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Co-pay 'dead', now for real health policy

PM talks health with AMA, p6

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In this issue

It's big picture time for health

BY AMA PRESIDENT ASSOCIATE PROFESSOR BRIAN OWLER

The scrapping of the GP co-payment may provide the Government with some electoral relief, but it also opens up a whole new world of health policy opportunity.

While the Health Minister Susan Ley still has some tidying up to do with the unpopular Medicare changes she inherited – including hopefully lifting the freeze on Medicare patient rebates – she can now start looking at political and policy opportunities elsewhere in the health system.

The co-payment created a ten-month vacuum as far as health policy is concerned.

The co-payment has sucked the life out of health policy development, discussion, and debate. This has not only been detrimental to the Government, it is also harmful for the practice of medicine and for our patients.

Minister Ley was thrown somewhat of a hospital pass when she took on the portfolio. Her attempts to consult and develop something more akin to health policy are laudable. However, it means she had little time to devote to the many potential crises brewing in her broad portfolio – and many crises there are.

She now has some clear air, but not necessarily a clear path ahead.

The biggest policy vacuum is public hospitals. Little has been said about public hospitals since funding was ripped out of the sector in last year's Budget, but recent media reports indicate there is trouble ahead.

There are concerns about hospital capacity in many States, with problems in NSW and South Australia in the news. The new government in Queensland has sacked the Director General of Health as investigations into its health system are underway. Targets are not being met across the country.

The vexed issue of public hospital funding and efficiency will come to a head when COAG meets in April. By then, State Treasurers will have assessed the impact that last year's Federal Budget cuts will have on their ability to keep their public hospitals running effectively to meet growing patient need – and meet targets for surgery and emergency departments.

Mental health is another neglected area.

In February last year, then Health Minister Peter Dutton tasked the National Mental Health Commission with conducting a review of mental health programs and services. That review has been completed and has been with the Government for some time, but we are still waiting on the public release.

The Personally Controlled Electronic Health Record (PCEHR) was not that long ago touted as the most important initiative in health. Today, all we hear about is the massive waste of taxpayer money in its development. The Abbott Government commissioned a review but, 14 months later, is yet to respond to the review's recommendations. The PCEHR remains in limbo, a very large white elephant.

The abolition of agencies, including the Australian National Preventive Health Agency and Health Workforce Australia, has resulted in a noticeable pause in policy development as key functions are moved to the Department of Health and bedded down. This process has been slow, which means that important planning for future medical workforce and medical training is delayed, and public health programs around alcohol, tobacco, and obesity, among others, are non-existent.

Primary Health Networks – the bodies set to replace Medicare Locals – have not yet appeared. The tender process is finished, but we are yet to know which organisations, possibly including private health funds, will be administering primary health care services across Australia.

The recent Close the Gap reports show that we are failing in Indigenous health.

Rural and remote areas of Australia continue to suffer health service inequity due to a lack of major rural health initiatives.

Aged care is under enormous stress. There needs to be a greater focus on palliative care.

The Minister is in the middle of negotiations on the new Pharmacy Agreement, which has involved discussions with many key stakeholders outside pharmacy.

The medical profession is still burdened with too much red tape.

All these pieces of the health system are linked. When one part is suffering, the effects are felt across the health system. There are many troubling ripples at work at the moment.

It is vital that the co-payment saga is dealt with as a matter of urgency. It must be off the table.

Minister Ley has shown she is full of energy and enthusiasm, and is consultative. She wants to get on with the job. She has to get on with the job.

The whole health system needs action – and good policy – right now. Let's get on with it.

The mental health of doctors – time for a culture change

BY AMA VICE PRESIDENT DR STEPHEN PARNIS

Early this year, I was overwhelmed by the news of the sudden deaths of four young doctors in Victoria, all within a few weeks of each other.

Such tragedies are unacceptably common, and it is time for candour in discussing mental health within the medical profession.

The landmark 2013 *beyondblue* survey of tens of thousands of Australian doctors and medical students found that we have substantially higher rates of psychological distress, burnout and suicide than the general population and other professions. Those at highest risk are young doctors and female doctors, but no medical group is spared.

> "I know and remember too many friends and colleagues who have taken their own life. I expect that many of you will have confronted similar tragedies"

While finding that doctors and medical students are, in general, very resilient, the survey revealed that one in 10 doctors and one in five medical students nevertheless had suicidal thoughts in the past year. Furthermore, 25 per cent of doctors and 40 per cent of medical students were highly likely to have a so-called minor psychiatric disorder.

I know and remember too many friends and colleagues who have taken their own life. I expect that many of you will have confronted similar tragedies.

The mental health of the medical profession is a serious and systemic problem. We have highly stressful, hierarchical, and competitive work environments, with an often unforgiving culture. We have all experienced the anxiety of potential inability to cope, and equated it with personal inadequacy in ourselves or our colleagues.

For a profession trained to care for others, medicine has been often quite inept at recognising and understanding, accepting or supporting doctors and medical students who are suffering from anxiety, depression, substance abuse, family conflict or other issues that impact on their own health. We must do better.

The *beyondblue* report highlighted that 40 per cent of doctors felt that doctors with a history of mental health conditions were perceived as less competent than their peers, and 48 per cent felt that these doctors were less likely to be appointed compared with those with no such history.

This stigma is entrenched, and it must be overcome.

It is essential for each doctor, practice and health service to take responsibility for the welfare of our colleagues, and to support and promote the services that make a difference. A great example is Monash Care, set up last year by Monash Health in Melbourne to support its 2000 doctors.

Since the 1990s, there has been slow but significant progress in developing designated health services for doctors, often led by heroic doctors prepared to speak about their own personal health concerns.

The advent of national medical registration in 2010 put a number of these services in doubt. Since then, the AMA has strongly advocated for a national model to support the work of the services that make up the Australasian Doctors' Health Network.

As a result, the Medical Board of Australia has set aside funding, and the AMA is working with the MBA to establish the right model for the national delivery of doctors' health services in each State and Territory. I expect that the details will be finalised soon.

The AMA will be able to support the roll out of nationally consistent doctors' health advisory services that will be available to AMA members and non-members alike. Nobody should be left behind.

Australians have come a long way in their awareness of mental illness. It is now time for our profession to do the same. It will make us better doctors, and save lives.

If you are concerned about your own wellbeing, help is available at the Australasian Doctors' Health Network via http://www.adhn.org.au/

Govt's hit on primary health care riles AMA members

BY AMA SECRETARY GENERAL ANNE TRIMMER

> "The provision of care to the medical profession is an important part of the AMA's mission of leading Australia's doctors. It also supplements and complements the work of the Australian Medical Students Association over the past year in developing programs for the care of medical students"

Notwithstanding the Government's reversal of its December announcement to introduce time charging to Medicare rebates for level A/B consultations, the AMA continued with its planned doctor forums during February.

These were well-attended in most capital cities by both AMA members and non-members.

Common themes were raised, principally the concern of many doctors about the Government's shortsightedness in attempting to extract health savings from general practice. The meetings supported the AMA's position that primary health care is a cost effective part of the health system and, instead of reducing funding, more should be invested to support its effectiveness.

The messages from the forums have been fed back to Health Minister Sussan Ley, who has been conducting her own consultations with doctors and consumer groups.

The Government is yet to commit to taking the further changes to Medicare funding off the table – a $5 rebate cut and a freeze until 2018 of Medicare rebates (which applies to all MBS items, not just those used in general practice). The AMA continues to argue the case that these changes are not good health policy.

Another issue which has attracted attention over recent weeks is that of doctors' health.

Vice President Stephen Parnis writes on this issue in his column this month (see *The mental health of doctors – time for a culture change*, previous page).

Late last year, the AMA Board agreed to take on the responsibility of facilitating delivery of doctors' health services on a national basis, with funding to be provided by the Medical Board of Australia. The process to establish the national arrangement is underway, with a transition planned over coming months.

The provision of care to the medical profession is an important part of the AMA's mission of leading Australia's doctors. It also supplements and complements the work of the Australian Medical Students Association over the past year in developing programs for the care of medical students.

The national doctors' health program will address care for both medical practitioners and medical students.

In mid-February, the Prime Minister provided his annual report to Parliament on Closing the Gap in Indigenous health.

Progress has been disappointingly slow, with emphasis on education and employment – both important issues for Indigenous communities but unachievable if basic health care and wellness are not integral to the lives of Indigenous people.

A byproduct of the Government's proposal for changes in Medicare rebates is the impact on the health providers to Indigenous communities.

One of the areas of greatest health impact is in the incarceration of young Indigenous people, both men and women.

The statistics cited by Opposition leader Bill Shorten in his reply to the Prime Minister's address are compelling – one in every two Indigenous youths end up in the prison system. With imprisonment come many other social impacts that affect future health and wellbeing. It is one of the great health challenges for Indigenous communities, and an issue of concern for all Australians.

‘Lazy’ rebate freeze should join co-payment on scrap-heap: AMA

“The [Medicare Rebate] indexation freeze is very lazy policy”: AMA President Associate Professor Brian Owler on 3 March at Australian Parliament House

The AMA is pushing the Federal Government to dump the controversial four-year Medicare rebate indexation freeze “as soon as possible”, warning the measure could drive up out-of-pocket expenses for patients and hit private health insurance coverage.

Relief that the Abbott Government has scrapped a planned $5 Medicare rebate cut and taken GP co-payments “off the table” has been tempered by concern it still intends to proceed with a rebate indexation freeze until mid-2018.

Health Minster Sussan Ley early this month announced the co-payment had been “taken off the table”, but would maintain the indexation freeze while talks with the AMA and other health groups on alternative savings proceeded.

“It is clear the proposal for a co-payment and associated $5 cut to the [Medicare] rebate does not have broad support,” Ms Ley said following a Party Room meeting on 3 March. “[But], to ensure we protect Medicare for the long-term, the Government will be proceeding with its pause on indexation of Medicare rebates for GP and non-GP items while we work with the [medical] profession to develop future policies.”

AMA President Associate Professor Brian Owler said deterring people from seeing their GP by imposing a co-payment never made sense, and the medical profession was “very pleased” the idea had been scrapped.

But A/Professor Owler cautioned that the indexation freeze was equally poor policy, and the AMA was working with the Minister on smarter ways to deliver efficiencies that not only saved money but improved the health system.

“The indexation freeze is very lazy policy, and is something that will have significant consequences. Rates of private billing will increase and the rate of bulk billing will fall,” the AMA President warned, adding that out-of-pocket expenses for those with private health insurance were also likely to sky-rocket.

He said that, rather than look for quick savings from cuts and freezes, the Government need to take a more sophisticated approach that considered the health system as a whole and “look at long-term savings that can be achieved through more efficient practices”.

A/Professor Owler indicated that restructuring aspects of the Medicare Benefits Schedule would form part of the discussions the AMA will have with the Minister.

“We’ve already had very productive discussions with the Minister around ways that we might try and curtail the freeze to indexation. We are looking at the MBS. If we can improve things, hopefully we can get rid of the [rebate] freeze sooner rather than later,” he said.

