks of cancer diagnosis and

mortality consistently higher than when they allowed for competing causes of death.

The method used in Australia to determine estimates of lifetime risks of cancer

diagnosis and mortality could lead to an overestimation of these risks, especially for men, according to University of Sydney and Bond University researchers.

Cancer registries and organisations such as the Australian Institute of Health and

Welfare (AIHW), use age specific cancer incidence and mortality data in a calendar year to estimate lifetime risks of cancer diagnosis and mortality.

However, the method used to achieve these numbers assumes there are no competing causes of death, which may lead to overestimation of lifetime risk and the researchers have recommended that the more accurate methodology be adopted.

The research has been published by the *Medical Journal of Australia*.

Dr Katy Bell from the University of Sydney's Faculty of Medicine and Health, was senior author on the analysis, which was led by Dr Anthea Bach from West Moreton Hospital and Health Service and Dr Kelvin Lo from Westmead Hospital.

The researchers calculated their own estimates on lifetime risks of cancer diagnosis and cancer-specific death, adjusted for competing mortality, and compared their findings with the corresponding risks published by the AIHW.

"AIHW estimates were consistently higher than our competing mortality-adjusted estimates of lifetime risks of diagnosis and death for all five cancers," Dr Bell and colleagues wrote.

"Differences between AIHW and adjusted estimates declined with time for breast cancer, prostate cancer, colorectal cancer, and lung cancer (for men only), but remained steady for lung cancer (women only) and melanoma of the skin.

"In 2013, the respective estimated lifetime risks of diagnosis (AIHW and adjusted) were 12.7 per cent and 12.1 per cent for breast cancer, 18.7 per cent and 16.2 per cent for prostate cancer, 9.0 per cent and 7.0 per cent (men) and 6.4 per cent and 5.5 per cent (women) for colorectal cancer, 7.5 per cent and 6.0 per cent (men) and 4.4 per cent and 4.0 per cent (women) for melanoma of the skin, and 7.6 per cent and 5.8 per cent (men) and 4.5 per cent and 3.9 per cent (women) for lung cancer.

The authors stressed that they were not criticising the AIHW.

Richard Juckes, Head of Health Group at AIHW said cancer risk estimates are very important and should be as accurate as possible and suitable for answering the specific question of interest.

"Different methods are appropriate for different purposes," Mr Juckes said.

"The method used by the AIHW is best suited for international comparisons because it is able to be used for most countries and it is recommended by the World Health Organisation's International Agency for Research on Cancer (IARC) and the International Association of Cancer Registries (IACR).

"The competing mortality method has advantages in more accurately estimating lifetime risks of diagnosis and death from cancer. However, for the purpose of international comparisons it is better to have Australian estimates calculated on the same basis as other countries than to use estimates that aren't as comparable."

Violence against doctors increases globally



The World Medical Association is noting a rising tide of violence against physicians and health professionals being reported to it from around the globe.

Physician leaders from Central and South America, from India and Bangladesh, and from Germany have all recently reported incidents of physicians being assaulted and even killed.

Now the WMA is calling for security posts to be provided in all healthcare facilities to combat the incidents of violent attacks against healthcare professionals and facilities.

WMA President Dr Miguel Jorge said: "Violence has become a significant public health challenge. Attacks on healthcare facilities, healthcare personnel, and the sick and wounded are in direct breach of medical ethics, international humanitarian and human rights laws."

In a new policy statement, the WMA says that although many

countries accept the need for violence prevention programs they still face many challenges. These include inadequate or non-existent reporting of data, inadequate investment in prevention programs and support services for victims of violence, and failure to enforce existing laws against violence.

"These failures are to do with a lack of leadership, and social determinants such as unemployment, poverty, health, gender inequality, and poor access to educational opportunities," Dr Jorge said.

"So, we are proposing a series of measures, including the provision of security posts and efficient surveillance in all healthcare facilities.

"It is time that governments demonstrated their political commitment to tackle the shame of violence on our health services."



Floods spark disease fear across parts of Africa



The World Health Organisation has ramped up its disease surveillance actions and is providing critical supplies to populations across Africa and the Eastern Mediterranean Region in the wake of heavy flooding.

Successive storms, cyclones and heavy rains has been severe in 2019, and the impact is being in areas that have been hit the hardest.

More than a million people have been affected in some of the worst struck countries of Benin, Cameroon, Central African Republic, Somalia, South Sudan and Yemen.

Flood-hit populations face increased risk of illness or death from water-borne diseases and other diseases that spread easily in overcrowded, temporary shelters.

