AUSTRALIAN
Medicine
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AMA LEADERSHIP TEAM

President
Dr Michael Gannon

Vice President
Dr Tony Bartone

In this issue

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Time to take health seriously

BY AMA PRESIDENT DR MICHAEL GANNON

There has been much conjecture since election night about the significance of health policy, and the use of a 'scare campaign' in changing votes.

The Coalition attacked Labor over its 'Mediscare' campaign, which deliberately painted a picture of a fully privatised Medicare. The Prime Minister subsequently called it an 'extreme act of dishonesty'.

The AMA, too, was critical of the Opposition's Medicare privatisation claims. There is and was no move to privatise Medicare. All that was announced, and later withdrawn, was a plan to ask the Productivity Commission to look at outsourcing some backroom administration arrangements in the antiquated payments system, something that the AMA would still welcome and support.

Nevertheless, the political reality is that health played a major part in this election, and it was the Coalition that created and nurtured the fertile ground that allowed the scare campaign to grow and thrive.

The seeds of Medicare uncertainty, and fear, were sown more than two years ago with the Abbott Government's 2014 Budget and the birth of the co-payment bogeyman.

For almost the entire term of the last Government, the Coalition lacked a cohesive health policy narrative. The successive co-payment nightmares, followed by the Medicare freeze debacle, were succeeded by a series of reviews which, while worthwhile, were never going to report or translate into policy until well into a second term.

As a result, the Coalition did not have a coherent health message to take to voters at the election. This played into the Opposition's hands.

The AMA, the RACGP and other health groups campaigned on issues that have a direct impact on patients – the freeze on Medicare patient rebates, the need for more public hospital funding, and the impact of cuts to bulk billing incentives for pathology services and x-rays.

These are all issues that Australian families can relate to from everyday experience. These are all issues that impact negatively on patients, doctors, and other health care providers. But they were not issues that appeared from nowhere in the final fortnight of a long election campaign. They have been around since the 2014 Budget, and the Coalition did not acknowledge them as electoral threats, vote losers, and game changers.

The AMA warned the Government, under both Malcolm Turnbull and Tony Abbott, and directly to Health Ministers Peter Dutton and Sussan Ley, that the health policies from the 2014 Budget were bad and must be changed.

When Prime Minister Turnbull met with the AMA Federal Council in Canberra just prior to the election, he was told first hand by doctors from all States and all specialties that the Coalition had to change course on health policy.

During a meeting with the Prime Minister in Perth just weeks ago, in the middle of the campaign, I issued similar warnings.

But that is all now all in the past. The election has been run.

The Coalition will be returned for a second term, albeit with a wafer-thin majority in the Lower House, and a curious mix in the Senate to deal with on legislation.

There is no doubt that the Coalition will take health policy very seriously ahead of the next election. The Prime Minister has made that clear, saying that "*... a material number of Australians were sufficiently concerned about our commitment to Medicare that they changed their vote, and that is something we need to address*".

The first bit of advice we offer the new Government is to approach health policy as a means to improving public health and saving lives, not as a way to save money for the Budget bottom line.

Health policy must be driven by people who know health intimately, people with skin in the game, not bureaucrats from Treasury and Finance.

Investing in preventative health measures and in primary health care is not only a moral imperative, it is an investment in the economic productivity of our nation, and perhaps even political survival.

*This article first appeared in **The Australian** on 11 July 2016*

Patients depend on us – advocate for the future

BY AMA VICE PRESIDENT DR TONY BARTONE

As our nation's capital slowly adjusts to the fallout of a long election campaign and a small majority Coalition Government it is an opportune time to start planning and advocating health policy, which was clearly a resounding issue of the campaign.

There is a significant opportunity for the AMA to help shape the health policy debate. Our President, Dr Michael Gannon, has been very visible the last few weeks promoting the AMA's election priorities and setting down the groundwork for meaningful future conversations, especially regarding the funding and sustainability of our health system. I hope to assist in some of that dialogue and discussion.

We are all too aware of the medical workforce crisis and the lack of any semblance of a workforce strategy. All graduates should be entitled to appropriate opportunities for post-graduate training. The failure of the medical training system to produce graduates to work in regional and remote Australia is contributing to the lower health status and life expectancy of people living in these areas. The AMA's Community Residency Program should be adopted to encourage more young doctors to choose a career in general practice and to work in regional and remote Australia.

I am passionate about putting this issue and others front and centre of the AMA's agenda. I believe the AMA should be advocating for:

- acknowledging the increasing burden of ageing and chronic conditions, and the central role of GPs in the management of these conditions;
- palliative care - providing compassionate and easily accessible health care;
- aged care - especially the lack of continuity in family doctor care options for residents;
- mental health - especially community care options including subacute public care facilities. Many GPs are forced to deal with situations beyond their professional capability or comfort because of a lack of other options, especially in regional and remote areas;
- access to the same quality and range of public health endeavours and outcomes in rural and regional areas as in urban areas;
- prevention - exercise, healthy eating, alcohol and drugs, health literacy and education, are just a few areas where small investments can drastically change the health of Australians; and
- doctor health and wellbeing.

We are constantly told that the health system is unsustainable and there are insufficient funds. We need to focus on the areas of waste and duplication and ensure the savings are ploughed straight back into health. There are many examples including:

- delays in OPD visits/elective waiting list deferrals, often with unnecessary amounts of additional medications to manage complications of pain and or increased morbidity;
- time consuming amounts of red tape, especially the paperwork required to access systems rather than relying on our clinical acumen; and
- the duplication of pathology tests and other investigations between hospitals and private practice.

What often angers me are unnecessary hospital delays and burgeoning OPD and waiting lists. The never-ending quest for e-health records is another. More than seven years grappling with the PCEHR and its successors is an area of frustration. Though initially promising ideas, clinical advice and engagement has been ignored in their execution. Opt-out trials, hopefully, will rescue the situation and ultimately provide the answer to more timely and efficient interventions and outcomes for all areas of the health system.

Some people have asked me about why I became seriously involved in AMA. After many years of membership I found that I was constantly frustrated and sick of waiting for someone else to make the lives of others better. Patients depend on us. I feel that I should, and could, do more for them and for the health system with advocacy, rather than the one-to-one care of patients alone.

Personal family experiences, including watching ageing parents and loved ones deal with the complexities and tortuousness of the public health system, only further strengthened my resolve to give something back.

For the many friends I have made, and the many colleagues and mentors I have worked with, advocacy on behalf is just one of the ways of thanking them for their enormous wisdom, insight and dedication.

Election affirms the importance of health

BY AMA SECRETARY GENERAL ANNE TRIMMER

> "AMA President Dr Michael Gannon has used the election period to call on all political parties to consider good health policy for the future, including areas of health policy that had very little mention during the campaign, such as preventive health"

Another Federal election decided but with considerable uncertainty about the final result for a week or more after polling. Prime Minister Malcolm Turnbull has claimed victory following the concession of the Leader of the Opposition, Bill Shorten. At the time of writing the Health Minister has not been announced, nor the remainder of the Cabinet.

As the polling showed, health policy remained central to the election campaign and figured especially high in states such as Tasmania, where there are deep concerns about the capacity of the State Government to fill any void in Federal funding. The AMA has called for an open conversation about health care with the next Government, and also with the Opposition, the Greens, and the minor parties.

AMA President Dr Michael Gannon has used the election period to call on all political parties to consider good health policy for the future, including areas of health policy that had very little mention during the campaign, such as preventive health.

The AMA developed its election strategies before the start of the campaign through debate at Federal Council and engagement with the State AMAs. The document setting out the AMA's key issues for the election was launched on 11 May and guided the AMA's advocacy throughout the campaign period. In the week leading up to election day the AMA published an analysis of the positions adopted by each of the three main parties against the AMA key issues. It was informative reading.

The cycle of the AMA's internal elections has been completed this month with the election by Federal Council of Dr Beverley Rowbotham as Chair of Council. Dr Iain Dunlop was elected by the Board as Chair of the Board of Australian Medical Association Limited. The composition of the Board is relatively unchanged, other than the inclusion of Dr Gannon and Dr Tony Bartone as the incoming President and Vice President.

Federal Council will have a few new faces at its meeting in August, a welcome opportunity to bring some fresh ideas to the discussions at Council. New members of Council include the recently-elected Presidents of AMAV, Dr Lorraine Baker, AMAWA, Dr Andrew Miller, and AMA NSW Associate Professor Brad Frankum. Also joining Council are the representatives of private specialist practice, Associate Professor Julian Rait; doctors in training, Dr John Zorbas; the Victorian area, Dr Jill Tomlinson; rural doctors, Dr Sandra Hirowatari; psychiatrists, Dr Steve Kiseley; and pediatricians, Dr Paul Bauert.

Federal Council remains the centre of AMA's medico-political discussions and debates. With each new President there is an opportunity to refresh the composition of the Councils and Committees of Federal Council, a task that is now complete.

A new Government will bring fresh opportunities for AMA engagement in what is now acknowledged as a central tenet for the Australian population – health policy that ensures a viable and sustainable system, but also ensures that all Australians have appropriate access to affordable care.

Health policy in play as Coalition licks wounds

> "The Prime Minister, the Coalition, have had the scare of their life," Dr Gannon said. "It's very clear that Australians value their health, and many of them voted on the grounds that they were worried about their health care" – Dr Gannon

AMA President Dr Michael Gannon has intensified his calls on the Government to dump its Medicare rebate freeze policy and reverse other health cuts amid mounting pressure within the Coalition for changes to health policy following the narrow Federal election result.

Seizing on admissions from Prime Minister Malcolm Turnbull that health policy concerns swayed many voters away from his party, Dr Gannon has called on the Coalition to change course and treat health as an investment, rather than a cost.

"The Prime Minister, the Coalition, have had the scare of their life," Dr Gannon said. "It's very clear that Australians value their health, and many of them voted on the grounds that they were worried about their health care."

Last week the Coalition secured the 76 seats needed to form Government in its own right after suffering a national swing of 3.4 per cent against it. The narrow victory (the ABC predicts Labor will hold 68 seats, the Greens and Xenophon Team one each, and three independents) prompted a wave of finger-pointing and recriminations within conservative party ranks, including calls to revisit health cuts made in the 2014 and 2016 budgets.

Announcing his new Ministry, Mr Turnbull said he had already met with Dr Gannon and anticipated working closely with doctors over the next three years.

"I am confident we will have a better working relationship with the AMA and its GP membership," the Prime Minister said.

Rancour over the close election result extended to include speculation that Health Minister Sussan Ley would be dumped amid complaints she had not done enough to counter Labor's attack lines on the Government over Medicare. Her supporters, though, revealed that she had been muzzled from speaking out during the campaign by Liberal strategists, and Dr Gannon said that, from afar, it seemed "that the Coalition didn't want to talk about health in the campaign, and that they had silenced Minister Ley".

Dr Gannon said the big lesson for the Government from the election was that the public valued the health system highly, and in post-election talks with the Prime Minister he had reinforced the need to invest in general practice, increase public hospital funding and reverse cuts to bulk billing incentives for pathology and diagnostic imaging services.

The AMA President said Mr Turnbull understood the AMA's concerns.

"I think that in an ideal world he would unravel the freeze tomorrow," he told ABC radio. "What we have seen in the past, going back to the 2014 Budget, was a desire by the Coalition to introduce a co-payment to try and work out ways that those who can afford it can contribute more to the cost of their health care.

"Now, the reason that proposal failed so badly is because it didn't give the opportunity for individual GPs to make a judgement, knowing their patients well, who can and can't afford even a modest amount of money."

Asked if he would re-visit the idea of a patient co-payment, Dr Gannon said he was not seeking "a re-energisation" of the co-payment debate, but instead wanted a serious discussion about the future funding of Medicare.