> “As you know, I was a Health Minister for four years. I rapidly came to the conclusion as Health Minister that, in any dispute between a politician and a doctor, the doctor normally won”

It has been speculated that the Government might embrace some form of blended payment system, retaining fee-for-service for most doctor consultations but paying practitioners an annual lump-sum to care for some patients, such as those with chronic disease.

But A/Professor Owler said any shift from the predominant fee-for-service model would be a long-term undertaking, and the current focus was on efficiencies that would provide more immediate savings.

The Government’s move to scrap the co-payment follows sustained pressure from the AMA, doctors and other health groups who have argued that the plan would deter patients from seeking timely treatment, adding to health care costs in the longer term.

A/Professor Owler said it was disappointing that the co-payment had dominated so much of the health policy debate in the last 12 months, and urged the Government not to put off further health reform until after the next election.

"We have already wasted too much time talking about the co-payment," he said. "We do not want to wait another year-and-a-half".

The AMA President said he was keen to advance discussions with the Government on a range of areas including health workforce training, the role of private health insurers, public hospital funding and structural reform of the health system.

Health policy became a key battleground in the leadership turmoil that engulfed Prime Minister Tony Abbott and the Coalition Government early last month.

The decision to dump the $5 rebate cut is the third time the Prime Minister has been forced to ditch some form of co-payment, underlining doubts within his party about his political judgement.

In early December he was forced to ditch plans for a $7 co-payment in the face of steadfast opposition in the Senate, while a subsequent plan for a $20 cut to rebates for shorter GP consultations was abandoned just days before it was to come into effect amid fierce criticism from the AMA, grassroots GPs and other health groups.

Soon after surviving a motion to spill the party leadership, a chastened Mr Abbott admitted the folly of crossing swords with the AMA and the medical profession.

"As you know, I was a Health Minister for four years. I rapidly came to the conclusion as Health Minister that, in any dispute between a politician and a doctor, the doctor normally won," the Prime Minister said. "While the Health Minister can't be a Minister for Doctors, nevertheless, it is important to maintain the support of the medical profession because, let's face it, they have the best interests of their patients at heart. That is certainly something that governments have to take very, very seriously indeed."

ADRIAN ROLLINS

Health no place for a price signal: AMA

The Federal Government remains wedded to imposing a 'price signal' on patients seeing their doctor despite dumping a succession of proposals for a co-payment in the face of vehement opposition from the AMA and the broader community.

Health Minister Sussan Ley said it was reasonable to require patients who had the financial capacity to be charged a "modest contribution" to see their GP.

"It is definitely a good idea to have a price or value signal in health to make sure people value the service they get from their doctor," Ms Ley said.

While admitting the co-payment was "disliked by so many", the Minister said the intent behind the Government's policy remained a good one.

"The policy intent was, and remains, a good one," she said, "to make sure the Medicare system does not gobble up the entire national Budget. That was the intent behind the policy."

But AMA President Associate Professor Brian Owler said using prices to deter people from using a service was not something that belonged in health care.

"The idea of a price signal, of discouraging people from going to see their GP, is not something that we support," A/Professor Owler said. "In fact, there are many people who should see their GP more often, and getting people to see their GP for things like prevention and chronic disease management keeps them well and out of more expensive hospital care."

ADRIAN ROLLINS

Dearer medicine could be price of trade deal

The cost of life-saving medicines will go up and the Federal Government will find it harder to impose restrictions on the sale and marketing of alcohol, tobacco and other harmful substances under the terms of a massive trade deal being negotiated by the Abbott Government, health groups have warned.

As talks on the Trans-Pacific Partnership Agreement (TPP) between Australia, the United States, Canada, Japan, Mexico and seven other countries enter what could be their final stages, public health advocates and intellectual property experts have voiced fears it will include provisions extending drug patents, potentially forcing up the price of medicines and reduce competition from generics.

> The TPP has greater potential to affect domestic health policy and, ultimately, the quality of health services and public health

While the details of the talks remain behind closed doors, leaked drafts of the treaty's text indicate that proposals on the table include an investor-state resolution procedure under which companies would be able to challenge public health policies, such as Australia's tobacco plain packaging legislation, as well as plans to extend drug patents for up to 12 years.

A report on the TPP prepared by a team of health specialists from the University of New South Wales, Sydney University and La Trobe University, warned that if the draft provisions make it into the final treaty, patients are likely to be worse off.

It said proposed intellectual property provisions would prolong the monopoly supply of new medicines and delay the introduction of generics, holding up prices and reducing the ability of the Government, through the Pharmaceutical Benefits Scheme (PBS), to negotiate discounts.

"The TPP risks increasing the cost of the PBS, which is likely to flow on to the Australian public in terms of increased co-payments for medicines," the report, *Health Impact Assessment of the Proposed Trans-Pacific Partnership Agreement*, said. "This may result in medical non-adherence for prescription use and prioritising health costs over other necessities."

Health and legal experts are also concerned treaty provisions would compromise the Government's ability to regulate and restrict tobacco and alcohol marketing, by enabling companies to challenge the legality of public health measures through investor-state dispute resolution procedures, such as are currently being used by tobacco companies through the Australia-Hong Kong trade agreement in an attempt to force Australia to dump its ground-breaking tobacco plain packaging laws.

Trade Minister Andrew Robb has moved to hose down such fears, arguing that they are based on draft texts, not what is going to be in the final agreement.

The Federal Government has insisted it will not sign up to a treaty that compromises the PBS, and Mr Robb told Fairfax Media that, "I am not going to do something that I think is not in the public interest".

But the Government's attempts to provide reassurance have been undermined by suspicion about the treaty's purpose and the intense secrecy surrounding its negotiations.

Writing in the *Medical Journal of Australia*, Dr Anne Marie Thow of the Menzies School of Public Health, Dr Deborah Gleeson of La Trobe University and Dr Sharon Friel of the Regulatory Institutions Network, said the TPP was no ordinary trade agreement, and aimed at changing policy-making within countries and harmonising domestic policy between countries.

"The TPP has greater potential to affect domestic health policy and, ultimately, the quality of health services and public health," the authors said, though they admitted that independent assessment of its implications for public health was "severely limited by lack of transparency in the negotiations".

US President Barack Obama was early this month on track to be given trade agreement negotiation authority by the Republican-dominated Congress, underlining the bi-partisan nature of America's commitment to the agreement.

ADRIAN ROLLINS

Shrinking prices short-change hospitals

Public hospitals are being short-changed by a recalculation of the amount the Federal Government will pay for their services, increasing the strain on their finances amid signs performance gains are stalling.

The Independent Hospital Pricing Authority has announced that the National Efficient Price (NEP), used to calculate what around 260 hospitals – including all the large metropolitan hospitals - will receive under the activity-based funding arrangements, has been set at $4971 per National Weighted Activity Unit (NWAU) for 2015-16.

This represents a 3 per cent increase from this financial year's revised NEP of $4826, but a 0.7 per cent cut from the original NEP estimate for 2014-15.

The Authority said the downward revision of this financial year's NEP was due to the use of more up-to-date data showing that hospital costs were growing at a slower rate than originally anticipated.

Small rural hospitals, whose size makes the use of activity-based funding inappropriate and are instead funded according to the National Efficient Cost (NEC) formula, have also been hit by a funding cut.

The Authority said that the average NEC payment for the nation's 380 small country hospitals would be $4.784 million in 2015-16, down from $5.725 million this financial year.

The funding cuts come amid mounting evidence that public hospitals are struggling to cope with increasing patient demand and shrinking budgets.

As reported in 20 January edition of *Australian Medicine*, the nationally-agreed target to cut emergency department waiting times is under threat after New South Wales walked away from a commitment to ensure 90 per cent of all patients would be admitted, referred or discharged within four hours, and the previous Queensland Government put the standard under review.

The AMA's annual *Public Hospital Report Card* (see previous page) shows the performance of public hospitals is suffering as the Commonwealth scales back its contribution and pushes more of the cost burden on to the State and Territory governments.

In last year's Budget, the Federal Government disavowed hospital funding guarantees worth $1.8 billion up to 2017-18, and announced that from mid-2017 its contribution to public hospital costs would be indexed at just CPI plus population growth. The AMA warned that the two measures would rip $20 billion from the public hospital system in the next five years.

In addition, in its mid-year Budget update, the Government revealed a further cut of $941 million over four years.

Critics warn that the effect of these cuts is set to be compounded by IHPA recalculations of activity-based funding.

The Authority's practice of revising down its initial NEP estimate (it has occurred in each of the past three years) has raised concerns that the base price for hospital services is being gradually ratcheted back, and will be enshrined at a grossly inadequate level when Commonwealth funding becomes indexed from 2017-18.

ADRIAN ROLLINS

Stop stalling on Research Fund, Govt told

AMA President Associate Professor Brian Owler has called on the Federal Government to immediately act to establish the Medical Research Future Fund, amid surprise revelations that the centrepiece of its health budget is yet to be implemented.

A/Professor Owler said the fact the Government was yet to create the Fund even though $15 billion could be directed into it in the next six years, suggested it was no more than "an accounting trick" to make the Budget look better.

> The Fund has won the backing of a group of high-profile business leaders, but has split the medical research community because of the fact that it is to be created using funds diverted from other areas of health

"I think we should establish the Medical Research [Future] Fund, because we actually have about $15 billion in savings over the next six years, which has essentially already been passed," the AMA President said. "There is no reason why the fund should not be in existence as we speak. It has been held hostage over the co-payment and I think we need to get away from that."

Under the Government's plans, "every dollar" of savings from health, including a freeze of Medicare rebate indexation, almost $2 billion taken from public hospitals, and money freed up from the abolition of agencies such as Health Workforce Australia, would be channelled into the $20 billion Fund.

According to last year's Budget, the Fund would receive $1 billion from uncommitted funds in the Health and Hospitals Fund, $3.5 billion through the $5 Medicare co-payment, almost $2 billion from cuts to public hospital funding, $1.7 billion from extending the Medicare rebate freeze and the income thresholds for the Medicare Levy Surcharge and Private Health Insurance.

It would also gain $1.3 billion from increasing Pharmaceutical Benefits Scheme co-payments and safety net thresholds, as well as savings gleaned from shutting down a range of health programs and abolishing several agencies.

The Fund has won the backing of a group of high-profile business leaders, but has split the medical research community because of the fact that it is to be created using funds diverted from other areas of health.

Speaking at a Senate inquiry into health reform, A/Professor Owler said that although he supported the Fund, the AMA objected to the fact money was being plundered from other areas of health to help pay for it.

"We all want a Medical Research Future Fund," the AMA President said. "I have done research, [and] more money for research would be great. But it should not come at the expense of sick people going to the doctor."

A/Professor Owler said the spectacle of researchers being set against general practitioners and other sin the health system was "terrible".

"I think one of the worst things that we have had over the past eight months or so is this process of having researchers out there lobbying, ignoring where the money is actually coming from and essentially pitting researchers and GPs against each other," he said. "I think that has been a terrible episode."

The AMA President's criticism came as the National Association of Research Fellows warned delays in getting the MRFF up and running threatened the jobs of up to 2000 medical researchers.