Together with governments, other UN agencies and partners, WHO is working to reduce the risk of outbreaks of cholera, typhoid and other infectious diseases.

Almost one million people have been affected in South Sudan, where 60 per cent of flood-hit areas already faced extreme levels of malnutrition.

Since the latest rains began in July, 42 nutrition centres have been forced to suspend their services. WHO is sending experts and airlifting medical supplies to the most affected areas.

In Somalia and Somaliland, floods have led to the displacement of more than 300,000 people since September.

Many flood-hit districts are cholera hotspots, where people already faced limited access to health facilities. With many roads now impassable, and an upsurge of malaria and diarrhoea, the situation for many is critical.

WHO has helped deploy 20 emergency response teams, 10 rapid response teams, and distributed 483 medical supply packages that include supplies to manage cholera and trauma. More than 2,200 people have been treated for pneumonia, measles, diarrhea and other health issues.

In the Central African Republic, recent floods have left 23,000 people displaced. WHO is distributing mosquito nets, cholera treatment, and other vital supplies to tackle water-borne diseases.

In the Eastern Mediterranean Region, Cyclonic Storm Luban struck Yemen in October, killing 14 and displacing 800. In response, WHO's prepositioned supplies and medical kits are being used to aid stricken populations.

Storm Luban is just one example of how 2019 has become the most active North Indian cyclone season on record, with climate change stirring up extreme weather patterns worldwide.



BMA issues health manifesto ahead of election



The British Medical Association has called for increased investment to put the National Health Service back on a sustainable footing. It has also called for an end to a pension tax system, which it says is driving doctors out of the workforce.

These calls have been made in a manifesto the BMA has issued to the political parties contesting the upcoming UK general election.

In the manifesto for health, the Association urges a funding increase of 4.1 per cent, a focus on prevention with tougher action on smoking, alcohol misuse, physical inactivity and poor diet, a final say for the public on any Brexit deal, legislation for safe staffing and an end to the pension tax system.

There is growing evidence of the effect of the pensions crisis from a host of surveys carried out by medical royal colleges and other medical groups in the past weeks, the BMA says. The manifesto also urges fair pay for doctors – one that truly values the medical workforce and helps to retain staff.

The need for urgent action comes as new analysis from the BMA shows more than one million patients could experience waits of more than four hours at emergency departments this winter and

almost a third of a million will wait on trolleys to be treated.

The report warns that NHS is on track to endure its worst-ever winter, as analysis of emergency care four-hour wait times, emergency care admissions and attendances and trolley waits suggest that pressures on services look set to skyrocket in the coming months.

Ahead of the upcoming election, the BMA is calling on the Government to prioritise the NHS as it warns of a 'perfect storm' caused by a lack of recovery from the worst-ever summer, along with staff shortages, a predicted cold winter and bad flu season, as well as the effect of Brexit.

BMA Council Chair Chand Nagpaul said: "Enough is enough. Right across the health service, trusts and GP practices will be bracing themselves for what looks set to be the worst winter the NHS has ever endured.

"Patients should not fear needing hospital care or not being able to see their GP and should not have to accept that they may spend hours on a trolley in an emergency department, waiting to be treated.

"Equally, staff working in hospitals and GP practices across the country should not be facing the daunting prospect of having to care for those patients in these relentlessly pressurised environments.

"This perfect storm is brewing alongside the upcoming general election and politicians should be paying close attention to learn from the failures to invest in and support our health service for over a decade.

"Though the need for urgent funding this winter is pressing, this is not just about the short-term fix. This is about the current and any future Government putting the NHS back on a sustainable footing, with capacity to meet the demands on its services.

"That requires sufficient numbers of beds and facilities, and an adequately staffed workforce that is ready and motivated to meet rising pressures, that prioritises healthcare prevention and that puts patient care back in the focus."



Arts for health's sake



A World Health Organisation analysis has concluded that engaging with the arts is beneficial to both mental and physical health.

While that might not be news to most people, the study was comprehensive enough to actually make news headlines around the globe.

And the good old didgeridoo features! Didgeridoo lessons are apparently very good for your health.

WHO's Regional Office for Europe analysed evidence from more than 900 global publications, making it the most comprehensive review of evidence on arts and health to date and the first time the Organisation has looked at ways in which the arts can prevent and treat illness.

"Bringing art into people's lives through activities including dancing, singing, and going to museums and concerts offers an added dimension to how we can improve physical and mental health," said Dr Piroška Östlin, WHO Regional Director for Europe.