Health policy in play as Coalition licks wounds

... from p6

"My comments...are about being able to have conversations about why those two [co-payment] proposals from two years ago were not good policy, being able to have a conversation about how we fund Medicare, 15, 20 years in advance," he said on radio station 2GB.

"We're not far off the balance in Australia, it just needs some tinkering around the edges. And I'm really keen to, in this next Parliament, with a knife-edge result in the Lower House and a very interesting Senate...I'm just hopeful we can have these conversations that make sure that Medicare is there to protect people in 20 years' time, and have more than that two- or three-year view of it."

The Government appears receptive to calls to re-visit its health policies.

As the Coalition took stock of the extremely tight Federal election result, Mr Turnbull said it was clear that Labor's message that the Coalition posed a threat to Medicare had fallen on "some fertile ground".

"What we have to recognise is that many Australians were troubled by it. They believed it, or at least had anxieties raised with it. It is very clear - it is very, very clear - that [Deputy Prime Minister] Barnaby [Joyce] and I and our colleagues have to work harder to rebuild or strengthen the trust of the Australian people in our side of politics when it comes to health. There is no question about that," Mr Turnbull said.

"We have to recognise that there is a real issue for us if people voted Labor because they genuinely believed or they feared that we were not committed to Medicare, because that is not the case. So that is why Barnaby and I, as we reflect on this and our colleagues reflect on this, that is something that is an issue we have to address," Mr Turnbull said.

Dr Gannon told ABC radio the election result had shown just how important health policy was for voters, and it was clear that the Medicare rebate freeze, combined with earlier polices such as the GP co-payment, meant Labor's scare campaign on Medicare had resonated with voters.

"If we go back to the first co-payment model in 2014, which came out of the much-maligned Budget that year, if we look at Co-payment Mark II which came out later that year, it possibly showed that health policy was being run out of Treasury," Dr Gannon said. "The Coalition has realised maybe too late...that people do worry about their health, they do vote on it, they do regard it as one of the major issues when they decide how to vote."

ADRIAN ROLLINS

Don't let her drink dirty water

malaria, typhoid, dysentery, cholera, diarrhoea, intestinal worm infection, ... dirty water can kill.

6,000 children are dying every day – and it's because they don't have clean water. So they're forced to drink water that could make them sick with diarrhoea, cholera and typhoid.

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From $39 a month your support will help drill boreholes, protect water sources and provide health and hygiene training. You'll be helping communities to make long-term changes that ensure a clean water supply and basic sanitation.

Stop dirty water killing children,support Water Health Life:
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Basic Needs. Permanent Solutions

Health safety net 'a must'

AMA President Dr Michael Gannon has declared that the poor, vulnerable and disadvantaged must continue to have ready access to care, whatever changes are made to Medicare and health funding.

While acknowledging that the Federal Government was facing funding constraints, Dr Gannon said the AMA would fight to protect universal access to quality primary health care and make sure health care remained affordable.

"When we talk about universal healthcare, what we mean is that everyone gets treatment, and we must have that," Dr Gannon told radio 2GB. "We must have that safety net so that people of limited means are looked after, and people even of means, people who have money in the bank, when they face serious health problems, that they don't go bankrupt having them dealt with."

Though the Federal Government shows no signs of backing down from its controversial policy to extend the freeze of Medicare rebates to 2020, the AMA President warned that it needed to preserve those aspects of Australia's health system that made it among the best in the world.

"We do have a health system that's the envy of many other parts of the world," he said. "We're better than the American system, where tens of millions of people literally can't access health care. And we're better than systems in many countries in Europe which are basically bankrupt because they've promised for too long that you can have everything for free."

Dr Gannon said the balance between public and private systems was a major strength of Australia's health care.

"I can tell you that we're miles in front, especially of the British health system. One of the things which works really well, it's not perfect, but we've got a private system where people then spend more of their post-tax dollars in the health system. What that does is increases the total value of the health system," he said. "It is very easy to point to failures of public hospitals, they're not perfect; but...I think we do pretty well, and I think that both sides of politics are not far off the health system that's the envy of the rest of the world."

ADRIAN ROLLINS

INFORMATION FOR MEMBERS

Changes to the DVA Rehabilitation Appliances Program

The Department of Veteran's Affair's (DVA) has recently made some changes to the Rehabilitation Appliances Program (RAP) National Schedule of Equipment. The RAP assists entitled veterans, war widows and widowers, and their dependants, to remain as independent and self-reliant as possible in their own homes.

The schedule was recently reviewed and changes took effect from 1 June 2016.

The changes include new aids to assist members of the veteran community experiencing symptoms of dementia. These include medication timers, memory joggers, location finders and safely home bracelets in addition to orientation clocks, calendars and signs which were added in 2015.

Veterans will also now only have to undertake one hearing assessment, previously two, before being eligible for a smoke alarm package for hearing impaired.

A new RAP business rule has been added which will now require health providers to only use DVA contracted suppliers in situations where an item is a contracted RAP item and when prior approval is not required. The format of the schedule has also been modified to clearly identify whether the individual item is contracted.

For more information visit www.dva.gov.au/providers/provider-programs/rehabilitation-appliances-program-rap

Alternatively call 1300 550 457 (metropolitan callers) or 1800 660 457 (non-metropolitan callers)

Ley holds on to Health

Sussan Ley has been re-confirmed as Federal Health Minister as Prime Minister Malcolm Turnbull backs stability and experience in the key battleground portfolio.

Implicitly backing his Minister against critics who accused Ms Ley of going missing when Labor ramped up its 'Mediscare' campaign, Mr Turnbull said he had the utmost confidence in his ministerial team, and defended the Coalition's messages and tactics against what he said was an "unscrupulous" Opposition.

While some internal party critics complained Ms Ley was all-but invisible during the marathon eight-week Federal Election campaign, aside from a widely-reported remark early on in which she indicated she had been overruled by Treasury and Finance over the controversial decision to extend the Medicare rebate freeze to 2020, supporters said she was effectively muzzled by Liberal campaign directors keen to shut down health as an election issue.

AMA President Dr Michael Gannon defended both Ms Ley and Shadow Health Minister Catherine King, arguing that both had been pushed into the background by the increasingly presidential style of modern electioneering.

"It seemed to me from afar that the Coalition didn't want to talk about health in the campaign, and that they had silenced Minister Ley," Dr Gannon said.

"It was very much the Bill and Malcolm show, with occasional guest appearances by Richard Di Natale, Barnaby Joyce, and Derryn Hinch," Dr Gannon said. "I think that that's the reality of the way media covers politics now, it does become very Presidential.

"I would have loved to have seen a greater depth of analysis in the debate on health and in other areas. But I think that says more about our media and our politics than it does necessarily about either Catherine or Sussan, two very capable women who have the interest of patients across Australia at their heart."

Ms Ley embarks on her second term as Health Minister with a swathe of major issues outstanding, including the threat to bulk billing from the extended Medicare rebate freeze, and fears about the impact on care of reduced hospital funding and cuts to bulk billing incentives for pathology and diagnostic imaging services.

The New South Wales politician, who was appointed to the health portfolio mid-way through the Government's first term after Peter Dutton badly bungled attempts to introduce a GP co-payment, has largely turned her attention to other issues, and in the last term of Government initiated a swag of reviews and inquiries, most of which have yet to be finalised.

"While Ms Ley has been confirmed in her current portfolio, the role of Minister for Rural Health, held by senior National Party politician Senator Fiona Nash in the last Government, has been passed on to junior Nationals Minister Dr David Gillespie"

The most crucial of these is the MBS Review Taskforce headed by Professor Bruce Robinson, which is assessing all 5700 items on the Medicare Benefits Schedule. The Minister insists the aim is to modernise the MBS, though some are wary that the process is primarily aimed at achieving cuts and savings.

In addition, the Minister has commissioned trials of the My Health Record e-health system and the Health Care Home model of care for patients with complex and chronic conditions.

Ms Ley has also to bed down the Primary Health Networks system which, among other things, is being charged with organising and coordinating access to mental health services at the local level.

While Ms Ley has been confirmed in her current portfolio, the role of Minister for Rural Health, held by senior National Party politician Senator Fiona Nash in the last Government, has been passed on to junior Nationals Minister Dr David Gillespie.

Meanwhile, there is speculation that Ms King may be dumped as Shadow Health Minister amid factional manoeuvring in the Opposition for frontbench positions.

Opposition Leader Bill Shorten is expected to announce his frontbench team later this week.

Parliament is due to return on 30 August.

ADRIAN ROLLINS

Watchdog stays hand on codeine

The medicines watchdog has held off on making a final determination on its controversial proposal to axe over-the-counter sales of the common painkiller codeine.

Therapeutic Goods Administration has revealed that at its March scheduling meeting it deferred finalising its position on the re-classification of codeine following an interim decision late last year to make the painkiller a prescription-only medicine.

The delay follows an outpouring of concern by patients and consumer groups worried that taking codeine off the shelves would make it much harder for people to manage chronic pain and force some to pursue unsafe alternatives.

Following an interim proposal in October last year to end over-the-counter (OTC) access to the drug and reclassify it as a schedule 4 poison, the TGA received 127 submissions, including 113 opposing the move and just 14 in support.

In response, the watchdog said it would hold off on making a final determination until at least March, and any implementation would not occur before 2017.

In a submission to the TGA during its first round of consultations, the AMA did not come to a definitive position on the proposal.

While accepting that codeine dependence was "a real concern" and acknowledging the serious side effects caused by excessive consumption, the AMA voiced reservations that re-scheduling the drug would necessarily solve these problems.

It said there could be an argument to restrict access to higher dose and compound codeine preparations, and noted inconsistencies in current regulations that allowed over-the-counter sales of Panadeine Extra, while Panadeine Forte (one tablet of which is equivalent to two Panadeine Extra pills) was only available by prescription.

"Up-scheduling in isolation is unlikely to address the problems of misuse," the AMA said, arguing that any such move needed to be accompanied by better education about safe and effective pain management options.

But in its interim decision, the TGA indicated it was persuaded by concerns about the potential harm caused by inappropriate use of codeine and the availability of effective alternatives, paracetamol and ibuprofen.

The TGA said OTC codeine was intended to help manage acute, self-limiting pain, but instead people were using it to help treat chronic pain, potentially creating dependence and toxicity.

In addition, it said, at least 10 per cent of the population were "ultra-rapid metabolisers" of the drug, making codeine potentially deadly at even normal doses.

Its concerns have been echoed by Professor Stephan Schug, Director of Pain Medicine at Royal Perth Hospital, who said codeine was a poor painkiller, had become a drug of dependence for many who were taking it at dangerous levels, and was not as effective as other, safer, alternatives.

Professor Schug said he had seen patients who were taking up to 80 tablets of codeine combined with paracetamol or ibuprofen a day, raising the risk of fatal paracetamol and ibuprofen toxicity.

"Dependence on opioid analgesics is a significant concern in Australia, and OTC codeine contributes to this by providing unmonitored access to a drug which in the body is metabolised to morphine," Professor Schug said.

He said the number of overdose deaths related to codeine had jumped from 3.5 to 8.7 per million between 2000 and 2009.

Professor Schug said scheduling codeine would not reduce access to effective pain relief. He said adding low doses of codeine to paracetamol and ibuprofen did little to enhance their effectiveness, while combining paracetamol and ibuprofen instead provided significantly better and safer pain relief.

"As a practising clinician, I can tell you that under the current arrangements, the easy and widespread availability of these codeine-containing medicines is not limited or monitored at all well," he said.

The AMA has repeated its call for a national Electronic Recording and Reporting of Controlled Drugs system to provide doctors and pharmacist with real-time information on the prescription of medicines prone to misuse and harm.

The peak medical association has also suggested that pharmacies be required to record codeine sales in the same way as they do for pseudoephedrine.