Association President Professor Rob Ramsey told The Australian the NHMRC needed an extra $300 million a year if the nation was to sustain the "critical mass" of researchers that it had developed in recent years.

While the number of researchers supported by the NHMRC has more than doubled to 10,000 in the past decade, less than 15 per cent of grant applications are successful, making medical research an increasingly precarious career choice.

Professor Ramsay rejected comments by NHMRC head Professor Warwick Anderson that there was an over-abundance of researchers, and instead argued the country needed to lift its investment in research.

ADRIAN ROLLINS

Plain packaging under review as global fight lights up

The Federal Government has launched a review of the nation's breakthrough tobacco plain packaging laws amid continued local and international efforts to have the anti-smoking measure overturned.

The Government has engaged consultants Siggins Miller to examine the effect plain packaging has had on the tobacco industry and consumers and, "where possible, quantify the costs and benefits of the measure", with the information to be used as part of a post implementation review.

The review is a requirement of the Australian Government Office of Best Practice Regulation, and is intended to determine whether the law "remains appropriate", and how effective and efficient it has been in reducing the appeal of tobacco products and discouraging smoking.

But the review comes at a sensitive time, with a concerted international campaign by the tobacco industry well underway to have the Australian legislation overturned and prevent other countries from introducing similar laws.

Philip Morris Asia has launched a legal challenge against the legislation, claiming it breaches the terms of a 1993 investment agreement with Hong Kong.

The case represents the first time Australia has been subject to an investor-state proceeding.

The tobacco industry has also sought to undermine support for the laws by claiming they are driving an increase in the black market trade in cigarettes.

British American Tobacco Australia told *The Australian* newspaper last month it had discovered several counterfeit packets of cigarettes for commercial sale, and a KPMG study commissioned by the tobacco industry estimated illegal products comprised almost 14 per cent of the local market.

Several countries, including the Dominican Republic, Indonesia, Cuba and Ukraine, have also launched action against Australia at the World Trade Organisation, claiming the plain packaging laws breach international trade obligations regarding intellectual property rights, in particular trademarks, and geographical indications.

Despite the multi-pronged assault, other countries are moving to introduce similar laws.

The British Government has said it wants to introduce plain packaging laws before the general election, meaning that could come into force as early as May 2016, while the Irish Government has so far resisted enormous pressure from the tobacco industry to dump planned plain packaging legislation.

Industry giants Imperial Tobacco and Japan Tobacco have both threatened to launch legal action against the governments if they introduce plain packaging legislation, and the United States Chamber of Commerce wrote to Irish Prime Minister Enda Kenny warning the bill will "expose the Irish State to higher costs from compensation" and "potentially violate important aspects of Ireland's international commitments".

But Big Tobacco may be fighting an uphill battle, with other countries already considering introducing similar laws, including New Zealand, France and India, while many European countries are watching the developments closely.

Evidence suggests plain packaging is working to help reduce the incidence of smoking, particularly in deterring young people from taking up the deadly habit.

The National Drugs Strategy Household Survey released last year found a dramatic decline in smoking rates had coincided with the introduction of plain packaging laws.

The daily smoking rate plunged from 15.1 per cent to 12.8 per cent between 2010 and 2013, according to the nation's largest and longest-running survey on drug use. It found most people are now 16 years old before they smoke their first full cigarette, up from 14 years in 2010, and 95 per cent of 12 to 17-year-olds have never smoked.

The results have been claimed by public health experts as vindication for the effectiveness of the measure, and have undermined tobacco industry claims that they have had little effect on smoking rates.

ADRIAN ROLLINS

Dedicated national doctor health service 'soon'

The AMA is rushing to finalise details of a national health service for doctors amid calls for a culture change within the medical profession in how practitioners with mental health problems are treated and supported.

As the medical community reels from the sudden deaths of four young Victorian doctors earlier this year, AMA Vice President Dr Stephen Parnis has warned that poor mental health was a "serious and systemic" problem within the profession.

"For a profession trained to care for others, medicine has been often quite inept at recognising and understanding, accepting or supporting doctors and medical students who are suffering from anxiety, depression, substance abuse, family conflict or other issues that impact on their own health," Dr Parnis said. "We must do better."

Doctors have often been reluctant to seek help for fear that being known to have a mental health problem will harm their career.

Dr Bill Pring, who is Chair of the Australasian Doctors' Health Network, said there continued to be some who looked down on those diagnosed with a mental illness, but the stigma attached to mental health problems within the medical profession appeared to be gradually fading as attitudes changed.

Dr Pring said it was encouraging that doctors appeared to be increasingly receptive to the message that they needed to ensure their own physical and mental health in order to provide the best possible care for their patients, and growing numbers were willing to seek help for mental health conditions.

But the recent spate of deaths, coupled with the results of a beyondblue report from 2013 that found psychological distress, burnout and suicide were disturbingly common among doctors and medical students, have underlined concerns that practices within the profession are fuelling the problem and support is inadequate.

There has been a call to rigorously address the reasons some doctors find it hard to seek and obtain help, including the culture of the profession, the work environment, the training culture, and mandatory reporting.

There is concern that often doctors are deterred from seeking care for fear their treating doctor will be required under Medical Board of Australia mandatory reporting rules to notify the regulator.

But Dr Pring said this was not necessarily the case.

He said that under the interpretation of the law used by the ADHN, a treating doctor is only required to report a doctor who poses an imminent risk to their patients.

Dr Pring said often the fact that a doctor recognised they had a problem and was seeking help meant that there was no imminent threat to patients, and consequently there wasno need to report them.

But he was concerned about the number of doctors contacting his service because they did not have a regular GP, and Dr Parnis said the nature of the job as a doctor did not help: "We have highly stressful, hierarchical, and competitive work environments, with an often unforgiving culture".

Dr Pring said the pressures could be especially acute for young doctors, who not only had to deal with a highly stressful work environment, but also a highly competitive training environment.

He said the ADHN was working closely with medical colleges to do what it could to make sure doctors in training were better looked after.

While there has been a gradual increased in the number of health services specifically for doctors, Dr Parnis said current arrangements were inadequate, and the AMA had for a long time strongly advocated for a national model to support the work of the services that make up the Australasian Doctors' Health Network.

"As a result," he said, "the Medical Board of Australia has set aside funding, and the AMA is working with the MBA to establish the right model for the national delivery of doctors' health services in each State and Territory".

The AMA Vice President said the details of the new system "will be finalised soon".

ADRIAN ROLLINS

Spiralling drug costs not driven by R&D

Drug companies are charging increasingly astronomical prices for cancer-fighting drugs according to what the market will bear rather than what they cost to develop, a US study has concluded.

As controversy swirls around the cost of hugely expensive treatments such as the anti-melanoma drug Yervoy, which costs around $150,000 for a course of therapy, an investigation by American health economists indicates prices of new medicines are being set by reference to the cost of existing drugs, resulting in an upward spiral of charges that has seen the value of the global anticancer drug market soar to $116.6 billion in 2013.

The study, based on pricing trends for 58 anticancer medicines approved for use in the US between 1995 and 2013, found that the launch price for medicines were growing by an average of 10 per cent a year, forcing patients and insurers to pay increasingly higher amounts to extend lives.

Across the sample of drugs included in the study, the average cost of each year of life gained soared from $69,000 in 1995 to $178,000 in 2005, before reaching $265,500 in 2013.

The spiralling cost of treatment has alarmed clinicians and policymakers worldwide. In 2012, three leading oncologists at New York's renowned Memorial Sloan Kettering Cancer Centre announced they would refuse to prescribe the metastatic colorectal cancer treatment Zaltrap because of its massive mark-up compared with older therapies, and a year later The Lancet medical journal warned the world had reached "the crossroads of affordable cancer care," while a group of more than 100 prominent oncologists in the US publicly criticised the high cost of new cancer treatments.

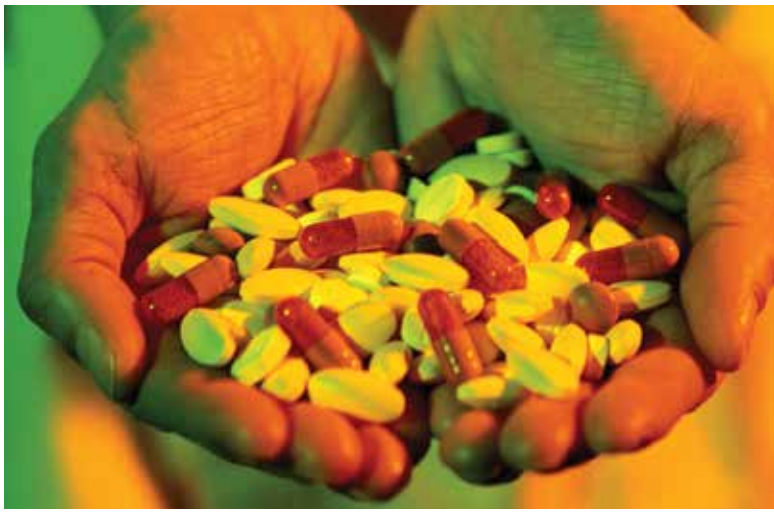
Governments, including those in Australia, the United Kingdom and Europe, are also turning an increasingly critical eye on the evidence for hugely expensive treatments, and taking more time to weigh up the cost against the likely extension to lives.

In 2013, for example, the Pharmaceutical Benefits Advisory Committee announced it would gather data on the use of Yervoy and its effects, the first such assessment for a drug approved for listing on the Pharmaceutical Benefits Scheme.

The drug was one of three cancer treatments listed on the PBS whose supply was estimated to cost $430 million over four years, for a claimed average 3.9 month extension to the lives of patients.

The pharmaceutical industry argues the high prices are justified by the high costs of research and development, and backers warn big returns are necessary to encourage further innovation.

But the authors of the US study, including Associate Professor



David Howard from Emory University in Atlanta, Peter Back from the Memorial Sloan Kettering Cancer Centre, and Ernst Berndt from the Sloan School of Management at the Massachusetts Institute of Technology, said the arguments were unconvincing.

"It is unlikely that changes in development and production costs alone can explain launch pricing trends," they said, noting that the low cost of generic relative to branded drugs suggested that production costs were only a small component of price.

Furthermore, they pointed out, research and development expenses were "sunk costs" at the time a product was launched, and so "ought not to factor into the pricing decisions of a profit-maximising firm once the product has been developed".

Instead, they said, the direction of causation between prices and research and development costs was the other way around: "manufacturers are willing to spend more to discover new drugs".

Instead, they found that prices of new drugs were set based on the cost of existing therapies as a reference.

Buyers tend to accept a relatively small premium above existing prices, giving manufacturers the opportunity to slowly bump up prices as new drugs enter the market.

This, rather than intrinsic development costs, is what drives the pricing of anticancer drugs, according to the study, which is published in the Winter 2015 issue of the *Journal of Economic Perspectives*.

ADRIAN ROLLINS

Poisoned berries spark food labelling overhaul

Shoppers will be able to use an easy-to-read symbol to quickly determine where the food they are buying comes from under changes to country of origin labelling standards ordered by Prime Minister Tony Abbott following an outbreak of hepatitis A linked to frozen berries imported from China.