"The examples cited in this groundbreaking WHO report show ways in which the arts can tackle 'wicked' or complex health challenges such as diabetes, obesity and mental ill health. They consider health and wellbeing in a broader societal and community context, and offer solutions that common medical practice has so far been unable to address effectively."

The report reviews arts activities that seek to promote health and prevent ill health, as well as manage and treat physical and mental ill health and support end-of-life care. It was launched in November during an event in Helsinki, Finland, which brought together experts, policy-makers, practitioners and service users to discuss the role of arts interventions in health care.

According to the report, the arts can positively influence health from before birth to the end of life. Young children whose parents read to them before bed have longer night-time sleep and improved concentration at school. Drama-based peer education can support responsible decision-making in adolescents, enhance well-being and reduce exposure to violence. Later in life, music can support cognition in people with dementia – singing in particular has been found to improve attention, episodic memory and executive function.

In healthcare settings, arts activities can be used to supplement or enhance treatment protocols. For example:

- listening to music or making art have been found to reduce the side effects of cancer treatment, including drowsiness, lack of appetite, shortness of breath and nausea;
- arts activities in emergency settings, including music, crafts and clowning, have been found to reduce anxiety, pain and blood pressure, particularly for children but also for their parents; and
- dance has been found repeatedly to provide clinically meaningful improvements in motor scores for people with Parkinson's disease.

The report highlights that some arts interventions not only produce good results, but can also be more cost-effective than more standard biomedical treatments. They can combine multiple health-promoting factors at once (such as physical activity and mental health support) and have a low risk of negative outcomes. Because arts interventions can be tailored





Arts for health's sake ... continued

to have relevance for people from different cultural backgrounds, they can also offer a route to engage minority or hard-to-reach groups.

Several countries are now looking to arts and social prescribing schemes, whereby primary-care doctors can refer their patients to arts activities.

The report outlines policy considerations for decision-makers in the health sector and beyond, such as:

- ensure the availability and accessibility of arts-for-health programs within communities;
- support arts and cultural organisations in making health and well-being part of their work;
- promote public awareness of the potential health benefits of arts engagement;
- include arts in the training of health-care professionals;

- introduce or strengthen referral mechanisms from health or social-care facilities to arts programs or activities; and
- invest in more research, particularly in scaling up arts and health interventions, and evaluating their implementation.

The report reviewed the health benefits (either through active or passive participation) in five broad categories of arts: performing arts (music, dance, singing, theatre, film); visual arts (crafts, design, painting, photography); literature (writing, reading, attending literary festivals); culture (going to museums, galleries, concerts, the theatre); and online arts (animations, digital arts, etc.).

The report can be found at: <http://www.euro.who.int/en/publications/abstracts/what-is-the-evidence-on-the-role-of-the-arts-in-improving-health-and-well-being-a-scoping-review-2019>

Abstracts call for international trauma conference in Jerusalem

The second International Conference on Trauma and Mental Health will be held in Jerusalem, Israel between September 6 and 8, 2020. It will bring together some of the world's leading trauma and mental health specialists to present the latest research and outcomes in the field.

An initiative of Hadassah Australia and supported by the Phoenix Australia Centre for Post-Traumatic Health, this conference follows the successful, inaugural International Conference on Trauma and Mental Health, which took place in Jerusalem in 2017 and was attended by 320 delegates from 16 countries.

The focus of this second conference will be challenges and innovations when dealing with the impact of trauma and adversity – particularly in the form of PTSD and as it relates to people living in long-term conflict.

Sub themes are consequences of living in long-term conflict zones and innovations in prevention and intervention in mental

health consequences of trauma.

There will be opportunity for practitioners, researchers, service developers and providers to hear from internationally regarded experts in the field, including Sir Prof Simon Wessely (UK), Prof Barbara Rothbaum (USA), Prof Tine Jensen (Norway) and Prof Richard Bryant (Australia).

Conference organisers are inviting submissions of abstracts of proposed presentations from psychiatrists, psychologists, GPs, social workers, paediatricians, academics and researchers, as well as administrators and policy makers covering any topic relevant to the field of trauma and mental health.

The deadline for submission for abstracts is 29th February 2020. Abstracts can be submitted via:

<https://www.traumaandmentalhealthconference.org/call-for-abstracts>



Breakthrough in vaping death cases



The US's Centers for Disease Control and Prevention have hailed a breakthrough in the investigation into vaping deaths and illness that has already claimed 39 American lives.

With vaping related illness cases having cracked 2,000, officials say they have detected the vitamin E acetate compound in all the lung fluid samples from 29 patients who were hospitalised after vaping.

The finding suggests a link that could prove to be responsible for the deaths and lung injuries from e-cigarette use.