The AMA warned that making codeine prescription only would also likely increase Medicare and PBS costs for the Government.

ADRIAN ROLLINS

More resources, faster internet the key for rural health

Rural doctors have overwhelmingly identified the need for improved public hospital funding and better internet access as the most important solutions for rural health care.

In the first AMA survey of rural doctors since 2007, GPs, other specialists, salaried doctors and doctors in training were asked to rank in importance 20 proposed solutions to improve the health of rural Australians.

Almost 600 doctors took part in the *2016 AMA Rural Health Issues Survey* in April.

And, as they did in 2007, they nominated "provide extra funding and resources to support improved staffing levels, including core visiting medical officers, to allow workable rosters" as their top priority.

In a sign of the growing use of internet-based communications and data, access to high-speed broadband was not a survey option nine years ago, but was ranked as second-most important in this year's survey.

Ensuring that rural hospitals have modern facilities and equipment rose one space to third, and encouraging medical colleges to include rotations for trainees to rural areas rose from sixth to fourth.

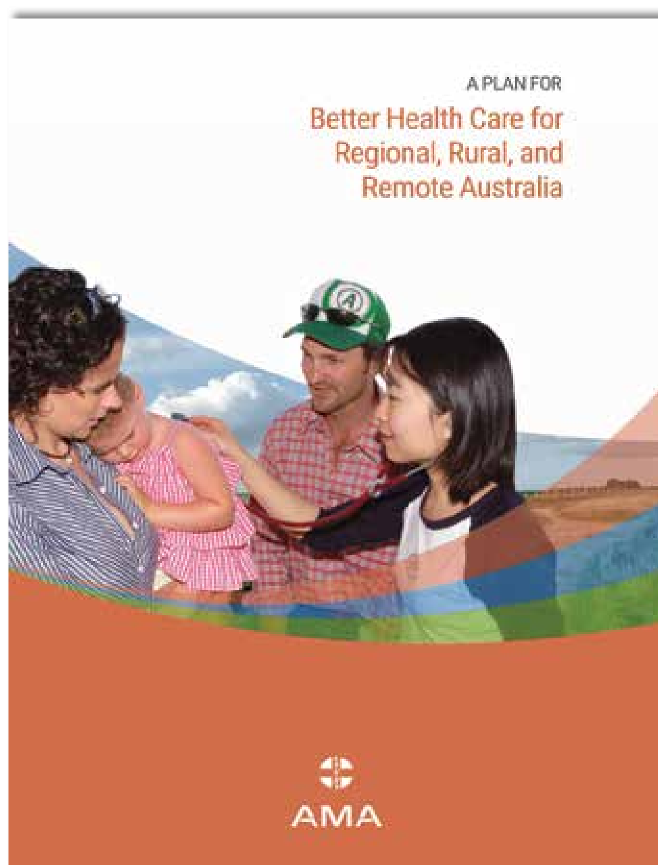
AMA President Dr Michael Gannon said the survey results showed that rural Australia needs more resources to recruit and retain doctors and other health professionals.

"We have record numbers of medical school places and, with sufficient numbers of medical graduates coming through, the focus must now be in how we can get them to work in the places they are needed the most," Dr Gannon said.

As one respondent said: "I cannot stress enough the importance of rotating specialist/vocational trainees into rural posts. The RACS and RACP have done so for years with great exposure and training of prospective doctors for a rural practice. Other colleges must follow suit, especially psychiatry, radiology, pathology, O&G, and emergency medicine, to name a few key deficiencies in rural placement or training."

The survey found that rural doctors enjoy their careers but struggle with the workload and lack of support.

"It's very hard to find locum support to take holidays/attend conferences, and as the only specialist in my field in all rural WA, extra support to maintain CPD and be able to go on holidays would be nice," one respondent said.



But the response from the community makes the job rewarding, doctors said.

"Small towns often appreciate what little I could do for them," one doctor said.

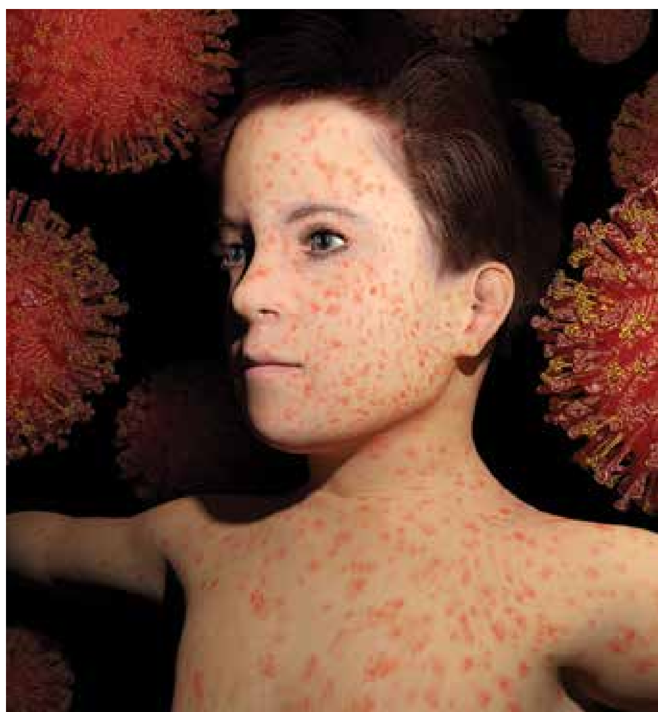
The survey results build on the AMA's *Plan for Better Health Care for Regional, Remote, and Rural Australia*, released in May.

The Plan proposes a focus on four key areas – rebuilding country hospital infrastructure; supporting recruitment and retention of doctors; encouraging more young doctors to work in rural areas; and supporting rural practices.

"Addressing and investing in these measures will make a long-term difference to the health of Australians living in rural communities," Dr Gannon said.

MARIA HAWTHORNE

Victoria on measles alert as infections mount



Victorian health authorities have issued a statewide measles alert to GPs and hospitals amid fears there are "multiple" undiagnosed people who are unwittingly spreading the highly infectious disease in the community.

Warning that the number of cases are likely to mount, Victoria's Acting Chief Health Officer Dr Finn Romanes said investigations were "strongly indicating there were now multiple undetected cases in the community potentially spreading the infection".

There are already five confirmed cases, including a young woman who had been in Shepparton, Melbourne's CBD, Melbourne Airport and Brisbane while infectious with the illness.

Authorities have revealed that three of the cases involved people aged between 18 to 30 years, all of whom became infected in early to mid-June, and none of whom had recently travelled overseas – the usual route by which measles is introduced to Australia.

"Because of this, our concern is that there was a person or persons who probably had travelled overseas, and have since unknowingly passed on measles to these three people in the western suburbs and Barwon area – and there may be more," Dr Romanes said.

"There is now the potential for these three people and anyone else was has been infected to pass on the disease and create a significant outbreak."

Dr Romanes said it was likely that the three had been infected while in Melbourne's CBD between 10 and 13 June.

But he admitted the source of the infection had yet to be determined, and it was likely that people in outer metropolitan Melbourne, as well as in some Victorian regional areas and interstate had been exposed – one of those infected travelled to Brisbane on 1 July.

"There are many other areas across metropolitan Melbourne where infections may have been acquired, and individuals have attended a range of public settings across Melbourne and in regional Victoria whilst infectious, including Shepparton," Dr Romanes said.

He said the infection may also have been acquired in Geelong and the Surf Coast, and warned that "it is likely there will be more cases related to this outbreak".

Family doctors and hospital emergency department staff have been put on alert for measles in patients who present fever at rash onset, particularly if they are not fully immunised or are unaware of their vaccination status.

While measles is uncommon in Australia because of widespread vaccination, it is still prevalent in many areas overseas, and local outbreaks were usually linked to returning travellers.

Nationwide, between 90 and 92 per cent of children are vaccinated against measles, but some adults – particularly those born after 1966 – are not immunised.

Dr Romanes recommended those unsure of their vaccination status to be immunised as soon as possible, and for parents to ensure their child's vaccinations are up-to-date.

He asked anyone unwell with a fever and rash who was not fully vaccinated for measles to ring ahead to their doctor or hospital and alert them that they may have measles.

"The doctor or hospital will then be able to immediately isolate them whilst assessing for measles, which will minimise spread to others," he said.

ADRIAN ROLLINS

Nation's health only partly on track

Australia is making progress in reducing rates of smoking and dangerous drinking but is losing the battle to rein in weight gain, high blood pressure, and salt and sugar consumption, according to a national snapshot of health trends.

Australia's Health Tracker, produced by the Australian Health Policy Collaboration with the support of 50 public health organisations, shows that the nation is making good progress toward reducing drinking and smoking, with the proportion of adults drinking at risky levels trending down toward 18 per cent and the country on track to cut the number of adults who strike up on a daily basis down to 10.6 per cent by 2025.

But adults and children are continuing to put on weight, eating too much sugar (and salt) and not doing enough exercise, according to the tracker.

It shows that more than 63 per cent of adults are overweight or obese, along with more than a quarter of children, and almost a half of adults and 70 per cent of children are eating too much sugar.

The tracker found that people are not doing enough exercise, particularly in light of their energy-rich diets – just 55 per cent of adults and less than 10 per cent of teens meet physical activity recommendations.

These readings underline concerns that not enough is being done to reduce the incidence of chronic disease by changing behaviour and encouraging healthier lifestyles.

According to the authors of the Health Tracker, 50 per cent of Australians have a chronic disease, and they estimate that almost a third of such illnesses could be prevented by eliminating smoking, losing weight, cutting down on drinking, taking exercise and reducing blood pressure.

"Chronic disease is the biggest health challenge of the twenty-first century," the authors said. "Australia lags well behind comparable countries in tackling the risk factors for preventable chronic diseases."

But, they said, "much of Australia's chronic disease burden is preventable or capable of significant amelioration", and urged that there be "population-level interventions that target risk factors shared by many population groups and communities".

There have been concerns that preventive health has been undermined in recent years by Federal Government policies and cutbacks, including the abolition of the Australian Preventive Health Agency, reducing spending on public health education campaigns, funding cuts for community organisations and programs undertaking preventive health activities and reduced policy emphasis on public health initiatives.

But both the Coalition and Labor have committed to trialling new models of chronic care in the primary health sector centred on general practice as the 'home' of health care and involving remuneration based not only on fee-for-service but also incorporating regular payments tied to the management of individual patients with complex and chronic illnesses.

But Public Health Association of Australia Chief Executive Officer Michael Moore said action was now needed.

"A lot of promises were made before the election to fight chronic disease," Mr Moore said. "This research is the first of its kind, and should be taken as not only a warning, but as a call to action. What we need to see is action from the elected Government."

Australia's Health Tracker can be viewed at: https://www.vu.edu.au/sites/default/files/AHPC/pdfs/australias-health-tracker.pdf

ADRIAN ROLLINS

Breaking bread delivers big health rewards

There has been a significant decline in serious birth defects following the mandatory fortification of bread with folic acid and iodine.

Signalling a major public health success, the Australian Institute of Health and Welfare has found that the rate of neural tube defects has plunged by almost 75 per cent in babies born to Indigenous mothers, and are down by 55 per cent among babies born to teenage mothers, following the mandatory fortification of bread with folic acid and iodine.

Since 2009, millers have been required to add folic acid and iodine to flour following evidence that deficiencies in the diet of mothers was helping prevent neural tubes in foetuses from closing, causing serious birth defects such as spina bifida.

Research has shown that folic acid taken at recommended levels for at least one month before and three months after conception can prevent most neural tube defects.

The AIHW reported that since mandatory folic acid fortification was introduced, the overall incidence of neural tube defects has declined by 14.4 per cent, including major declines among teenagers and the Indigenous community.