Mr Abbott has assigned Industry Minister Ian Macfarlane and Agriculture Minister Barnaby Joyce to present plans for clearer food country of origin labelling to Cabinet by the end of March in response to widespread community disquiet about the safety of imported food when more than 20 people contracted hepatitis A after eating Chinese frozen berries.

"For too long people have been talking about country of origin food labelling, and nothing much has changed," Mr Abbott said. "Whenever we have a problem with imported food in particular, people want to know more about where their food's coming from. It's important that we grasp this particular nettle and actually make a difference."

Attempts in the past to tighten labelling standards have met strong resistance from food manufacturers, who complain changes will add significantly to production costs.

The Prime Minister said the Government would seek to ensure any changes were as "business-friendly" as possible, but Mr Macfarlane warned additional costs were unavoidable.

"We are in a position where we are going to have to break eggs to make an omelette," Mr Macfarlane said. "There will be costs and there will be changes, but those changes have to be made if consumers are going to have the information they need on their food products."

"We are looking at a symbol where someone can walk into a supermarket and say 'yes, that is entirely Australian', or 'that's ninety per cent Australian in produce', or 'there's no Australian produce in this'," Mr Macfarlane said on ABC Radio, adding the Government was also reviewing biosecurity arrangements.

Commonwealth authorities have placed a "holding order" on berries imported from two Chinese factories linked to the outbreak, but shipments of the fruit from 29 other Chinese suppliers are still being admitted into the country.

Senior Agriculture Department officials told a Senate estimates hearing that the hold order had been imposed after the food safety regulator, Food Standards Australia New Zealand (FSANZ), had determined that products from the two factories "pose a medium risk to public health until further information becomes available".

But the officials admitted the only tests being applied to berries

being imported from other Chinese suppliers were for pesticides, and said the Department was seeking advice on conducting tests for hepatitis.

Altogether, 30 companies import frozen berries from China.

The Department of Health reported 26 verified cases of hepatitis A linked to eating frozen berries as at 4 March, and said that "detailed analyses of food consumption histories...confirmed a possible association with frozen berries", which were "the only common exposure".

The company at the centre of the scare, Patties Foods, has recalled all supplies of Nana's Mixed Berries and Nana's Raspberries (1 kilograms packs), as well as Creative Gourmet's Mixed Berries (500 and 300 gram packs).

Chinese authorities are investigating the possible food contamination, but the Health Department said hepatitis A was spread by food and water, "including ice that has been contaminated with faecal matter from infected people".

Patties Foods Managing Director Steven Chaur said the recall had been initiated as "a precautionary measure. There is still no detailed viral analysis from accredited laboratories that proves any firm association of hepatitis A virus with our recalled products".

Small Business Minister Bruce Billson said the new laws would require that producers disclose where food originated from and, possibly, where it was packaged and processed.

ADRIAN ROLLINS

AMA in the news

YOUR AMA HAS BEEN ACTIVE ON POLICY AND IN THE MEDIA ON A RANGE OF ISSUES CRUCIAL TO MAKING OUR HEALTH SYSTEM BETTER. BELOW IS A SNAPSHOT OF RECENT MEDIA COVERAGE.

PRINT

Medicare cuts will force up surgery fees, *Adelaide Advertiser*, 6 February 2015

The Government's Medicare cuts will not only affect GP visits but drive up costs for private health fund members. AMA President A/Professor Brian Owler said the Government's four-year freeze on Medicare rebates for specialists would undermine health fund no-gap schemes and force patients out of health insurance.

Future fund an accounting trick, *The Australian*, 6 February 2015

The Government's $20 billion Medical Research Future Fund seems to be an accounting trick to make nation's debt look more desirable, according to the AMA. Speaking at the Senate Committee, AMA President A/Professor Brian Owler said the announcement of the MRFF in last year's Budget had led to a terrible episode, pitting GPs and researches against each other.

Medicare architect: employers should pay for medical certificate visits, *Sunday Canberra Times*, 8 February 2015

Medicare architect John Deeble has suggested a new funding stream for the health system as an alternative to charging patients to see the doctor – making businesses pay for medical certificates. AMA Chair of General Practice Dr Brian Morton believed the proportion of patients who visited GPs simply for a certificate was unnecessarily high.

Retreat signalled on Medicare, *The Australian*, 10 February 2015

Tony Abbott will only pursue changes to Medicare that win the support of doctors. AMA President A/Professor Brian Owler welcomed the Prime Minister's comments, but called for him to clearly rule out the $5 rebate cut and proposed freeze to rebate indexations.

Soar throat? Dr Google will see you now, *The Age*, 13 February 2015

Google will respond to medical queries with vetted fact boxes and illustrations in a bid to steer users away from websites with shonky advice. AMA Vice President Dr Stephen Parnis said Google's efforts could never replace the expertise of a doctor.

Co-payment or not, GP's fee may rise, *West Australian*, 18 February 2015

Patients could still face higher out-of-pocket costs even if the Abbott Government dumps its unpopular co-payment proposal. AMA President A/Professor Brian Owler said the freeze also affected privately insured patients.

Health funds offer doctors managed pay, *Courier Mail*, 19 February 2015

Private Healthcare Australia has presented a plan to the Government that shows taxpayers could save billions if Medicare and health funds pay for evidence-based care along clinical guidelines. AMA President A/Professor Brian Owler said it was simply the latest attempt by the health funds to introduce failed US-style managed care.

RADIO

Dr Stephen Parnis, 2CC Canberra, 26 January 2015

AMA Vice President Dr Stephen Parnis commented on Prime Minister Tony Abbott's backdown on proposed changes to the Medicare rebate.

A/Professor Brian Owler, Radio National, 1 February 2015

AMA President A/Professor Brian Owler discussed the Abbott Government's attempt to spend less on health care. A/Professor Owler said backing down on the Medicare rebate cut was a significant win for GPs and patients.

A/Professor Brian Owler, ABC NewsRadio, 9 February 2015

AMA President A/Professor Brian Owler talked about the future of the GP co-payment. A/Professor Owler said more people needed to access primary care to stay out of hospital, and a price signal would deter them from seeing their GP.

Dr Brian Morton, 774 ABC Melbourne, 9 February 2015

AMA Chair of General Practice Dr Brian Morton talked about suggestions that employers pay for employee medical certificates. Dr Morton said it was not a good idea, and there were better ways to avoid having to produce a doctor's certificate.

Continued on p16 ...

AMA in the news

YOUR AMA HAS BEEN ACTIVE ON POLICY AND IN THE MEDIA ON A RANGE OF ISSUES CRUCIAL TO MAKING OUR HEALTH SYSTEM BETTER. BELOW IS A SNAPSHOT OF RECENT MEDIA COVERAGE.

... from p15

A/Professor Brian Owler, 666 ABC Canberra, 10 February 2015

AMA President A/Professor Brian Owler requested a meeting with Prime Minister Tony Abbott to discuss Medicare after the Prime Minister declared he wouldn't persevere with the Medicare co-payment unless doctors agreed to it.

TELEVISION

A/Professor Brian Owler, A-Pac Daywatch, 5 February 2015

AMA President A/Professor Brian Owler gave evidence to the Senate Select Committee on Health.

Dr Stephen Parnis, Southern Cross Tasmania, 10 February 2015

AMA Vice President Dr Stephen Parnis talked about an American study that found children who consume energy drinks are more at risk of hyperactivity and inattention disorders. Dr Parnis said the AMA wanted the Government to impose tougher restrictions on the sale of energy drinks.

A/Professor Brian Owler, Sky News, 19 February 2015

AMA President A/Professor Brian Owler has called for children to be released from immigration detention centres and the appointment of an independent panel of medical experts to oversee the health care of detained asylum seekers.

AMA in action

AMA President Associate Professor Brian Owler has spent much of the past month meeting with Health Minster Sussan Ley and other Government ministers and members in a successful effort to have the $5 cut to Medicare rebate dumped. But he and other senior AMA officials, including Vice President Dr Stephen Parnis and Council of General Practice Chair Dr Brian Morton, have also been working to ensure other important areas of health policy are not neglected. A/Professor Owler attended the release of the Prime Minister's release of the latest Closing the Gap report, and met with Doctors for the Environment representatives to underline concerns about the health effects of climate change. He also urged increased attention on issues including doctor training, hospital funding, aged care and public health. Dr Parnis highlighted the need for a shift in attitudes within the medical profession toward doctor mental health, and met with the Council of Doctors in Training to discuss concerns about faltering Government efforts in health workforce planning.

ADRIAN ROLLINS

AMA President A/Professor Brian Owler at the launch of the Closing the Gap ampaign Report with (from l to r) Dr Tammy Kimpton, AIDA Board member, NACCHO Chief Executive Lisa Briggs, Dr Frank Jones, RACGP President and A/Professor Brad Murphy, Chair, National Faculty of Aboriginal and Torres Strait Islander Health

A/Professor Brian Owler responds to the Federal Government's decision to scrap the GP co-payment on ABC TV

A/Professor Brian Owler meets with members of Doctors for the Environment Australia at AMA House, (from l to r) Professor Kingsley Faulkner, Dr Sally Forrest, and Dr Helen Redmond

AMA Vice President Dr Stephen Parnis met with the AMA Council of Doctors in Training in Sydney on 21 and 22 February

A/Professor Brian Owler tells 2GB listeners the AMA is “very pleased” with the decision to scrap the GP co-payment

A/Professor Brian Owler meets with the Federal Member for Gippsland, Darren Chester

Discouraging high volume medicine

BY **DR BRIAN MORTON**

Recently, the Government tried to address high volume service provision by introducing an amendment to the Health Insurance (General Medical Services Table) Regulation that would have seen a minimum 10-minute requirement applied to Level B consultations. For patients, this would have meant a rebate cut of $20 for a consultation of less than 10 minutes.

> "The AMA successfully lobbied against this change, and Health Minister Sussan Ley took it off the table on 15 January, four days before it was to come into effect"

The AMA successfully lobbied against this change, and Health Minister Sussan Ley took it off the table on 15 January, four days before it was to come into effect.

Bettering the Evaluation and Care of Health (BEACH) data tells us that 26 per cent of GP consultations are completed within 10 minutes. BEACH has further shown that around 10 per cent of consultations are six minutes or less, and that these types of consultations account for a little more than 3 per cent of a GPs claimable time.

Restricting Level B consultations, which account for 83 per cent of in-room GP consultations claimed, was too blunt an approach, and not the way to ensure the provision of quality care.

As the AMA argued, plenty of quality care can be provided in less than 10 minutes, particularly when provided by experienced GPs, and where there is an ongoing relationship between the patient and their GP.

Nevertheless, the AMA still has concerns about those models of practice where viability is sustained by high volume throughput.

Quality practice should represent a mix of attendance items. Some consultations will be straightforward; others will have varying degrees of complexity. Patients should be able to discuss with their GP more than one concern per consultation, particularly when, increasingly, patients are presenting with more than one problem to be managed.

A lot of care provided in general practice is opportunistic, particularly in relation to preventive medicine. Any model of practice or payment structure that discourages GPs from spending necessary time with patients to discuss their health issues is bad medicine.