Hundreds of vaping patients had acknowledged vaping THC, which is the main psychoactive component of marijuana. Tests have previously detected vitamin E in samples of THC vaping products.

"Vitamin E acetate is a known additive used to dilute liquid in e-cigarettes or vaping products that contain THC," said Dr Anne Schuchat from the Centers for Disease Control and Prevention.

"We have detected a potential toxin of concern. These findings provide direct evidence of vitamin E acetate at the primary site of injury within the lungs.

"When Vitamin E acetate is inhaled, it may interfere with normal lung function."

Vitamin E acetate is usually safe to swallow or apply on the skin, and is found in many foods, skin creams, and supplements.

Chinese jailed over fentanyl smuggling to America

A joint US-China investigation has led to nine Chinese nationals being jailed in China for smuggling fentanyl into the US.

It is the first time officers from both countries had worked on such a case together.

The investigation and subsequent arrests followed US President Donald Trump publicly claiming China was not doing enough to stop the opioid being smuggled into America.

Of the nine jailed, one was given a suspended death sentence and life in prison; two other others were given life sentences; and the rest were given sentences between six months and 10 years in prison.

A White House statement from the Office of National Drug Control Policy praised the "concrete action" taken by China.

"We look forward to further cooperation to stop the flow of these deadly substances into the United States," the statement said.

The operation began in August 2017 and involved a "cooperating defendant" and a sting that led to the arrests.

The investigation also led to three major criminal arrests in the US.

President Trump has claimed fentanyl kills "100,000 Americans a year," but official figures put the number at about 28,000.



From wheels to wings

BY DR CLIVE FRASER

It has been exactly 100 years since a duo of intrepid explorers set off from Longreach in Western Queensland in a Model T Ford to survey landing strips for an air race.

The story began with a competition proposed by Australia's Prime Minister (Billy Hughes) for an air race between London and Sydney.

The rules stipulated that the pilots must be Australian and the journey had to be completed in under 720 hours.

Billy Hughes offered a prize of £10,000 which in today's money is a huge \$791,885.88.

The explorers had both served at Gallipoli and then in the Flying Corps in Palestine prior to returning to Australia.

They had intended to be participants in the air race, but their generous sponsor (Sir Samuel McGauhey) died before their funds were secured.

The explorers were Hudson Fysh and Paul McGinness and their support crew consisted of their driver/mechanic George Gorham.

The overland trip to Darwin was of 2180 kilometres with mostly no made roads, no bridges and barely a track to be followed.

Damage to the vehicle included bent axles and a broken radiator and fan, but the Model T made it all the way.

The journey also marked the first crossing of the Gulf of Carpentaria by automobile.

With conditions on the ground being impossibly harsh it was no wonder that Fysh and McGinness dreamt of making the journey by air.

Those dreams were realized in 1920 with the formation of the Queensland and Northern Territory Aerial Service.

Their first planes were a pair of Australian assembled two-seater Avro 504Ks almost identical to those flown in World War One.

Instead of taking two days to travel from Winton to Cloncurry by horse-drawn coach, flying with Qantas would shorten the journey to three hours.

Hudson Fysh continued to steer Qantas to great success until his retirement as Chairman in 1966.

Fast forward to 2009 and a second set of intrepid explorers attempted to re-trace the original trek in another 1919 Model T Ford.

This time around they'd have GPS and a satellite phone, but the tracks were the same as Fysh and McGinness had travelled on.



They would also only be carrying 47 gallons of fuel, the same as in 1919.

The journey was filmed and their Model T named 'Molly' is on display in Longreach at the Qantas Founders Museum.

The vehicle suffered a broken front axle which was re-welded en route.

The Model T was powered by a 2.9 litre four-cylinder engine delivering 20 horsepower (15kW).

There were times during the 1919 journey that an extra two horses were required to pull the vehicle through some deep creek crossings.

But in 2009, the extra horses would come from modern SUVs.

So with so much extra horsepower there should have been no excuse for not completing the trip.

But all of that extra gear does come at a cost with the added weight limiting travel over land.

And so it was that at Sandy Creek 'Molly' floundered and just would not make it up the bank.

With no horses in sight the decision was made to re-trace the journey back to a more conventional route.

Disappointed the crew were left thinking that they'd failed, only to discover that Fysh and McGinness had probably back peddled at just about the same spot.

In 1919 Fysh and McGinness took 51 days to drive from Longreach to Katherine.

It's now a 22-hour drive on the Landsborough Highway according to my GPS.

Safe motoring,

Doctor Clive Fraser

doctorclivefraser@hotmail.com

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