It also found that the addition of iodine to bread had addressed the emergence of mild iodine deficiency in the general population.

AIHW spokesperson said these were “promising” results, but said further data collection was required to ensure these findings were accurate and sustained.

The full report is at: http://www.aihw.gov.au/food-and-nutrition/folic-acid-and-iodine/

ADRIAN ROLLINS

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DecisionAssist

Jump in mothers needing life-saving surgery after birth

The number of mothers undergoing lifesaving hysterectomies after giving birth has climbed almost 40 per cent amid a surge in the rate of caesarean section deliveries.

In the first such national report of its kind, the Australian Institute of Health and Welfare has found that although peripartum hysterectomies (the surgical removal of a mother's uterus following birth) are rare – fewer than 300 a year – their number increased by 37 per cent between 2003-04 and 2013-14.

Importantly though, despite the increase in number, their rate has so far remained relatively stable at around 0.79 for every 1000 mothers giving birth.

Nonetheless, health authorities are watching the area carefully because peripartum hysterectomies are strongly associated with caesarean sections, which are themselves becoming much more common.

Peripartum hysterectomy can be a life-saving procedure but, as the Institute notes, because it brings an end to fertility and is associated with considerable morbidity for both mothers and their infants, it is not one that is undertaken lightly, and is most commonly performed to treat otherwise uncontrollable haemorrhage.

And, like any procedure, it is not without risk. In the 10-year period examined by the Institute, 16 mothers undergoing peripartum hysterectomies died, as did 93 foetuses.

"There is concern that the rising rates of caesarean section in Australia, from 18 per cent in 1991 to 32 per cent in 2011, will lead to a marked increase in the rate of peripartum hysterectomies," the AIHW said.

In addition to this, women are tending to give birth later in life, which increases the risk of peripartum hysterectomy, as does having previously given birth by caesarean section, having had multiple births (such as twins) and being overweight or obese.

The risk of hysterectomy doubles for mothers who have previously given birth by caesarean section attempting vaginal birth.

ADRIAN ROLLINS

Do you know that more than 25% of Australian women continue to drink during pregnancy?

We know that it is safest not to drink alcohol during pregnancy, and that prenatal alcohol exposure is the most preventable cause of fetal brain damage and subsequent diagnosis of Fetal Alcohol Spectrum Disorder (FASD).

Training for doctors to assist in equipping you to confidently discuss alcohol and pregnancy with women is available via the Royal Australian College of General Practitioners and the Royal Australian New Zealand College of Obstetricians and Gynaecologists. This training is also accredited with the Australian College of Rural and Remote Medicine.

For more information on the free accredited training or to access the **Women Want to Know** resources visit **www.alcohol.gov.au**

Managing elderly diabetes no simple task

Most elderly diabetics are prescribed glucose-lowering medications, and only one in five use insulin to manage their diabetes, according to a report by the Australian Institute of Health and Welfare.

Highlighting the complexity of treating type 2 diabetes in older patients, the AIHW used linked data from the Pharmaceutical Benefits Scheme and the National Diabetes Services Scheme (NDSS) to show that while most (85 per cent) of patients 65 years and older were on glucose lowering medications, just 40 per cent used a single medication. One in five used two glucose lowering therapies simultaneously, and 11 per cent were on triple therapies.

In addition, 77 per cent were also using agents to lower their blood pressure, 74 per cent were using drugs to modify lipids (68 per cent were using both), 24 per cent were being supplied with anti-depressants, 20 per cent were using insulin and 4 per cent were on anti-psychotics.

Generally, the authors of the report said, the longer since type 2 diabetes was diagnosed, the more likely it was that a patient would be prescribed with all medicine types, and the more intensive (dual or triple therapy) their glucose lowering treatment regimens would be.

Increasingly, type 2 diabetes in older patients is being treated with drugs rather than diet and exercise alone.

This was significant, the authors said, because the high prevalence of co-morbidities in such patients made the balance of risks and benefits in using medicines a finely-tuned calculation.

The release of the report coincides with changes to the NDSS that came into effect on 1 July.

Under the changes, people with diabetes can continue to access NDSS products such as needles, syringes, blood glucose test strips and urine test strips from NDSS community pharmacies, but can no longer access the products from Diabetes Australia or local state and territory diabetes organisations.

In addition, people with type 2 diabetes not using insulin will receive an initial six month supply of subsidised blood glucose test strips under the NDSS. After six months, they will only be eligible for further access to subsidised test strips if their doctor or other authorised health professional considers it clinically necessary to use test strips.

The change follows advice from the Pharmaceutical Benefits Advisory Committee which recommended restrictions to access blood glucose test strips based on research which found there was limited evidence that self-monitoring of blood glucose improved blood glucose control, quality of life or long term complications in people with type 2 diabetes who are not using insulin.

Patients with diabetes using insulin or women with gestational diabetes will not be affected by these changes.

The restrictions will come into effect six months from the date of a NDSS Registrant's first test strip purchase.

There is no limit on the number of extensions to access that may be obtained from an authorised health professional while there is a continuing clinical need.

For more information about the changes visit https://www.ndss.com.au/important-changes-to-the-ndss

The AIHW report can be found at http://www.aihw.gov.au/publication-detail/?id=60129555607

KIRSTY WATERFORD

Cancer success more than skin deep

Advances in the detection and treatment of melanoma have meant those diagnosed with the potentially deadly disease have far greater chances of survival than for most other forms of cancer.

While Australia has an unwelcome record for having the second-highest rates of melanoma in the world, the Australian Institute of Health and Welfare (AIHW) has reported that those with melanoma have a five-year survival rate that is 90 per cent of their counterparts in the general population – well in excess of the 67 per cent five-year survival rate for all types of cancers combined.

In further good news, the Institute has found that although skin cancer is a major cause of illness, its prevalence among younger people is declining. After peaking at 13 cases per 100,000 in 2002, the incidence of melanoma in people aged 39 years or younger has since declined to 9.4 cases per 100,000.

The result has been seen by some as a sign that young people are heeding sun-safe messages, and has spurred calls from public health advocates for greater Government investment in campaigns encouraging people to protect their skin.

The Cancer Council Australia said this was much more cost-effective than the huge expense of treating skin cancer once it develops.

The AIHW said Medicare benefits worth almost $137 million were spent on skin cancer services in 2014, and the Cancer Council has estimated that treating the disease costs the country more than $1 billion a year.

Those costs appear likely to escalate.

While the incidence of melanoma in young people is declining, it is rising strongly in the broader population.

Australia's melanoma rate has doubled in the last 34 years from 27 to 49 cases per 100,000, according to the AIHW, and its incidence (35 new cases a year per 100,000) is now second only to New Zealand (36 per 100,000) in the world.

The Institute estimates that almost 13,300 people will be diagnosed with melanoma this year and 1770 will die, while further 560 will be killed by other forms of skin cancer, and almost 140,000 will be hospitalised.

Even though the prognosis for many is good, the distress for individuals and families, and the costs to the health system, are substantial.

The hospitalisation rate for patients with melanoma surged 63 per cent between 2002-03 and 2013-14, while the number of surgical procedures undertaken to treat melanoma jumped almost 54 per cent over the same period and the number of chemotherapy treatments more than doubled.

Though the hospitalisation rate for those diagnosed with other forms of skin cancer did not increase as sharply over this period (up 39 per cent between 2002-03 and 2013-14), surgical procedures increased 40 per cent and chemotherapy treatments were up 65 per cent.

In addition, effective but hugely expensive drugs are being used to treat melanoma. In the latest development, Melanoma Institute Australia is reporting promising results from the use of two immunotherapy medicines, Yervoy and Keytruda, in combination to treat advanced melanoma. The two drugs, which can cost up to $120,000, are available at a reduced price through the Pharmaceutical Benefits Scheme, but have so far been denied full listing.

The AIHW findings have fuelled a backlash against celebrity chef Pete Evans, who last week described sunscreens as "poisonous chemicals" that gave people the illusion of protection from the sun's harmful rays.

Cancer Council Chief Executive Professor Sanchia Aranda said skin cancer was the most preventable form of cancer, and the AIHW data underlined the need for campaigns to encourage people to take steps to protect themselves from sun damage.

"Given the rapid growth in skin cancer treatment costs, and mounting pressures on the health system as our population ages, there is an urgent need to get skin cancer prevention back on the federal agenda," Professor Aranda said. "We need a mass media campaign, this summer and the next."

ADRIAN ROLLINS

Protection of olympian proportions

Athletes travelling to Brazil for the Rio Olympics have been advised to avoid unprotected sex for at least eight weeks after returning home to reduce the risk of sexual transmission of the Zika virus.

The Communicable Disease Network Australia (CDNA) has released updated information to assist GPs in discussions with their patients about the risks of sexual transmission and pregnancy associated with travel to Zika affected countries.

Only about one in five people infected with the mosquito-borne virus shows symptoms. But infection in pregnant women can have devastating consequences, with severe birth defects including microcephaly.

Concerns about the virus have led to several athletes pulling out of the Rio Games, including Australian World No.1 golfer Jason Day, the father of two young children.

The Australian Olympic Committee has advised pregnant women not to travel to Rio, with team doctor Dr David Hughes warning that the effects on unborn children could be catastrophic.

"We have given a very comprehensive and detailed, but easy to understand, piece of advice to every member of the Australian Olympic team about how they should manage themselves to avoid mosquito bites in Rio, and also on those who have reproductive intentions when they get back," Dr Hughes said in May during a media conference at the AMA National Conference.

The CDNA said that as of 29 June 2016, 10 countries had reported instances of sexual transmission of Zika, including 13 in the United States. None of the 60 cases reported so far this year in Australia was sexually transmitted.

All but two confirmed cases have been transmission from males with symptomatic infection to their female partner through vaginal sex.

It is not yet known if a man without symptoms can transmit Zika virus through sexual activity, although the virus has been detected in semen up to 62 days after infection.

It is also not known if women can transmit the virus to men via sexual contact.

The CDNA recommends that pregnant women or those attempting to conceive should defer travel to a Zika affected country, while those at risk of pregnancy should avoid unprotected sex for at least eight weeks after leaving the affected country.

Men with a pregnant partner should avoid unprotected sex for the duration of the pregnancy, while those with a confirmed infection should avoid unprotected sex for at least six months from the time of diagnosis.

Men with no symptoms should avoid unprotected sex for at least eight weeks after leaving the affected country, and should consider being tested four weeks after the last day in the affected country.

The advice is available on the Department of Health website www.health.gov.au.

MARIA HAWTHORNE

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

The opportunities of the new Australian Parliament

BY PROFESSOR STEPHEN LEEDER AND DR ANGELA BEATON*

The composition of the new Federal Parliament provides excellent opportunities for the development of a health policy for Australia.

This is because the many points of view that need to be reconciled to achieve a comprehensive and inclusive policy will be represented in the new parliamentary configuration. While this may at first sight seem clumsy and inefficient, it is a process critical to developing a policy that will guide health service provision and financing on behalf of the community. As the Canadian commentator John Ralston Saul has written, the price of democracy is inefficient conversations – lots of them – that on the United Kingdom's allow for all voices to be heard.

> "... all too often insufficient consideration is given to the unintended side effects of what appear to be bright new policy initiatives"

There is a further reason to be pleased that in the new arrangements a more cautious, inclusive and conversational approach will be applied to the development of a national health policy. It is that all too often insufficient consideration is given to the unintended side effects of what appear to be bright new policy initiatives.

Amartya Sen, a Nobel Prize winning Indian philosopher and economist, refers to this omission as one of the more common cardinal errors of social policy makers. If asked, all the players may be able to provide more insights than one thinking alone.