As it stands, it could be said that the current Medicare Benefits Schedule structure, with its declining rate of return, does little to encourage GPs to spend more time with patients.

But making changes to the MBS, as the Government has learned, can be fraught.

So what approach might the Government take next to discourage high throughput? It might start looking at making changes to the 80/20 rule, by perhaps decreasing the number of services allowed to be provided or decreasing the number of days where 80 services can be tolerated. Or perhaps, a combination of both.

This, too, would be a rather blunt approach, particularly where comprehensive care is being provided.

It should be noted at this point that 80 services does not just refer to Level A-D consultations. It covers a range of items. For example, if you conduct a Health Assessment and participate in a Residential Medication Review on the one patient on the one day, that rightly counts as two services. If you had also provided a clinically necessary consultation, that would be three services.

The 80/20 rule also takes no account of the hours worked in day. If Medicare's systems identify that you have breached the 80/20 rule referral, to the Professional Services Review is automatic.

Only then can a practitioner outline the circumstances which led to the breach. The PSR process, while an important one to have, can be time consuming and legally complex.

This is a matter we can expect the Minister to want some advice on in the coming weeks and months.

How do you think the Government could best support the provision of quality care? Let me know your views and suggestions by emailing me at gpnetworknews@ama.com.au.

Designing hospitals to meet new needs

BY **PROFESSOR STEPHEN LEEDER, EMERITUS PROFESSOR**
PUBLIC HEALTH, UNIVERSITY OF SYDNEY
EDITOR-IN-CHIEF, *MEDICAL JOURNAL OF AUSTRALIA*

Imagine yourself entering a shoe store in search of hiking boots. You greet the assistant and sit down. The assistant examines your feet and then explains that their shape send size are not fit-for-purpose - meaning the shoe store's purpose, not yours. The salesperson suggests that you consult a surgeon to alter your feet to fit the boots the store does have for sale. The assistant may receive a bonus for the boots he or she did NOT sell.

There is similar rhetoric on the loose about what a hospital can and cannot do for patients with chronic illness. Keeping these people out of hospital is now a key performance indicator or KPI. But patients with chronic heart failure for good reason expect that a hospital is where they should go if they deteriorate, even if assistants tell them otherwise. Two quite serious concerns derive from this frivolous tale.

First, hospitals, although big businesses, must retain a clear sense of civic purpose.

Of course, there are hospitals that provide highly specialised services that are not designed to manage the entire illness and injury spectrum.

But a hospital with an emergency department generally, and appropriately, meets the needs of sick people of every stripe. Yes, there need to be filters to deter inappropriate presentation, depending on the availability of alternative services. If those services, usually general practice, are not there - ever, or just not at night - then the hospital must accept responsibility to be the port in the storm.

Publicly-funded hospital services surely need to be developed and redeveloped in response to public patient needs, not staff convenience or the latest KPI obsession.

With increasing demand for ambulatory care, hospitals should be adapting - and many are - to the majority of their patients being vertical rather than horizontal. That said, any compromise of the ability of a general hospital to save life in an emergency is unacceptable. It is not either-or.

But serious thought is required to tune the services provided by hospitals to the frequency of the growing demand of patients with multiple chronic problems, not all of which can be dealt with through general practice.

"Publicly-funded hospital services surely need to be developed and redeveloped in response to public patient needs, not staff convenience or the latest KPI obsession"

Second, financing of hospitals should consider not only levels of activity, but the appropriateness of that activity. While funding according to activity has enjoyed a vogue, and has led to improved financial accountability and insight into where the money goes, there is now a need to encourage and support new ways of doing business that make use of new technologies, including electronic records, to assess what is being achieved.

All new and refurbished hospitals should have a large Centre for Information Science to be a powerhouse for new ideas about how to apply genuine advances in IT to patient care, information flow, quality assurance, financial management and translational research. Such a centre could assist patients and clinicians adapt to the world of social media and big data.

Globally, 33,000 iPhones are sold each hour, and three billion You Tube uploads occur each day. These technologies can assist, especially in creating and maintaining communication networks among patients, hospitals, doctors and other carers. Take a look at the power and place of IT in sophisticated systems of comprehensive health care as offered through Kaiser Permanente in California.

It is critical that those charged with building and managing health care have an accurate understanding of what hospitals do at present. They also need 20/20 vision of what they might do in future and what else is needed, including substantial investment in general practice, to get the best deal for our patients of tomorrow.

E-cigarettes threaten to wind back health gains

BY AMA VICE PRESIDENT DR STEPHEN PARNIS

Internationally, Australia is seen as a leader in tobacco control.

Over decades, it has imposed increasingly tighter restrictions on the promotion, sale and use of tobacco products, and in 2012 became the first country in the world to introduce plain packaging legislation, to prevent tobacco companies using subtle marketing to create brand loyalty. Some groups, particularly children and young people, are particularly vulnerable to this sophisticated 'under the radar' marketing.

These initiatives have worked.

According to the most recent National Drug Strategy Household Survey, fewer than 13 per cent of Australians lit up every day in 2013, a massive improvement from 1991, when almost a quarter smoked daily.

This is great news, and it shows that public health measures are working.

But there is no room for complacency, as shown by the rapid emergence of

e-cigarettes – battery powered devices that mimic smoking by emitting a vapour that users inhale. Typically, the vapour is flavoured, and may or may not contain nicotine.

The use of e-cigarettes, both in Australia and overseas, has increased dramatically. A recent study found one in five Australian smokers had tried e-cigarettes, and already 7 per cent of smokers are using them.

It is particularly worrying that the biggest uptake has been among young adults.

Some advocates claim e-cigarettes actually help people quit smoking. But the evidence for this is mixed and of low level. In Australia, e-cigarettes are not recognised by the Therapeutic Goods Administration as a cessation aid.

This means they are not allowed to be marketed as a quitting aid, though you don't need to look for long to find examples where this is occurring.

During December, an AMA Working Group was established to develop the AMA's position in relation to e-cigarettes.

The Working Group considered the available evidence, and obtained the support of AMA Federal Council for its conclusions.

A major focus for the Working Group was the marketing of e-cigarettes, and the way they could be used to encourage tobacco smoking.

Much of the marketing for e-cigarettes occurs online, and is clearly designed to appeal to young consumers.

Many e-cigarettes have a very sleek appearance, are brightly coloured, and use sweet, fruit and chocolate flavoured solutions – all features intended to appeal to younger users.

Because e-cigarettes essentially mimic the act of tobacco smoking, there are realistic concerns that e-cigarettes, even when used with solutions that do not contain nicotine, can act as a gateway to smoking.

These concerns have been given added substance by the results of a recent investigation in New South Wales that found a large number of e-cigarette solutions marketed as nicotine free actually contained the drug.

The risk is that non-smokers who use e-cigarettes will develop an addiction to nicotine.

This is extremely concerning. A study conducted by the United States Centers for Disease Control and Prevention found a large number of non-smoking middle and high school students had used an e-cigarette, and were twice as likely as those who hadn't to report that they intended to start smoking tobacco cigarettes.

Given these concerns, the AMA believes the marketing and advertising of e-cigarettes should be subject to the same restrictions as those that apply to tobacco products, and they should only be available to those older than 18 years.

The AMA has raised its concerns with the Federal Government, and is lobbying Health Minister Sussan Ley and Treasurer Joe Hockey for restrictions on the marketing of the devices, particularly to children and young people.

It would be an enormous backward step for public health if all the gains in tobacco control made in recent decades were to be undermined by increases in nicotine addiction through the use of e-cigarettes.

Government needs to execute policy about-face and show that it cares

BY DR DAVID RIVETT

On the south coast we have had the best spring and summer rains that anyone can recall.

Grass is growing on grass in my paddocks, the cows and their offspring are blissfully content, and cattle prices are up substantially. In addition, I recently caught my first marlin just off the coast, a long cherished item to tick off my bucket list. So, if I am sounding less cranky than usual, you will realise my mindset.

There is some good news.

The New South Wales Government has promised to increase subsidies for rural patients travelling to receive care in urban centres from September. Patients who need to stay away longer than a week will receive higher accommodation subsidies, as will patients travelling to receive specialised allied health care, such as the fitting of prosthetics. In addition, the whole process, which is currently burdened with red tape, will become more user friendly.

But there was less promising news from the Council of Doctors in Training. At its 16 February meeting, the AMA Rural Medical Committee heard that recently announced reforms to District of Workforce Shortage criteria, which would mean that return-of-service obligations for bonded scholars would apply to all towns with fewer than 15,000 residents, was yet to be implemented by the Department of Health.

AMA Federal industrial officers are dealing with the matter on behalf of the affected doctors in their usual effective manner, but if you know of similar cases, please advise the doctors concerned to contact the Federal AMA.

AMA NSW hosted a successful GP forum in Western Sydney on 8 February, attended by around 140 GPs, who expressed their angst about the Coalition's proposed cuts to GP patient Medicare rebates, even though the 'Captains call' to slash rebates for sub-10 minute consultations had been overturned before the meeting was held.

The AMA is now knuckling down to fight the $5 rebate cut looming on 1July, as well as the decision to freeze the indexation of Medicare rebates through to mid-2018.

Now is the time for all members to call on non-members to join up and get behind the AMA to empower it to lobby for sensible and fair outcomes.

They say a week is a long time in politics. But recent columns in which I publicly wondered whether Tony Abbott would be a one-term Prime Minister now look overly optimistic about his chances of survival.

The Coalition must execute a profound about-face on health care and focus on patient outcomes, rather than persist with its current approach, which seems to be all about bean counting and to hell with the inadvertent consequences.

INFORMATION FOR MEMBERS

Essential GP tools at the click of a button

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

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

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

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

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

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

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

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

What junior doctors really think about the training they get

BY **DR DANIKA THIEMT**

By the time you read this, the second AMA Specialist Training Survey (STS) will have been launched at the 2015 CDT Trainee Forum.

The survey was completed last year, and allowed the comparison of outcomes to those of the inaugural STS completed in 2010.

The results of the 2010 STS have been invaluable in advocating for better access to quality vocational training and training conditions in the last four years, providing a strong and unified voice for trainees Australia-wide. The 2014 STS was designed to complement these results, and to examine how the current training environment compared to that in 2010.

> "Overall, the 2014 results showed that vocational trainees are very satisfied with their training and enjoy most aspects of their training experience"

In 2014, we surveyed both hospital-based specialty trainees and GP registrars to monitor trends in vocational training, with the goal of identifying what the big issues are when it comes to modern training experiences. The ability to run two parallel surveys allowed an insight into two unique training environments, and to see where trainee concerns were aligned.

Overall, the 2014 results showed that vocational trainees are very satisfied with their training and enjoy most aspects of their training experience.

Trainees are more positive about their training, career choices, access to supervision and the quality of teaching than four years ago, and they indicated higher satisfaction regarding exam content and relevance.

Additionally, the 2014 data showed that 79 per cent of trainees felt as though they were practicing within safe working hours, which was a fantastic improvement from 69 per cent in 2010.

Interestingly, GP trainees are happier when it comes to their training, reporting higher satisfaction regarding the cost of training, health and wellbeing, flexible training options and the relevance and quality of educational activities.