Simply having many players at the policy table does not, of course, guarantee freedom from this error. As the Chilcot Report on the United Kingdom's involvement in the recent Iraq war points out, a 'coalition of the willing' failed to question in depth what the consequences of war would be in the longer term. It was as though the policy stopped halfway.

The unintended side effects of the (good) policy to fund clinical psychologists to assist with the management of patients with mental health problems via general practice – workforce redistribution and budget over-runs – are examples of side effects that may have been anticipated if more 'thought experiments' – thinking through what might follow – had been conducted prior to implementation.

By what process might this policy be developed?

First, parliamentary leadership is required. A policy development oversight group that is genuinely multi-partisan should be established. This is not a matter of setting up yet another expert committee or commission of advice. The politicians need to lead. How the group wishes to proceed is, of course, entirely up to them.

Second, it is critical that high on the group's agenda be a discussion about what Australia may reasonably expect from its health services, private and public, hospital and community, curative and preventive. There must be limits: what are they? How far do we wish to go in ensuring equity of access? How far in privatising the costs of health care? This is a special problem for patients who have serious and continuing complex problems, as my colleagues and I and many others have documented. Chronic illness is a fast track to poverty at present.

There are many topics to be discussed – which underlines my argument in favour of an inclusive conversation, auspiced by the Parliament, to begin. Attitudes vary in relation to prevention, and in the last Parliament a national agency for prevention was abolished. Is that what we want to do, or the best we can do?

And what are our expectations of research as a society? We know what experts and academics expect, but there are other voices as well that need to be heard, including those of some who have values espoused by science (and some who don't).

Finally, there are ways of doing policy development well. From my personal perspective, I place a high premium on the contribution that solid data can make to the process. But my experience with policy development leaves me in no doubt that the 'voice' of data is but one voice. For a policy to work, data elegance is not enough. There must be buy-in from those whose lives and livelihoods are affected by it.

The new parliamentary structure requires a more humble and inclusive approach to policy formation. Nowhere is this of more value than in working out where we as a nation are going with health and health care.

Family doctors: invaluable to health

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

As the new Chair of the AMA Council of General Practice, I am honoured to follow on from my predecessor, Dr Brian Morton, and wish to acknowledge him for his six years of leadership and service to the Council and to general practitioners.

> "Throughout Family Doctor Week (24-30 July) the AMA will be highlighting how invaluable the family doctor is to patient health, and to the health system more broadly"

It is certain that as a profession we will have some interesting times ahead of us as the dust from the Federal Election settles. If there is one thing we know for sure from the last few weeks, it is that putting health on the backburner is risky business. The Government must be in no doubt now that health is a priority, and that it will have to do more than it has to date to ensure vulnerable patients do not have to worry about whether or not they can afford to see their GP when required, and to have pathology and radiology investigations when requested.

Next week we will be celebrating general practice and the primary role played by Australia's GPs, our family doctors, as frontline and holistic health care providers. Throughout Family Doctor Week (24-30 July) the AMA will be highlighting how invaluable the family doctor is to patient health, and to the health system more broadly.

We know from international comparisons that countries with a strong GP-led primary care system have lower rates of ill health, better access to care, reduced rates of hospital admissions, fewer referrals to other specialists, less use of emergency services, and better detection of adverse effects of medication.

The comprehensive care provided by our nation's family doctors needs to be seen by Government as an investment rather than as an expense. With only 6 per cent of Australia's total health expenditure on general practice, our family doctors have proven the value of their care. Ending the freeze on Medicare rebates, raising the rebates and lifting rates of indexation to cover the true costs of care must be at the top of the Government's to-do list.

For most patients, our general practices are their medical home. If appropriately funded, rather than struggling for viability, we know we can do more to help our patients live the healthiest life they can. We can do this though appropriate health screening and life-stage assessments, through structured care that is patient-centred and planned, through greater use of innovative technology that not only empowers patients in managing their conditions, but enables us to monitor their progress, through better use of medicines, and through care that is streamlined and coordinated within our multidisciplinary health care team.

Family Doctor Week will highlight that, properly funded, the medical home has the potential to both improve the care patients receive, and to save on more costly downstream health costs.

Supporting general practices to bring non-dispensing pharmacists into the health care team is but one way Government can invest to deliver better patient outcomes and minimise avoidable hospital admissions. The AMA's Pharmacist in General Practice Program would deliver $1.56 in savings for every $1 invested by ensuring the quality use of medicines, medication optimisation and increased medication compliance, reducing adverse drug events and hospitalisations as a result.

In rural and remote areas, Government needs to assist general practices with appropriately designed and implemented infrastructure grants to expand their facilities to better meet the complex health needs of people in these communities.

You can support us in supporting you by visiting the website https://ama.com.au/family-doctor-week-2016 and downloading and displaying the poster and your Family Doctor Logo, and by using #amafdw16 if tweeting or sharing FDW content on social media.

Rural doctors want support

BY DR HIROWATARI, CHAIR, AMA COUNCIL OF RURAL DOCTORS

"… the doctors clearly want support more than hard cash … they want more of their kind with them, helping the roster, adding specialised services, locum relief, allied and ancillary staff, trainees to mentor and, of course, they want their family with them"

In the first part of 2016, the AMA has been involved in three studies concerning rural health care. Briefly, they are:

1. AMA Plan for Better Health Care for Regional, Rural and Remote Australia. This plan is focused on four clear areas needing our attention: rebuilding and cherishing the 'good ol' country hospital'; recruitment and retention of 'fit-for-purpose' rural doctors; fostering a new workforce of bright-eyed, bushy tailed young doctors eager to remain in the Outback; and support of rural practices – this includes CPD, infrastructure and workforce distribution.
2. Building a sustainable future for rural practice - the Rural Rescue Package. A Joint AMA/RDAA Policy Statement. This is an easy-to-read, short paper with a rather brilliant suggestion for a two-tiered incentive system. The first tier is incentive payments and stipends to entice a happy workforce to stay and thrive in rural regions. The second tier of incentives is to encourage procedural and special skills in the rural workforce. Someone recently said that plumbers are so well compensated in the Outback that to find rural plumbing jobs is difficult. Can you imagine a future where rural medical positions were so sought after that doctors will be competing for that position?
3. The 2016 Rural Health Issues Survey.

It is this third study which is the most personal of the three. It is the voice of the rural doctors themselves speaking by way of a survey sent to them. The questions were posed by asking the doctors to rate the importance of 31 different proposals.

I was humbled when I read and re-read the results of the survey.

The way I read the results, the doctors clearly want support more than hard cash. None of the top 10 proposals would increase the income of the rural doctor. Instead, they want more of their kind with them, helping the roster, adding specialised services, locum relief, allied and ancillary staff, trainees to mentor and, of course, they want their family with them.

They also want to see support by way of "stuff". Such amenities as walls, equipment, facilities. More evanescent, but definitely under the heading of amenities, is the need for broadband. These are doctors 500 kilometres from the nearest restaurant or movie theatre. They may be holed up on the other side of a flooded road in the Wet; they have no privacy - everyone in the community knows "the Doc". These overworked souls need the World Wide Web for sanity, for education, to communicate. Handy that it also helps with work.

Finally, they want to feel confident and competent. Every day there is a chance of going out of one's comfort zone. They want opportunities to upskill, and support for skills that are not always needed but could be readily used. The support should come from colleges, that camera on the ceiling above the resus bed, the specialists on the phone encouraging them, and a medical board that is slow to criticise.

I tip my hat to you who answered the survey, you are fine people. You ask for things for your fellow doctors before you ask it for yourself. You are looking at the future where there is optimism, self-sufficiency and pride in your work. The choice of a rural location is not just a choice but a calling. You see yourself as part of the Outback, a key and respected member of that rural community. I see that you are trying to bring more doctors to the fold. As you watch another brilliant sunset, with a black cockatoo chiding at you and 10 roos ignoring you, be proud of your career path. You are the best. Thank you for being there.

The dead don't rest

BY DR JOHN ZORBAS, CHAIR, AMA COUNCIL OF DOCTORS IN TRAINING

It's February 12th, 2009. The time is 9pm at Newark Liberty International Airport. Dr Alison Des Forges is waiting to board a flight to take her back to her home in Buffalo, New York. Alison's spent most of her work life in Rwanda, investigating killings, kidnappings and human rights transgressions. She was one of the loudest voices to be heard on the world stage in 1994, when she called for the recognition of what we now know as the Rwandan genocide.

She was named a MacArthur Fellow in 1999, as well as taking a senior position with Human Rights Watch. But the year isn't 1994, and we're not in Rwanda. It's 2009, and she's flying home to be with her family in the USA.

The plane has already been delayed by two hours, and the bleary eyed passengers are finally allowed to board the plane. They aren't the only tired people on-board, however. First Officer Rebecca Shaw has made the commute from Seattle to Newark to co-pilot the flight, and complains to her pilot of feeling tired and unwell. Similarly, Captain Marvin Renslow complains of fatigue, due to a lack of rest over the preceding few days and abrupt changes to his sleep-wake cycle.

What follows is a series of errors that ultimately result in a fatal stall during the landing approach. The Captain responds incorrectly to the stall, as does his First Officer, and the errors are compounded. The plane ploughs into the house of Douglas and Karen Wielinski, and a total of 50 people perish that day, including Dr Des Forges.

To err is human, but we often don't like facing this harsh reality. This is equally as true in medicine as it is in aviation.

Our workforce is by no means in balance, and it poses a headache for doctors and employers alike.

We're awash with graduates, but hospitals struggle to fill gaps in rosters due primarily to a lack of workforce coordination. This leads to over-employment of current doctors, increasingly unsafe shifts, workplace dissatisfaction, absenteeism and resignations, all which continue to compound the initial problem.

Sound dramatic? Good. It should. We're human and we're not that special. You'd no sooner go to work with a blood alcohol level of 0.05 than you would eat your own face, but we know that after eighteen hours of continuous work, humans behave as if they're too drunk to drive a car.

In the case of Eastman vs Namoi Cotton Co-Operative (2014), an employee was awarded $498,950 in compensation for a car crash where she drifted into oncoming traffic. The cause? Six 12-hour night shifts in a row with a two-day break. I can name at least five hospitals around Australia off the top of my head with similar rosters, and that's without breaking an investigative sweat.

Around the time Dr Des Forges was being named a MacArthur Fellow, the AMA was adopting a National Code of Practice for Safe Working Hours.

The code was, and remains, a flexible and common sense guide to work hours. Rather than being a prescriptive and unmanageable set of rules, the code instead highlights patterns and situations which lead to unsafe working hours.

It outlines the responsibility of both the employee and the employer, recognising that fatigue management involves both parties. It's tailored to the Australian medical workforce, and it has recently been renewed and updated by the AMA Federal Council.

In August, the Council of Doctors in Training will be conducting its five-yearly safe working hours audit, to see whether we as a country are getting better or worse at managing fatigue.

I've heard many emotive arguments for and against the importance of fatigue management.

I've heard people glorify the dark old days as a superior form of education. I've seen workforce units threaten doctors with future offers of employment as incentive for unsavoury rosters. I've seen doctors belittled by other doctors for their lack of 'commitment' to their vocation. But I've also seen a 66-year-old human rights activist, and fervent advocate for hundreds of thousands of slaughtered Rwandans, die partially as a consequence of poor fatigue management.

It is unconscionable to think that fatigue management isn't core business for doctors, and a key element of good patient care. After all, if one person can fight for thousands of oppressed people, surely I can fight for the welfare of my patients.

Doctors: a force to be reckoned with

BY ELISE BUISSON

When I participated in my first Federal Election at the age of 18, I didn't see my individual voice or my individual vote as a contribution to democracy that carried much weight. If experience hadn't already done so, the 2016 Federal Election would have dispelled me of that notion.

This year, as President of the Australian Medical Students' Association, I have the opportunity of speak to medical students around the country. Whenever I do, I try to take the time to remind them of the way they saw the profession of medicine when they first entered it. Those days and weeks when they realised that medicine is unlike many other undertakings; in medicine, we are a community.

> "... at early count, we are a force almost as significant as the number of votes between the two major parties in this Federal Election"

Medical students throughout Australia form a group of 17,000. If you add doctors into the mix, you get a town the size of Toowoomba, where I grew up. All of us share a common experience and a common motivation to provide communities with the best attainable health. In this way, myself and the consultant on my ward round and the other 120,000 of us, medical students and doctors alike, are our own little team. There's a powerful collegiality in medicine, and where that can be even partially harnessed we are a significant and credible force.

In fact, at early count, we are a force almost as significant as the number of votes between the two major parties in this Federal Election.

This community of medical professionals has an ability to positively impact health that is far greater than the sum of its parts. As a community, we can drive a successful public health campaign; we can restore the health of a region after a time of crisis; we can drive the development and defence of good health policy for our nation.

Engaging with policy and politics is not always high in the priorities of medical professionals, not least because their workload leaves them little time for other endeavours. In addition, doctors and medical students don't necessarily believe themselves to be inherently political, and at times face criticism when they step outside the clinical sphere. However, each of us came into this profession to improve the health of those who need us, and often times that requires more than treating the patients that walk through hospital or clinic doors.

I often frame the political relevance of the medical profession with the words of Rudolph Virchow: "Medicine is a social science, and politics is nothing else but medicine on a large scale. Medicine, as a social science, as the science of human beings, has the obligation to point out problems and attempt their theoretical solutions: the politician, the practical anthropologist, must find the means for their actual solution."

Elections can be won and lost over health, and doctors are at the coalface. If every one of our 120,000 strong community was to raise their voice on health issues affecting the populations we serve, Australia's political discourse would be far richer for it. We would not all agree, and would in fact raise almost as wide a variety of views on health as can be imagined. However, it is from the clear enunciation of all of these views that sound health policy can be derived.

In the years since my first Federal Election, I have learnt both in theory and through experience that an individual can have a significant impact on our country through their vote, and through their voice. I hope to continue to learn again and again throughout my career the significance of the impact of 120,000 individuals, in particular. If each one of our community were to engage with the wider questions facing our nation's health, all communities would be better for it.

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Stewardship and the road ahead for health financing

BY ASSOCIATE PROFESSOR SUSAN NEUHAUS, CHAIR, HEALTH FINANCING AND ECONOMICS COMMITTEE

Associate Professor Susan Neuhaus, Chair, Health Financing and Economics Committee

As the new Chair of Health Financing and Economics Committee (HFE), I am looking forward to the challenges ahead for health financing and how HFE's work can assist the AMA to advocate and achieve the best outcomes for AMA members and our patients.

The dust has yet to settle on the outcomes of the 2016 Federal Election, but it is clear that the campaign focus on health, Medicare and affordability resonated with the Australian public.

There has never been a more important opportunity to have a national discussion about the future of the Australian health care system. As both consumers and providers, we know that our health care system needs strategic, systematic reform. We understand that it must be efficient, equitable and sustainable. We also understand that Australians see access to 'Medicare' (a universal public health insurance scheme) as being non-negotiable. With major reviews underway into the Medicare Benefits Schedule and private health insurance, and calls to reform private health insurance and limit excessive fees to patients, it is imperative that health reform is coordinated, integrated and not victim to short term political expediency or reactiveness.

There will be a continuing, even increasing, pressure to constrain growth in health expenditure. Changing health demographics and an increased burden of complex and chronic disease strain existing systems and resources. Emerging technologies threaten to further increase health care costs unless new technologies and information systems can be used to support primary health care and preventive health care measures and streamline accessible, affordable and appropriate specialist care.

There are cost savings to be had within the system, but these must not be generated by simply 'shifting' costs within the system or passing these costs onto consumers.

HFE has recognised that 'stewardship' is an important and useful approach for clinicians to take an influential role in these issues and decisions.

Earlier this year, HFE developed an AMA position statement on Doctors' role in stewardship of healthcare financing and funding arrangements 2016. This complements the AMA position statement developed through Ethics and Medico-Legal Committee on The Doctor's role in Stewardship of Health Care Resources 2016, which focuses on the role of the individual doctor in stewardship of health care resources in the clinical setting.

Stewardship in relation to health financing and funding means ensuring health funding is directed to achieving health outcomes, does not have adverse impacts or involve wasteful expenditure, and is sustainable and able to meet future needs.

Why do doctors have a role in stewardship of heath financing?

Health care financing and funding arrangements and decisions need to be appropriately managed to ensure health funding enables all patients to continue to receive the best quality care, now and in the future.

As individual doctors we affect health care expenditure through our clinical recommendations and decisions regarding patient treatment. As doctors we also bring a practical and informed perspective from the real world of our clinical practice to health financing and funding decisions.

When major decisions affecting health care are taken without such clinical involvement, the results are often sub-optimal and unsustainable. Recent examples include GP co-payments, MBS indexation freeze, fee reductions, and public hospital funding.

We have yet to see how the post-election health policy and health financing climate unfolds. The AMA must develop its own credible health economic narrative and contribute to collaborative processes where the input of the medical profession is both sought after and listened to in the development of health policy. The alternative clearly hasn't worked.

Australia has an enviable health care system. Reform is required to ensure that, in the face of changing health demographics and new health care developments, it remains 'fit for purpose' and meets the needs of all Australians.

Where decisions involving the allocation of health care resources are being made, doctors have a responsibility to advocate for the best interests of patients, the improvement of health outcomes, and the sustainable use of resources.

End of life care: we can do better

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

On 27 May Dr Michael Gannon (who would be elected AMA President two days later) chaired a forum on assisted dying (euthanasia and physician assisted suicide) at the 2016 AMA National Conference in Canberra.

The session, moderated by Tony Jones of the ABC's *Q&A* program, included contributions from a panel of four medical practitioners, Emeritus Professor Bob Douglas, Dr Karen Hitchcock, Professor Malcolm Parker and Associate Professor Mark Yates, as well as AVANT medico-legal expert Georgie Haysom.

The session was well-received. Both panellists and members of the audience passionately but respectfully expressed views both supporting, and opposing, doctor involvement in assisted dying.

Discussion focussed on a broad spectrum of issues including:

- the role of patient autonomy, choice and individual rights;
- the treatment of the elderly, the disabled and others requiring care;
- the perception of becoming a 'burden' to others in relation to disease progression, disability or ageing;
- the concept of 'suffering', the fear of dying 'badly' and the effect a 'bad' death has on family members;
- the difficulty of distinguishing euthanasia and physician assisted suicide from suicide generally;
- the role of palliative care in supporting patients and families, the need for more education and training, and recognition of the wider health care team, including pastoral and spiritual care;
- the impact on community perception of the medical profession should the role of the doctor allow for providing euthanasia and/or physician assisted suicide;
- different models of assisted dying legislation such as the Oregon law (based on physician assisted suicide); and
- the need to improve doctor knowledge of the law in relation to end of life care; for example, it is within the law for a doctor to provide treatment to a patient with the primary intention of alleviating the patient's suffering that has a secondary effect of hastening death.

While opinions clearly diverged on whether or not doctors should be involved in euthanasia and/or physician assisted suicide, there appeared to be consensus on at least one major issue - the medical profession can do better to support patients and their family members at the end of life.

For those who would like to view the National Conference session, it can be accessed on YouTube at https://www.youtube.com/watch?v=eQGNkOGpuUw.

Where to from here for the review of AMA policy on euthanasia and physician assisted suicide?

The results of the recent AMA member survey on euthanasia and physician assisted suicide are being collated and will initially be discussed by the AMA's Federal Council at its upcoming meeting in August. Members will be informed of the survey results when Federal Council has had sufficient opportunity to review them.

Along with the survey, Federal Council will consider the issues raised during the other major member consultation initiatives - the 2016 National Conference session and last year's Australian Medicine consultation on the current AMA policy.

Federal Council will also consider background information on national and international opinions and relevant legislative initiatives before making a policy decision in relation to euthanasia and physician assisted suicide. Federal Council is likely to undertake these deliberations over their next two meetings.

The AMA has endeavoured to make this policy review transparent and inclusive to allow a wide range of member views to be heard.

We will keep members informed of the review's progress and appreciate your patience and participation throughout the review process.

Time to ramp up Indigenous health action

BY AMA PRESIDENT DR MICHAEL GANNON

As the new President of the AMA I will, like my predecessors, chair the AMA's Taskforce on Indigenous health. This recognises and emphasises the importance of the AMA's efforts to improve the health and wellbeing of Aboriginal and Torres Strait Islander people, and our desire to keep 'Closing the Gap' initiatives at the top of our agenda.

The Taskforce, which was established in 2000, is comprised of representatives of the AMA Federal Council, AMA members and Indigenous health groups, including the National Aboriginal Community Controlled Health Organisation (NACCHO) and the Australian Indigenous Doctors' Association (AIDA).

The Taskforce is a robust and dedicated entity which identifies, develops and recommends Indigenous health policy and strategies for the AMA and oversees the AMA's annual Report Card on Indigenous Health.

This year, the 2016 Report Card on Indigenous Health will focus on rheumatic heart disease (RHD) – a major preventive health issue that significantly affects Indigenous people, particularly those in remote areas. As AMA WA President, I supported legislative change to improve reporting and reduce the burden of disease in Aboriginal communities in Western Australia.

RHD is a classic example of the many preventable chronic diseases that are largely responsible for the health gap between Indigenous and non-Indigenous people, with its burden largely extinguished in other parts of the Australian community. We can no longer allow the prevalence of chronic diseases like RHD to remain unaddressed.

The 2016 Federal election provided an opportunity for the AMA to present all political parties and candidates with the issues that the AMA sees as vital in meeting the challenge of closing the health gap.

While we have seen some recent improvements in Indigenous health, particularly in reducing infant mortality and smoking rates, the AMA wants to see the Commonwealth commit to improving resourcing for culturally appropriate primary health care for Aboriginal and Torres Strait Islander people.

The AMA has repeatedly said that it is not credible that Australia, one of the world's wealthiest nations, cannot address the health and social justice issues that affect 3 per cent of its citizens. We say this again. The fact that it is our nation's first people makes it an even greater moral imperative.

With the re-election of the Turnbull Government, the AMA will continue its call for long-term funding and commitments to Indigenous health. We will work closely with key ministers, government departments and other key stakeholders to ensure that appropriate action is taken.

As outlined in its *Key Election Issues* statement, the AMA urges the Federal Government to:

- correct the under-funding of Aboriginal and Torres Strait Islander health services;
- establish new, or strengthen existing, programs to address preventable health conditions that are known to have a significant impact on the health of Aboriginal and Torres Strait Islander people, such as cardiovascular disease (including rheumatic fever and rheumatic heart disease), diabetes, kidney disease, and blindness;
- increase investment in Aboriginal and Torres Strait Islander community-controlled health organisations. Such investment must support services to build their capacity and be sustainable over the long term;
- develop systemic linkages between Aboriginal and Torres Strait Islander community-controlled health organisations and mainstream health services to ensure high quality and culturally safe continuity of care;
- identify areas of poor health and inadequate services for Aboriginal and Torres Strait Islander people and direct funding according to need;
- institute funded, national training programs to support more Aboriginal and Torres Strait Islander people become health professionals to address the shortfall of Indigenous people in the health workforce;

Time to ramp up Indigenous health action

... from p27

- implement measures to increase Aboriginal and Torres Strait Islander people's access to primary health care and medical specialist services;
- adopt a justice reinvestment approach to health by funding services to divert Aboriginal and Torres Strait Islander people from prison, given the strong link between health and incarceration;
- increase funding for family violence and frontline legal services for Aboriginal and Torres Strait Islander people;
- appropriately resource the National Aboriginal and Torres Strait Islander Health Plan to ensure that actions are met within specified timeframes; and
- support the establishment of a Central Australia Advanced Health Research and Translation Centre. Central Australia faces many unique and complex health issues that require specific research, training and clinical practice to properly manage and treat and this type of collaborative medical and academic research, along with project delivery and working in remote communities, is desperately needed.