GP registrars were also largely positive about their employment prospects at the end of training, which is an emerging concern for many other vocational trainees.

Unfortunately, many areas of trainee dissatisfaction remain unchanged from 2010, including the responsiveness of colleges to complaints of bullying and harassment, as well as concerns about feedback, repeals and remediation processes.

The 2014 survey shows that cost of training is an ongoing concern for trainees, one that little has been done to address in the last four years.

Other concerns included limited access to academic and global health opportunities within vocational training, and dissatisfaction with communication from the training colleges.

The results of the AMA STS reinforces the importance of maintaining quality of training in the face of the powerful external forces affecting the current training environment.

Given ongoing pressures on vocational training places, uncertainty surrounding workforce planning and changes to many areas of vocational training, these survey results have the power to direct the attention of specialty training colleges to areas of trainee dissatisfaction.

The CDT hopes that these results prompt colleges to review their education and training policies to ensure that they are meeting the needs and expectations of their trainees.

Increased pressure on vocational training positions highlights the need for accurate and accessible workforce data.

This survey is the only current mechanism to gather independent insight into the experience of trainees, and it allows a unique perspective not often expressed in workforce surveys.

AMA Council of Doctors in Training believes that there is a need for a National Training Survey to independently monitor and inform specialty colleges, the Australian Medical Council and vocational trainees about the quality of training and the training experience in Australia.

A single national survey would reduce survey fatigue, replace the numerous fragmented surveys that currently exist, and provide the colleges and the AMC with more timely and reliable data.

Sky high uni fees to worsen rural GP shortage

BY JAMES LAWLER

Unless you've been under a rock, you'll know that the Federal Government is planning changes to the funding of higher education in Australia.

They are intending to cut their own contribution to higher education by 20 per cent, and to de-regulate the fees which universities can charge students.

> "If university fees for medical degrees are de-regulated, the cost of medical degrees would be expected to rise to more than $200,000"

As a medical student and a future doctor, it perplexes me that anyone could consider this good policy.

If university fees for medical degrees are de-regulated, the cost of medical degrees would be expected to rise to more than $200,000. Some people might not care that graduating medical students have large debts to pay off, since they are eventually paid well once they graduate. But asking prospective medical students to consider taking on a six-figure debt might make them seriously reconsider their choices.

I can attest to this. I grew up on the west side of Maitland in the Hunter Valley, one of three children to two nurses. I was very happy with my final HSC mark, but took a year off to work in hospitality once I'd finished school.

When the possibility of studying medicine arose, it was an easy choice.

But, if someone had said to me that I'd be leaving my degree with a debt of more than $200,000, would that have changed my decision? I could have worked in hospitality for a further six years and have been $500,000 ahead of my future self.

These issues become more complicated as you go further down the rabbit hole.

The Australian community is in desperate need of more rural general practitioners – my mum waits three weeks to see hers. But would I choose the lower-paid general practice over something like surgery or cardiology with a large debt hanging over my head, and hopes of buying a house and starting a family?

This hypothetical is backed up by good evidence from the United States, the United Kingdom and New Zealand showing that debt is a major factor in the choices that future doctors make.

Prospective students from low socio-economic backgrounds will be less likely to enter higher education if a large looming debt is a reality.

And medical students and junior doctors with a high debt burden are less likely to work in rural areas.

Most worryingly, the evidence shows that high debt tends to drive graduating medical students away from general practice, the nation's shortage of GPs notwithstanding.

These concerns from the medical community seem to be falling on deaf ears in Canberra.

Education Minister Christopher Pyne is continuing to push forward with the reforms, despite the fact that it might shift a future generation of medical students away from general practice, and away from rural areas – even though these two aspects are arguably the most neglected of the nation's medical workforce.

As for me, I was lucky enough to be accepted into medicine on a bonded medical scholarship, which will see me provide a return of service in an area of need for five years after I graduate – something I'll be happy to do.

But if Mr Pyne's reforms pass through the Senate, I'm not sure that the next generation of doctors will be as happy to make those choices.

James Lawler is a medical student from the University of Newcastle and is the President of the Australian Medical Students' Association. You can follow @youramsa and @jmslwlr on Twitter.

Healthy doctors fundamental for healthy patients

BY **DR ROD MCRAE**

Suicide, stress-related illness, and substance abuse – particularly of alcohol – occur at unacceptably high levels among registered medical practitioners and trainees.

There may be several reason for this, including the challenging (and often confronting) environment in which we work, the long hours we put in, the profession's culture of self-sacrifice, the pressure of remote practice, relentless bureaucratic demands, the desire of individuals to excel and their commitment to the ethos of causing no harm.

If that wasn't enough, there is the added strain caused by mandatory reporting regimes.

Regrettably, doctors do get ill. Some may be more predisposed to illness than others, due to pre-existing health problems or other factors.

We all know about, though all-too readily deny, the risks of seeking informal care from colleagues, as well as those of self-diagnosis and treatment.

Salaried doctors, most of whom work in hospitals, are as prone to illness and breakdown as any other practitioner - perhaps more so, given the challenging, emotionally-charged round-the-clock nature of the environment, not to mention the pressure stemming from high patient expectations.

The AMA has over many years consistently highlighted evidence that doctors are at greater risk of stress-related problems than the general population.

The 2013 beyondblue National Mental Health Survey of Doctors and Medical Students found that doctors reported substantially higher rates of psychological distress, depression, anxiety and attempted suicide compared with other professionals, let alone the broader Australian population.

Doctors need to be well in order to provide quality health care for their patients, and to experience medicine as a satisfying, long-term career.

This is why Doctors' Health Advisory Services (DHAS) are vital to the both the profession and the public good.

They provide a service that is not met by other established medical services. They have specialist skills to recognise and support a doctor in difficulty, and the resources to refer that person to appropriate treatment.

Even the sturdiest practitioner can give way to transitory illness.

It is important that doctors have a nationally consistent, confidential, independent, fully-funded health service that they can turn to when they need it, and have no qualms about using.

In its Position Statement on Health and Wellbeing of Doctors and Medical Students – 2011, the AMA recommended a number of measures that should be adopted, including:

- promoting good health and healthy lifestyles;
- each doctor having their own general practitioner;
- ensuring access for practitioners to confidential and high-quality medical and health services;
- adopting a 'no-judgement' culture that supports those in difficulty;
- ensuring that the workplace supports doctors' health, conduct and performance; and
- implementing safe rostering practices and working hours.

The Medical Board of Australia (MBA) has undertaken to fund DHAS from its existing resources for the moment, and to completely separate this from its regulatory role of managing impaired practitioners.

The AMA has welcomed this announcement, and is now working with the MBA to establish a national governance model and funding arrangements for State and Territory DHAS.

Importantly, funding arrangements will be structured so as to guarantee independence from the MBA and Australian Health Practitioner Regulation Agency.

This is considered essential if doctors are to trust these services and use them at an early stage in their illness.

Doctors work hard, and that's not going to change.

But we can change the culture that often seems to discourage doctors from seeking help.

We can also better prepare junior doctors, in particular, to cope with the apparently increasing stressors of medicine.

Equally importantly, we have to ensure a safe working environment, in every sense of what that means.

Intuitively, doctors will provide a more convincing healthy lifestyle model for their patients if they are healthy themselves.

INFORMATION FOR MEMBERS

Doctor Portal: the doctor's complete online resource

All the resources and information a busy practitioner needs is now just a click away following the launch of the AMA's Doctor Portal website.

Doctor Portal brings together all the tools and resources doctors look for on a daily basis – the GP Desktop Toolkit, the Find a Doctor feature, the CPD tracker, the Fees List, policy guidelines, position statements, practice advice and support – as well as access to AMA publications including the *Medical Journal of Australia* and *Australian Medicine*, all in one convenient location.

No more wasted time digging around through the entrails of the web to find the information you need – Doctor Portal is your one-stop information hub.

Not only does Doctor Portal give you ready access to the information and resources you need, it gives you a way to connect with colleagues near and far through public and private forums.

Click on the Doctor Portal link to check out these and other features:

- **Content sharing:** Doctor Portal allows you to securely share information and ideas with colleagues, providing public and private forums that only other registered medical professionals can access and participate in;
- **Find a Doctor:** locate practitioners using the Find a Doctor feature, which gives you access to Medical Directory of Australia information, including current practice contact details and a scalable map – perfect for when you are referring patients;
- **All in one convenience:** Doctor Portal features a refreshed MJA Bookshop, careers and jobs resources and the GP Desktop Toolkit, all at one site;
- **Free access:** Doctor Portal is a free service, and includes features exclusive to AMA members.

Doctor Portal is continually updated, ensuring that all information is current and you are never left out-of-date.

To explore all that Doctor Portal has to offer, visit: http://www.doctorportal.com.au/

INFORMATION FOR MEMBERS

AMA Careers Advisory Service

From graduates preparing their first resume to experienced doctors seeking to carve out a new career path in the Commonwealth public service, the AMA Careers Advisory Service is on hand to provide practical advice and information.

The Careers website, which is at: http://careers.ama.com.au/, gives members access to both general and specific careers advice and information. In addition to direct links to external websites and specific sources of information, the Service also offers practical advice for medical professionals as their medical careers advance.

The Careers Service provides information and support relevant to all stages of an individual's career, from medical students looking for assistance preparing internship applications - particularly writing resumes and covering letters - through to doctors in training who want to brush up their interview skills to give them a competitive edge at all-important medical college interviews.

But the Service is not only there for those in the early stages of their medical careers. It has also helped qualified medical professionals looking to apply their skills and expertise in jobs beyond medical practice. Among these have been those looking for non-clinical roles in Commonwealth and State public services that take advantage of their skills and experience.

The Service is constantly updating content on its website, including listings of career-related events being staged across the country, and uses feedback from members to help add and develop resources.

Members are encouraged to visit the website, if they haven't done so already, and we welcome feedback, which can be submitted via the online feedback form on the website.

Health on the hill

POLITICAL NEWS FROM THE NATION'S CAPITAL

Release children from detention, reinstate health watchdog: AMA

AMA President Associate Professor Brian Owler has called for children to be released from immigration detention centres and the appointment of an independent panel of medical experts to oversee the health care of detained asylum seekers.

Following the release of an Australian Human Rights Commission report showing hundreds of children held in detention have suffered violence, sexual assault and serious mental harm, A/Professor Owler told Sky News that any children currently being held should be immediately released into "a safe environment".

In a damning assessment of Australia's immigration detention system, the Commission reported that between January 2013 and March 2014, children in detention were the victim of 233 assaults, most of the 33 reported sexual assaults and 128 instances of self-harm. In addition, a third of children detained last year suffered serious mental health problems.

Among its findings, the Commission reported that, "in the first half of 2014, 34 per cent of children in detention were assessed as having mental health disorders at levels of seriousness that were comparable with children receiving outpatient mental health services in Australia."

Commission President Professor Gillian Triggs said the overarching conclusion of the Commission's investigation was that "prolonged, mandatory detention of asylum seeker children causes them significant mental and physical illness and developmental delays, [and] is in breach of Australia's international obligations".