Closing the gap in health and life expectancy between Indigenous and non-Indigenous people is an achievable task - it is also an agreed national priority.

The Federal Government must build on existing platforms and ramp up its ambitions to achieve health equality for Aboriginal and Torres Strait Islander people. Without commitment and action from our national leaders, the gap will remain wide and intractable. The Taskforce will inform the AMA's advocacy in ensuring that this does not remain the case.

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Health on the hill

POLITICAL NEWS FROM THE NATION'S CAPITAL

More funding needed for Health Care Homes trial

GPs are still waiting for clarity on whether appropriate funding will be offered for services to patients under the Government's $21 million Health Care Homes trial.

Under the model, also known as the Medical Home, patients suffering from complex and chronic health problems will be able to voluntarily enrol with a preferred general practice, with a particular GP to coordinate all care delivered.

The Government announced the model in March, with $21 million to allow about 65,000 Australians to participate in initial two-year trials in up to 200 medical practices from 1 July 2017.

The trial was one of the recommendations of the report of the 2015 Primary Health Care Advisory Group, headed by former AMA President Dr Steve Hambleton.

It was hailed as a step in the right direction for chronic disease management, with the Labor Opposition announcing plans for a similar trial.

However, the Labor proposal came with $100 million of funding, while under the Government model, the funding is not directed at services for patients, but rather on clinical need.

Professor Jane Gunn, the head of the General Practice Department at the University of Melbourne's medical school, said the outcomes of similar trials, such as the 1994 coordinated care trials and the more recent diabetes care project, highlighted the difficulty in driving health delivery reform.

"The coordinated care trials showed some promise but were costly to implement and too costly to scale up," Professor Gunn wrote on *The Conversation* website.

"They were difficult to replicate and few were sustained outside the trial environment.

"The impact of the diabetes care project was also disappointing. The diabetes care project included many of the elements of [the advisory group's] report, such as bundled payments, yet only small gains were made in health outcomes and the cost-effectiveness of the model was not proven.

"The bundled payment used in the diabetes care project was viewed as inadequate."

Making improvements in chronic disease management would require strong buy-in from all stakeholders, but it would be a challenge to get eligible practices and patients to sign on for the trial, she said.

"One of the biggest challenges will be to work out exactly how much the Government should pay a practice for providing a person with all their chronic disease care in a year," Professor Gunn said.

"Working out how an individual GP will get their fair share of the chronic disease payment is likely to make for interesting negotiations and new ways of working for practice managers.

"Female GPs will be vulnerable to further pay inequities as they are less likely to be practice owners and more likely to work part-time.

"It is also not clear whether the recommended 'bundled payment' would include more radical models where the practice has to fund payment for pathology, imaging and medications from the 'bundled payment'."

AMA President, Dr Michael Gannon, said the AMA was keen to work with the Government to make the trial a success, but appropriate funding would be a critical test.

"The Medical Home is fundamental to the concept of the family doctor who can provide holistic and longitudinal care and, in leading the multidisciplinary care team, safeguard the appropriateness and continuity of care," Dr Gannon said.

"BEACH data shows that GPs are managing more chronic disease. But they are under substantial financial pressure due to the Medicare freeze and a range of other funding cuts.

"GPs cannot afford to deliver enhanced care to patients with no extra support. If the funding model is not right, GPs will not engage with the trial and the model will struggle to succeed."

With the right support, GPs can provide more preventive care services and greater management and coordination of care, keeping patients healthier and out of hospital, he said.

"Health played a major part in the Federal Election and the Government must now demonstrate that it has heard the people's concern regarding the ongoing affordability of their health care," Dr Gannon said.

"The Medical Home must be appropriately funded to succeed."

MARIA HAWTHORNE

Health on the hill

POLITICAL NEWS FROM THE NATION'S CAPITAL

Aged care sector calls for cuts to be deferred

The aged care sector has called for a taskforce to review the sector's funding process, as new analysis shows the 2016-17 Budget would strip funding to older people in care by 11 per cent per resident each year.

The Turnbull Government announced $1.2 billion in cuts to aged care funding in the May Budget, largely through reductions in the complex care component of the Aged Care Funding Instrument.

The Government argued that providers were overclaiming by wrongly classifying residents as high complex care patients.

"There's no hiding away from the fact that the residential aged care budget will blow out by a further $3.8 billion over the next four years without action to address inconsistencies in the way claims are made, with as many as one in five ruled to be too high," Minister for Health Sussan Ley said in June.

Ms Ley's comments were borne out by a Health Department response to a Freedom of Information request by the *Australian Financial Review*.

The Department rejected the request, saying that there were more than 26,000 pages detailing non-compliance in relation to claims for Government funding from aged care providers.

Making public such a significant volume of related information would be too time-consuming, the Department said.

"A preliminary search has identified that there are approximately 1100 emails, 430 documents and 800 page reports, comprising over 26,000 pages that may fall within the scope of the request," it told the newspaper in July.

The Labor Opposition has also refused to reverse the cuts.

But a coalition of service providers said, while the sector understood the need to manage growth in health care spending, the cuts went too far.

UnitingCare Australia (UCA), Aged and Community Services Australia (ACSA), and Catholic Health Australia (CHA) commissioned Ansell Strategic to undertake a review of 501 aged care homes and almost 39,000 residents around the country.

The modelling indicated that the actual impact of the cuts would be more than $2.5 billion over the next four years alone, nearly $840 million more than the Government's forward estimates.

"The 2016-17 Budget was particularly harsh as it targeted people with complex health care needs and those receiving treatment for severe pain and chronic diseases like heart disease, diabetes, and dementia," UCA Chair Steve Teulan said.

"We wanted to fully assess the impact of the funding reductions so we commissioned modelling that looked at the potential impact on nearly 39,000 people in aged care homes.

"The results are stark. The cuts far exceed the amounts stated by Government and will reduce funding to support older people in care by $6,655 - or 11 per cent - per resident each year."

Under these arrangements, the funding would not cover the costs of services currently provided to residents with complex needs, meaning many older people in care might miss out on vital treatments including physiotherapy, pain management, and skin care, Mr Teulan said.

"If these cuts are implemented as stated, by 2017 service providers will be forced to seriously consider both turning away sick old people who are seeking admission from hospital and reducing services, particularly allied health," Mr Teulan said.

The providers called on the Government to defer the proposed cuts until it undertook proper analysis of their impact, and an evaluation of the relative costs of providing care to frail aged people in nursing homes.

They also called for a taskforce to review the funding process for aged care, with a view to establishing a more sustainable model which provides certainty to providers, residents, their families and carers, and long-term affordability for taxpayers.

MARIA HAWTHORNE

Health on the hill

Baggoley steps down

The former deputy Chair of Health Workforce Australia has been appointed to replace Professor Chris Baggoley, who has retired as the nation's Chief Medical Officer.

Professor Brendan Murphy, who served on the now-defunct HWA and has been Chief Executive Officer of Austin Health in Victoria since 2005, has been selected by Health Department Secretary Martin Bowles to succeed Professor Baggoley in the frontline role.

Mr Bowles announced Professor Baggoley's departure last week, and praised the leadership he had shown in the CMO role in the past five years, particularly in advancing the nation's response to mounting global antibiotic resistance, the threat of communicable diseases, and improved detection of non-communicable illnesses such as cancer.

The Health Department head singled out Professor Baggoley's significant contribution to the international response to epidemics including Ebola, Middle East Respiratory Syndrome (MERS) and, most recently, the Zika virus.

In addition to his work on the World Health Organisation's International Health Regulations Emergency Committee – which played a central advisory role during the Ebola, MERS and Zika outbreaks – Mr Bowles said Professor Baggoley had also been instrumental in work to improve the nation's defences against, and response to, international health emergencies.

Professor Murphy will take up the CMO position on 4 October. In the interim, the position will be filled by Dr Tony Hobbs, who has been appointed Deputy CMO.

ADRIAN ROLLINS

Research

Bad breath could be seriously unhealthy

Bad breath may not only be unpleasant for those around you, it could be seriously bad for your health, according to research into the link between oral bacteria and pancreatic cancer.

While an association between poor oral hygiene and pancreatic cancer has been previously established, researchers at New York University have for the first time found that an imbalance of bacteria in the mouth precedes the development of the cancer, opening up potential methods for early detection and the tantalising possibility of a causal link.

The study, which involved sequencing DNA extracted from the saliva of 361 pancreatic cancer patients and 371 healthy participants, found that those with porphyromonas gingivalis in their mouth were at 59 per cent greater risk of developing pancreatic cancer than those who did not, while those with aggregatibacter actinomycetemcomitans were at 50 per cent greater risk (though the association was not considered to be as statistically strong).

Significantly, the increased risk remained the same even after excluding pancreatic cancer cases that occurred less than two years after the samples were taken. Lead researcher Jiyoung Ahn says this means it is unlikely that the imbalance in oral bacteria has occurred as a result of the pancreatic cancer, and instead predates it.

The discovery provides for several promising new avenues for investigation.

It raises the potential for developing a screening test for pancreatic cancer using the two oral bacteria as markers – an important advance for a disease that often goes undetected until it reaches an advanced stage, contributing to its high mortality rate.

Researchers are also intrigued by the possibility that the two bacteria may somehow cause the cancer to develop, though Ahn cautions that it is premature to reach such a conclusion.

Ahn says it is possible that the imbalance of the two bacteria in the mouth is the correlate of systemic inflammation or other processes occurring within the body.

"Inflammation is related to cancer," she says. "The bacteria could be causing inflammation in the pancreas – that's one theory. But maybe the bacteria in the mouth is just a marker for the susceptibility of the body to inflammation."

Ahn and her colleagues are planning further research, including injecting the two bacteria into the pancreas of mice genetically engineered to be susceptible to pancreatic cancer to see what effect this might have, as well as examining possible links between viruses in the mouth and pancreatic cancer.

In the meantime, the scientist says, it is too soon to advise people that flossing and brushing their teeth will help stave off pancreatic cancer.

ADRIAN ROLLINS

Global emergency call on yellow fever outbreak

The World Health Organisation has been urged to take emergency action over a rapidly spreading yellow fever epidemic that has so far infected more than 2000 people in Africa and Asia.

Health experts at Georgetown University's Institute for National and Global Health Law, writing in the *Journal of the American Medical Association*, have warned that "quick and effective action" is needed to halt the spread of the disease, which has already killed more than 250 people in Angola and has appeared in Congo, Kenya and China.

The experts, Dr Daniel Lucey and Professor Lawrence Gostin, said that shortages in the supply of the yellow fever vaccine raised the risk of a "health security crisis" if the disease spreads through Africa and reaches Asia (which has never experienced a yellow fever epidemic) or the Americas (where the mosquito that can transmit yellow fever is endemic).

"The WHO should urgently convene an emergency committee to mobilise funds, coordinate an international response, and spearhead a surge in vaccine production," they said.

Dr Lucey and Professor Gostin said delays in the international community's response to the 2014 Ebola outbreak that eventually infected 28,646 people and claimed 11,323 lives should serve as a salutary lesson of the costs of a tardy response.

"Prior delays by the WHO in convening emergency committees for the Ebola virus, and possibly the ongoing Zika epidemic, cost lives and should not be repeated," they said. "Acting proactively to address the evolving yellow fever epidemic is imperative."