A/Professor Owler said that although the Abbott Government had overseen a significant fall in the number of children being held in detention, the harm caused showed it was an inappropriate environment for any child, and those remaining in detention should be immediately released.

The confinement of children in immigration detention centres has long been a highly controversial aspect of the tough asylum seekers polices pursued by successive governments since the early 2000s.

The number of children being held behind wire peaked in July 2013, when, under the former Labor Government, 1992 were held in detention. Since then, a sharp slowdown in the arrival of asylum seekers by boat has seen the number of children in detention plunge, down to around 1100 when the Human Rights Commission inquiry began, and the Government claims there are just 192 now.

The AMA President added that the treatment of those being held in immigration detention should be the subject of oversight by an independent panel of experts, such as the Immigration Health Advisory Group, which was disbanded by the Abbott Government in December 2013.

A/Professor Owler said the standard of health care provided to asylum seekers, particularly in the offshore detention centres, was "well below what we would accept on the mainland", and should be subject to independent scrutiny.

But a spokeswoman for International Health and Medical Services, which has a contract to provide health services at the immigration detention centres, rejected claims of sub-standard care and invited A/Professor Owler to visit the facilities, including those at Manus Island, Nauru and Christmas Island, so that "he can make statements based on the facts".

Prime Minister Tony Abbott responded to the release of the report *Forgotten Children: National Inquiry into Children in Immigration Detention* by accusing the Human Rights Commission of engaging in a "blatantly partisan politicised exercise".

Mr Abbott rejected the Commission's call for a Royal Commission, and instead launched an extraordinary attack on the watchdog.

"There won't be a Royal Commission into children in detention, because if there were a Royal Commission into children in detention, it would condemn them," Mr Abbott told Parliament.

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Health on the hill

POLITICAL NEWS FROM THE NATION'S CAPITAL

... from p27

He continued his attack on Macquarie Radio, claiming "this is a blatantly partisan, politicised exercise and the Human Rights Commission ought to be ashamed of itself."

The issue has since become mired in legal controversy amid allegations the Government attempted to induce Professor Triggs to resign before the publication of the report.

It was revealed in Senate estimates that that the Secretary of the Attorney-General's Department, Chris Moraitis, acting on instruction from Attorney-General George Brandis, approached Professor Triggs just before the report was released to inform her she had lost the confidence of the Minister and to discuss a possible alternate "specific senior role" for her, though the Government has denied it sought her resignation.

Professor Triggs strongly rejected the Prime Minister's accusation of bias.

"I can assure you and the Australian public that this is not a politicised exercise," she told *The Australian*. "It is a fair minded report and I ask all Australians to read the report and you will see that the evidence on which we rely is evidence that covers the period of the former government as well as the nearly 18 months of the current government."

ADRIAN ROLLINS

Mental health future cloudy despite short-term funds relief

The Federal Government has announced a one-year extension of funding for services supporting people suffering mental illness and their carers, allaying fears tens of thousands would be left stranded without help.

Assistant Minister for Social Services Mitch Fifield has said contracts for organisations currently receiving funding to provide services under the Personal Helpers and Mentors program and the Mental Health Respite: Carer Support program would be extended to 30 June 2016, taking them through to the full implementation of the National Disability Insurance Scheme on 1 July next year.

The decision is a relief for the operators of around 150 federally-funded programs that were struggling to hold on to staff and plan ahead because of funding uncertainty.

Up to 4000 mental health workers were at risk of losing their jobs before the Government announced its decision.

"The extension of these contracts will ensure people living with mental illness, and those who care for them, can still access these support services," Senator Fifield said. "This one-year funding extension will help ensure a smooth transition to the NDIS for these services."

While the decision has provided short-term reassurance to many, the sector is still gripped by uncertainty as the Government sits on the results of a major review of the nation's mental health system.

It is understood that the National Mental Health Commission delivered the results of its Government-commissioned inquiry into mental health services to the Minister in November last year, but the Government has so far withheld the findings, causing consternation among service providers, practitioners and patients.

The Australian Medical Students' Association is among those calling on the Government to release the results of the review and use the forthcoming Budget to announce greater investments in mental health services.

AMSA President James Lawler said the Budget was the "ideal time" to act on the review's findings and invest in severely underfunded mental health services, particularly for young people.

Shadow Mental Health Minister Jan McLucas, who has been pushing hard for the Government to release the Commission's report, said that although she had misgivings about the competency of the Commission to undertake an inquiry focused on the finances of mental health services, now that the report had been completed, the fact that it would be used to steer Government mental health policy decisions meant it should be released immediately.

"It is absolutely essential that this [policy making] be done transparently, that the conversation is held in a way that each and every participant has an understanding of the direction of the Government," Senator McLucas said. "We need an informed discussion about the future of mental health programs in the country."

Senator McLucas has moved a motion in the Senate calling on the Government to the final report, as well as two interim reports provided to the Government in February and June.

The Government has so far resisted these calls.

ADRIAN ROLLINS

Persistent Indigenous disadvantage 'profoundly disappointing': PM

The nation is making little headway in narrowing the life expectancy gap between Indigenous people and other Australians despite long-term progress in halving the mortality rate for Aboriginal and Torres Strait Islander children.

In a result that Prime Minister Tony Abbott admitted was "profoundly disappointing", the seventh annual Closing the Gap report showed there had been little or no improvement in key measures of Indigenous disadvantage, fuelling criticism of Commonwealth spending cuts.

The report found that although Indigenous death rates from chronic disease have declined significantly, there has been no improvement in mortality from diabetes, suicide or traffic accidents, and the death rate gap for cancer has widened.

Overall, the report said, improvement had virtually stalled between 2006 and 2013, and the life expectancy gap remained wide, including 10.6 years for men and 9.5 years for women.

The report concluded that "the current rate of progress will have to gather considerable pace" if the goal of closing the life expectancy gap by 2031 was to be met.

The finding has underlined calls by AMA President Associate Professor Brian Owler for governments nationwide to sustain reform momentum.

A/Professor Owler said some promising gains were being made in improving child and maternal health, but the report showed that health gulf between Indigenous Australians and the broader community remained wide.

"Achieving equality in health and life expectancy for Aboriginal and Torres Strait Islander peoples is a national priority, but the reports show that there is still a way to go before we see meaningful and lasting improvements," the AMA President said.

A/Professor Owler said Federal Government funding cuts for primary health care and Indigenous health services would undermine recent progress and make it much harder to achieve improvement.

"There are significant numbers of Aboriginal and Torres Strait Islander people with undetected treatable and preventable chronic conditions, which impact on life expectancy," the AMA President said. "Community controlled health organisations and Aboriginal Medical Services need greater support to be able provide Indigenous Australians with access to the comprehensive primary care services that other Australians enjoy."

Despite these concerns, Mr Abbott reiterated the Government's priority was improving school attendance and employment, where efforts have so far met with mixed success.

While the country is on track to halve the gap on year 12 attainment between Indigenous and non-Indigenous students, there has been no improvement in Indigenous reading and numeracy, and employment outcomes have actually declined since 2008.

"Closing the gap starts with getting the kids to school. And it starts with expecting much of them while they are there," he told Parliament. "This Government is determined to break the cycle of truancy."

The Government's focus on truancy and employment has been criticised for underplaying the importance of health, a line of attack that Mr Abbott moved to blunt by declaring the Government's commitment to the National Aboriginal and Torres Strait Islander Health Plan developed under the previous Labor Government.

"Without good physical and mental health, it is hard to go to school, to go to work, to raise children, to contribute to the community, or to live a long and fulfilling life," the Prime Minister said. "The National Aboriginal and Torres Strait Islander Health Plan does capture the voices of the community and the experts, and through this plan we will continue to support families and communities to manage their health and wellbeing."

Continued on p30 ...

Persistent Indigenous disadvantage 'profoundly disappointing': PM

... from p29

Commitment to the implementation of the Health Plan is bipartisan, but Opposition Leader Bill Shorten used his speech to Parliament to take a swipe at the Government over its cuts to spending on Indigenous policy.

While closing the gap was "an endeavour where every Opposition wants the Government to succeed", Mr Shorten said he was compelled to point out the ramifications of Budget cuts to Indigenous programs and services, which he said amounted to $500 million.

"Right now, a host of vital organisations don't know whether their funding will be continued or withdrawn," the Labor leader said. "When essential preventive health programs are helping tackle smoking, cuts will jeopardise that progress. When strides are being made to prevent chronic disease – cuts will hobble our advance."

Mr Shorten's criticisms prompted a walkout by several Coalition MPs, and Indigenous Affairs Minister Nigel Scullion said it was unfortunate the Opposition leader had used the occasion to engage in what he considered to be "political point-scoring".

Mr Scullion added that the $500 million figure cited by Mr Shorten was "a furphy".

Aboriginal and Torres Strait Islander Social Justice Commissioner Mick Gooda welcomed Mr Abbott's commitment to the implementation of the Health Plan.

"But the work is just beginning," Mr Gooda added. "To be truly effective, the Health Plan must be adequately funded. We therefore expect the Federal Government to follow through on its commitment to Indigenous health and ensure no further budget cuts to this critical area."

ADRIAN ROLLINS

Govt must be in for long haul

Indigenous life expectancy is improving, but Aboriginal and Torres Strait Islander people are still likely to die a decade younger than other Australians.

In an update on initiatives to boost Indigenous health, the Close the Gap Campaign reported that although Aboriginal and Torres Strait Islanders are expected to live, on average, 1.6 years longer than they did in the middle of last decade, their average life expectancy of 69.1 years was still more than 10 years less than other Australian men. The life expectancy gap for Indigenous women, who can expect to live to around 73.7 years, was similar.

The Campaign's *2015 Close the Gap Progress and Priorities Report* found that the gain, while encouraging, was negligible, and the nation's governments needed to make a sustained commitment to investing in Indigenous health over many years in order to achieve lasting and significant change.

It said the small narrowing of the life expectancy gap achieved between 2005-07 and 2010-12 (of 0.8 years for men, and 0.1 years for women) was limited by increases in the life expectancy of non-Indigenous Australians, and "such small relative gains are within the margin of error, and could in fact be non-existent".

The Campaign said that in such a short period of time it was unrealistic to expect to see any major narrowing of the life expectancy gap, and the figures should instead be used as a base line against which to assess future changes.

Campaign co-Chair Kirstie Parker said experience in New Zealand showed Maori life expectancy increased by four years following two decades of sustained effort.

Mr Parker said there could be similar improvements achieved for Aboriginal and Torres Strait Islander people in the 2020s "if the effort to close the gap in this country is maintained".

There have been marked improvements in maternal and child health. The country is on track to halve the gap in child mortality by 2018, and the low birth weight gap is narrowing.

In addition, Indigenous people are cutting down on smoking. The proportion lighting up daily dropped from 51 to 41 per cent in the 10 years to 2012.

But they remain far more likely to smoke than non-Indigenous Australians, and more than 70 per cent of Indigenous adults are overweight or obese, compared with 62.6 per cent of non-Indigenous adults.