Yellow fever kills around 30,000 people a year, mostly in Africa, and the latest outbreak has added impetus to mass vaccination programs. More than 7 million Angolans have been immunised against yellow fever, and in May the Democratic Republic of Congo Government announced plans to vaccinate 2 million of its citizens.

Dr Lucey and Professor Gostin warned that these mass immunisation campaigns "could be a tipping point in exhausting global vaccine supplies".

Medical experts have already advised that just one-fifth of normal vaccine dose be administered to avert the risk of an acute shortage if the disease spreads, but Dr Lucey and Professor Gostin said it was time for the WHO to step in.

They said the world health body should invoke procedures similar to those used during the Ebola epidemic to safeguard vaccine supplies.

"Stewardship of scarce vaccine supplies is essential, but requires the WHO's Director-General to declare a public health emergency of international concern," they wrote. "[But] it is only by convening an emergency committee that the Director-General could declare a public health emergency of international concern.

"Given the world's vital health security interest, the WHO's Director-General should use [the procedures] to authorise a reduced vaccine dose to control the epidemic in Angola."

Dr Lucey and Professor Gostin said the yellow fever outbreak, combined with the experiences of the Ebola and Zika epidemics, showed that the WHO needed to have a standing emergency meeting that met regularly, rather than having to be formed each time a serious global health threat arose.

"The complexities and apparent increased frequency of emerging infectious disease threats, and the catastrophic consequences of delays in the international response, make it no longer tenable to place the sole responsibility and authority with the WHO's Director-General to convene currently ad hoc emergency committees," they said.

ADRIAN ROLLINS

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Minnow 'stares down' Big Tobacco

Tobacco giant Philip Morris has been ordered to pay Uruguay US$7 million in damages and court costs after it lost a legal challenge to the South American country's anti-smoking laws.

In a ruling hailed as a landmark outcome by public health advocates, the International Centre for the Settlement of Investment Disputes (ICSID) early this month rejected a claim by Philip Morris that Uruguay laws banning smoking indoors, increasing tobacco taxes and requiring cigarette packets carry prominent health warnings breached the terms of a 1998 trade agreement between the Latin American country and Switzerland.

The ICSID, a branch of the World Bank, judged that "the responsibility for public health measures rests with the government, and investment tribunals should pay great deference to governmental judgments of national needs in matters such as the protection of public health".

Public Health Association of Australia past President Professor Mike Daube said the case was "a historic win for global public health".

"It confirms the sovereign rights of all governments to protect the public's health," Professor Daube said. "Uruguay refused to be intimidated by Big Tobacco and has been completely vindicated."

Under the Uruguayan laws, the Government ordered manufacturers of 12 different brands of cigarettes to increase the size of the health warnings on their packaging by 80 percent. The resulting costs forced Philip Morris to withdraw seven of the 12 types of cigarettes that it sold in Uruguay.

The case had been watched closely by health advocates worldwide. It was feared an adverse outcome for the Uruguayan government would have been a major setback for tobacco control measures, particularly in the developing world where smoking rates are continuing to increase.

Instead, the judgement has emboldened activists and policymakers to intensify their efforts to control tobacco.

Welcoming the tribunal's decision, Uruguayan President Tabare Vazquez said that, "we have proved before the ICSID that our country, without violating any treaty, has met its unwavering commitment to the defence of the health of its people".

In a statement following the ruling, Philip Morris Vice President Marc Firestone said his company had "never questioned the authority of Uruguay to protect public health and this case did not address broad issues on tobacco policies".

But the case is expected to provide a boost to plans for countries such as Canada to follow Australia in introducing tobacco plain packaging laws.

Rob Cunningham, a senior policy analyst with the Canadian Cancer Society, told CTV News that the Uruguay case provided a very useful precedent for countries like Canada because the issues raised were similar.

"The tobacco industry claims these measures are invalid, but they keep losing these cases," Mr Cunningham said. "That's going to provide encouragement to governments to make sure their regulations are not only adopted but they are as comprehensive as possible."

The ICSID ruling is the latest setback for the tobacco industry in its attempts to frustrate tobacco control measures and overturn plain packaging laws.

A legal challenge to Australia's world-first plain packaging laws was thrown out by the High Court in 2012, and last year the Permanent Court of Arbitration rejected a claim by Philip Morris Asia that the legislation impinged on investor rights under the terms of a trade deal between Australia and Hong Kong.

Uruguay's fight to control tobacco drew international support.

The US-based Campaign for Tobacco-Free Kids established a fund to help Uruguay and other small countries to fight legal challenges to anti-smoking laws, and drew contribution from Bloomberg Philanthropies and the Bill & Melinda Gates Foundation.

"It shows countries everywhere that they can stand up to tobacco companies and win," Bloomberg Philanthropies founder Michael Bloomberg said. "No country should ever be intimidated by the threat of a tobacco company lawsuit, and this case will help embolden more nations to take actions that will save lives."

ADRIAN ROLLINS

Andrew Thomas - its all about the red and white

BY DR MICHAEL RYAN

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4

Sounds obvious for a wine maker that the passion for the red and white would be all consuming.

In Andrew Thomas's case, he is also passionate about the red and white in the jersey of the mighty Sydney Swans. For a country New South Wales boy situated in rugby league heartland this might seem strange.

You have to go back a step and realize he is McLaren Vale born and raised. His dad, Wayne Thomas, was well known in South Australian wine circles and has a scholarship named after him. Hence the love of the all-dominant game of AFL.

The grape doesn't fall far from the bunch, as wine folk who admired the work of his father are also impressed by the enthusiasm and finesse of Andrew's wine making skills. Throw in a big dose of larrikinism and a 'tell it like it is, no bullshit' policy, and you have Andrew in a nutshell.

Roseworthy College gave him his degree in oenology. He has worked on vintages in Sonoma, Piedmont, Tuscany and Provence. These iconic wine making areas lend themselves to structure and finesse, hence the pull of Andrew towards the Hunter Valley. He worked for Tyrells for an invaluable 13 years.

Andrew had an opportunity to lease wine making facilities and enjoys relationships with some of the best fruit producers in the region. The first vintage was in 1997. He has recently opened a designated cellar door in Pokolbin. The website is www.thomaswines.com.au

Semillon and Shiraz rule in the Hunter. It can be a tough place to make wine with tropical rain and thunderstorms peppering some vintages. So when these winemakers create little masterpieces, the wine world should stand and applaud.

All wine regions should be idiosyncratic in their final product. The Hunter is indeed this. The Semillons are usually grassy with citrus notes, and have sharp acidic finishes. They last for decades and transform into highly sought-after wines. The reds, often described with funk and leather, sweaty etc. have been created in a fresher mid-weighted wine style.

As the palate of this writer develops, you appreciate the affection great wine writers like Len Evans and James Halliday have for the Hunter. Noone else makes anything like these expressions of Semillon and Shiraz. Andrew as opened a designated cellar door

WINES TASTED

1. 2015 Six Degrees Semillon Hunter Valley

Pale lemon/lime color. Bouquet - white peach aromas with and interesting mushroom/herbal complexity, from subtle suspended yeast contact. Palate - this is an off-dry style, with 38 grams per litre of residual sugar. It will not appeal to all palates due to its sweetness, but I believe it to be a balanced wine with a lush, fruit-driven style and supporting acids. At 8 per cent alcohol, it's a great lunch wine with a fisherman's basket. It could serve as an aperitif with soft cheeses.

2. 2015 Braemore Semillon Hunter Valley

Pale lime colors. Bouquet - classic Hunter Semillon with grassy lemon notes. Palate - quite lush with fruit. It finishes somewhat mid-palate, with a crisp flinty, acidic structure. This wine has won many trophies and medals and will cellar for 12-plus years.

3. 2014 Elenay Shiraz Hunter Valley

Garnet in color. Lush red currant notes with vanillin oak aromas. There are smoky herbal notes that make this wine quite alluring. It is a medium-bodied red with a full anterior palate and mid-palate structure. Have with a charcuterie plate. Cellar for five to seven years.

4. 2014 Synergy Shiraz Hunter Valley

Purple garnet in color. A deeper red currant maraschino cherry nose. Hints of violets and Chinese Five Spice. A lush full wine with lovely mouth feel and structural tannins. Any Japanese food would match. Cellar seven to 10 years.

Oil spills!

BY DR CLIVE FRASER

Twenty-five years ago Iraqi forces opened oil valves to impede the troops trying to liberate Kuwait.

What unfolded was easily the biggest oil spill in human history, with 4000 square kilometres of Kuwait covered in a 10 centimetre thick oil slick.

Four million barrels, or 480,000 m^3, of oil spilled out onto the land and sea.

It was almost enough oil to fill Sydney Harbour.

About 50 per cent of the volume evaporated, 25 per cent was recovered and the rest is still sitting there, including a lot of oil that enters waterways and washes up on Saudi beaches.

Quite a mess to clean up.

Reminded of this, I recently helped a colleague to clean up a much smaller oil spill in the rear foot-well of his Honda Civic.

Seems that he'd bought 5 litres to do an oil change which he then completed.

The remaining 1.5 litres in the container didn't find a place on the shelf in his workshop, but rather was put back behind the driver's seat.

Sometime in the next two weeks the container slipped side-ways and, can you believe it, the top wasn't sealed.

Discovering that there was one litre still left in the container, we estimated that the total spill was only 500 millilitres.

But how do you pick up two cupfuls of oil and put it back where it came from?

The internet was the obvious place to seek advice.

Absorbent paper towels did a good job in step one, but the carpet still seemed sodden with oil and felt greasy no matter how many paper towels we used.

Step two would necessarily involve a chemical attack, but that would have to be after the laborious job of removing the carpet from the vehicle.

Most automotive carpets have a perforated backing so that dampness can dry out.

Those perforations are just as able to allow fluid to get under the carpet as well.

Half a day was all it took to get the carpet out after the seats, door sills and centre console were removed.

Cleaning the shiny metal floor-pan was easy with just a rag and any old detergent.

Cleaning the oil from the carpet was going to be a lot harder.

According to the internet, the best place to start was with bicarb of soda or sodium bicarbonate ($NaHCO_3$).

Sprinkle it on, let the crystals soak up the oil and then vacuum them up.

Sorry, but that didn't cut the mustard - though sodium bicarbonate is still a pretty good antacid.

Next thing was dry cleaning fluid or tetrachloroethylene ($Cl_2C=CCl_2$).

A chemical solvent should dissolve the oil, but with the carpet fibres having such a big surface area, there seemed to be no way of shifting the oil without flooding the carpet, which might also be dissolved by the cleaner.

Next we tried degreasing oil.

On paper this approach did look promising with a greater volume of solvent.

In practise, the carpet was just as greasy after de-greasing and, to make matters worse, it now smelt like degreaser.

Our final line of attack was with good old-fashioned amphiphilic detergent.

The hydrophobic "fat-loving" end of the detergent molecule would dissolve the oil, which should then just wash away with water.

As the spill had been in a car, we started with car wash detergent.

Somehow, it just didn't seem to cut the grease, so we tried dishwashing detergent, which similarly failed to impress.

While the process was gentle on our skin, the carpet still felt oily.

With the options reducing and the distinct possibility of admitting defeat and ordering a new carpet on eBay for US$200, we gave it one last try.

Laundry detergent was never meant to be tested on humans or animals, but it was good for cleaning overalls.

With more surfactants, enzymes and optical brighteners this had to work, and it did.

That corner of the carpet was now so clean it left the remainder looking decidedly dirty.

So there was no other choice but to push on and remove the chocolate, mud and two litres of dehydrated Coca-Cola that was deposited elsewhere on the flooring.

Next job, Kuwait.

Safe motoring,

Doctor Clive Fraser

doctorclivefraser@hotmail.com

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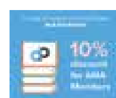

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