The Campaign called on the Federal Government to reinstate funding for the Tackling Indigenous Smoking program, and to maintain and improve funding and support for primary health care, particularly Aboriginal community-controlled health services.

ADRIAN ROLLINS

Trainee doctors face uncertain future

There is significant uncertainty among specialist medical trainees about their job prospects as new Fellows face increasingly fierce competition for a limited number of employment opportunities.

In a further sign that the health and medical training systems are struggling to cope with recent rapid growth in the number of graduates, an AMA survey of specialist trainees found little more than a third were confident about finding employment as a Fellow after completing their training.

The AMA said that managing "exit block" from training was an emerging issue, with graduating Fellows in several specialties finding it increasingly difficult to secure positions in either the public or private systems.

It said this could have knock-on effects that could derail the training of many aspiring doctors.

"Failure to ensure there are sufficient employment opportunities for new Fellows will effectively shift the bottleneck in the medical training pipeline from the beginning to its end," the AMA warned in its 2014 Specialist Trainee Survey report. "Newly graduated Fellows who are forced to occupy senior registrar positions because of a lack of employment opportunities will block the training pipeline, and the capacity for vocational training within the health system will be compromised."

The AMA said urgent work was needed to find out why many new Fellows were finding it difficult to find employment opportunities, and recommended more be done to help medical students and junior doctors identify specialties with better employment prospects.

While many trainees are worried about they will be able to find a job, most felt well prepared for work, as long as they could find it.

The survey, which involved responses from 583 out of 13,801 hospital-based trainees (a 4.2 per cent response rate), found a high level of satisfaction with the quality of their training and their career choice.

Overall, 78 per cent said they were satisfied with their training program, 84 per cent were happy with the amount of supervision they received and 79 per cent felt they received sufficient clinical experience to meet the objectives of their training.

Encouragingly, almost 80 per cent reported that the demands of their training were compatible with safe working hours, a significant improvement from the 69 per cent who responded similarly in 2010, adding to evidence of success in the past decade in clamping down on excessive hours and reducing fatigue risk.

AMA President Associate Professor Brian Owler said the results showed that the medical colleges were performing well in most areas of vocational training, which was gratifying given recent rapid growth in the number of trainees coming through the system.

But A/Professor Owler said the survey showed "significant areas where colleges have fallen short of their trainees' expectations", including in the way they handled complaints about bullying and harassment, providing feedback for trainees, and their appeals and remediation processes.

The AMA President said colleges and health departments should draw on the survey's results to help improve the quality of vocational training, and called for the establishment of a regular National Training Survey to monitor the training experience and inform improvements.

"A National Training Survey, similar to the successful United Kingdom model, would dramatically improve workforce planning, including important downstream planning to guarantee employment for doctors when they have finished their specialist training," A/Professor Owler said.

ADRIAN ROLLINS

What price a medical career?

Cost remains a big gripe for specialist trainees.

Only a quarter of those surveyed by the AMA last year felt their training program represented value for money, and almost 75 per cent complained that the justification for the fees being charged was not at all transparent or clear.

The cost of training is a significant issue. In 2013, trainees were charged an average of $11,369 a year, and a fifth reported that they had delayed or cancelled part of their training because of the costs involved, and 14 per cent indicated that education expenses influenced their choice of specialty.

The AMA has recommended that colleges "actively demonstrate" how training fees are apportioned, and ensure that they are not used to subsides unrelated activities.

Who are the doctors of the future?*

54% Women

71% Married/de facto

69% No children

74% have Australian medical degree

97% Training in public hospitals

71% City-based

* characteristics of respondents to AMA Specialist Trainee Survey 2014

Queen of the vines

BY DR MICHAEL RYAN

1 2 3

It is with great admiration that I call one of the most respected and revered wine writers the Queen of the Vines.

Jancis Robinson is one of the most influential wine writers of our time, and deserves the many accolades bestowed upon her. Adding to this remarkable career has been the ability to break into the boys' club that has dominated the world of wine for centuries.

Jancis, born in Cumbria in the north of England, was originally a Reader in Philosophy and Mathematics at Oxford University. She ended up working in the travel industry, and was inspired by a year spent in Provence to take up a career in food and wine.

Her first writing foray was with the trade magazine Wine and Spirit. She became the first person outside the wine trade to receive a Masters of Wine. There are just 260 Masters of Wine worldwide.

As time proceeded, she became a prolific writer, and has had many books published.

One of her recent publications is an awe-inspiring collaboration on the DNA origins of commercial wine called Vines, Grapes and Wines.

The old school way of identifying vines, known as ampelography, was based on leaf structure. But, due to advances in DNA, identification has become much more accurate, with an astounding number of previously identified and named grapes being identical to others grown elsewhere under a different name.

Jancis typifies these discoveries by claiming that Cabernet Sauvignon is a hybrid of Cabernet Franc and Sauvignon Blanc, with the name being quite coincidental. She and her partners, Swiss botanist Jose Vouillamoz and web editor Julia Harding, have collated and described 1368 wine grape varieties.

Apparently, there are more than 10,000 vine varieties, though only the commercial varieties are described.

Jancis' love for Riesling is well-known, and it is reinforced by the fact that she has the work Riesling tattooed on her right forearm.

She recently listed 10 varieties that astounded her because of their quality or historical variance. I mention just a few of these, and it is worth searching out more information: Alvarinho/Albarino - Spanish and Portuguese origins; Assyrtiko - Greek origin; Koshu – Japan; Mtsvane – Georgia (often made in clay pots); Vermintino/Pigato/Favorita - Corsica, Sardinia, Italy; Cabernet Franc - known in France, but probably from Spain's Basque region; Mazuelo/Carignan - France and Spain; Okuzgozu - Turkish; Sankt Laurent – Austrian; and Tribidrag/Zinfandel/Primitivo/Crljenak Kastelanski - Croatian/American/Italian.

The book is worth a look, and can help settle those arguments on origins and names of grape varieties.

WINES TASTED

1. 2014 Petaluma Hanlin Hill Clare Valley Riesling

Tasted in honour of Jancis' obsession, this is a pale wine with tinges of green. The nose is incredibly aromatic, with lemon-lime zest and hints of spice. The anterior palate is zinging with plenty of acid. A true keeper, but enjoy now with some very sharp, freshly made guacamole.

2. 2012 Patritti McLaren Vale Saperavi

A red from Georgia in Russia, it's name literally means ink and it is indeed a dark inky colour. Aromas of cherries and plums, with spicy Chinese notes. A full, juicy palate with a medium body structure. Will be interesting in five to seven years. Juicy enough for any red meat.

3. 2009 Pertaringa McLaren Vale Tannat

Its name implies tannin. From the south- west of France, it is also the national grape of Uruguay. Dark purple, getting some aged brown colours. A dusky plummy nose with herbal notes. The palate is subdued but interesting, with the hints of spice and big tannins, as its name implies. Hard to get now, but worth the search. A Guinness pie is what it needs.

Mini Cooper S Restoration (Part 2)

BY DR CLIVE FRASER

Last month's column took us through the arduous process of resuscitating a middle-aged car, a 1970 Mini Cooper S to be precise.

We got as far as stripping it back to its skeleton and renewing the bodywork to as-new condition.

By now, the Mini was looking great on the outside, but the mechanical restoration was the next step.

Ask anyone, and they'll tell you that Minis are difficult to work on.

For the restoration, an array of special tools was needed to reach into those hard-to-get-to spaces.

The Mini's compact design left no room to move, as well as a few design flaws inherent in a car less than 10 feet in length.

For starters, the original Mini used an existing British Motor Company engine.

Because it was mounted transversely (or east-west), this meant that the radiator and fan sat on the right side of the engine bay.

The fan blades were reversed, which meant that hot air from the engine bay was pushed across the radiator - not exactly an ideal arrangement for dissipating heat from a cramped engine compartment.

The distributor sat in front of the engine, just behind the grill.

In early models, the electricals were completely exposed to water splashing into the engine bay, and Minis were notorious for stopping because of a wet ignition, even after a simple car wash.

Uniquely, the Mini's engine and gearbox shared the same sump.

This could lead to some interesting noises if metal sheared off a gear and found its way into the delicate engine bearings.

An oil filter and a magnetized sump plug would help to pick up any metallic debris, but engines and gearboxes were never really meant to use the same lubricant.

The plethora of front wheel drive cars that followed the Mini wisely avoided this configuration to increase the service life of both the engine and the gearbox.

But this design was used in the Mini to help make it as compact as possible.

On the plus side, the drive shafts were very similar in length, because the differential was centrally situated behind the gearbox/engine.

This meant that, in their normal configuration, Minis did not suffer the torque steer of later front wheel drive cars that had asymmetric drive shafts of unequal length or diameter.

The Mini's previous owner had said that "the motor needed a tune-up", but closer inspection revealed that the head was cracked.

A new set of piston rings for the 1275cc engine was an affordable $80, but the rings are brittle and, unfortunately, the last ring to be installed broke, meaning another set was needed for another $80.

The internet is a marvellous thing, and all the parts seemed to be readily available and surprisingly affordable.

Just to be sure that everything would be right, my friend replaced the gearbox cluster gear set.

Even a meticulous inspection of this part might not identify a tiny amount of wear that would make the transmission noisy.

My friend wanted to be sure that everything worked like new, and his attention to detail and hand-crafting of everything was leaving me thinking that his car would be better than the original.

But after, 45 years of service, there was always the possibility that something would be missed, and my friend might only find out about that problem once he had the Mini Cooper S on the road.

To be continued.

Safe motoring,

Doctor Clive Fraser
doctorclivefraser@hotmail.com

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Careers Advisory Service: Your one-stop shop for information and resources to help you navigate through your medical career.

CPD Tracker: Record your continuing professional development (CPD) online with the AMA's CPD Tracker, a free service for members.

Amex: American Express is a major partner of the AMA and offers members special discounts and extra rewards on a range of credit cards, merchant services and offers for existing AMA cardholders.

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A0507P

Yes, I would like to make a gift of:

❑ $25 ❑ $50 ❑ $100 ❑ $200 ❑ My choice $ _____

Or I will make a regular monthly gift of:

❑ $25 ❑ $50 ❑ Other $ _____ (minimum $15 per month)

until cancelled in writing by ❑ Credit card OR ❑ Direct debit
(Direct debit authority will be forwarded)

MY DETAILS Please print clearly

Title: _____ First name: _____ Family name: _____

Address: _____

Suburb/Town: _____ State: _____ Postcode: _____

Phone H/W: (___) _____ Mobile: _____

Email: _____

PAYMENT OPTIONS

❑ Cheque/money order (payable to The Fred Hollows Foundation)

❑ Charge my credit card

❑ Visa ❑ Diners ❑ AMEX ❑ MasterCard

Card No: _____ _____ _____ _____

Expiry Date: _____

Name on Card: _____

Signature: _____

❑ Please send details on making a gift to The Foundation in my Will

Complete coupon and post to: Reply Paid 75965 BURWOOD NSW 1805 (no stamp required) or fax to 02 8741 1999.
Donations of $2 and over are tax-deductible. If for any reason you do not wish to receive appeal updates, please contact us (details above).

The **Fred Hollows** Foundation