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Medi-duddled

Medibank Private accused
of putting profits before
patients, pp4-5



AMA

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Associate Professor
Brian Owler



Vice President
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Medibank putting profits before patients, says AMA



The nation's largest health insurer has been accused of putting profits before patients amid revelations that it has refused to cover the medical expenses of a mother who dies in childbirth.

AMA President Professor Brian Owler told the National Press Club that maternal death in childbirth was one of the more than 150 'preventable' clinical conditions Medibank Private was refusing to cover in hard-ball negotiations with private hospitals.

The AMA President said maternal death during childbirth, while rare, did happen, and Medibank's position was "offensive" and betrayed a lack of understanding of medicine and the motivations of doctors and other health workers.

"I find it offensive that a private insurer would refuse to cover the costs of that patient and hospital in such a tragic event," he said. "If someone thinks that a financial incentive will motivate doctors, nurses or anyone else in a hospital to prevent maternal death any more than they desire to do so now, then they have no understanding of medicine or the people in it."

"They are putting shareholders before patients."

The issue blew up last month after Medibank abandoned negotiations with the Calvary Health group on health cover.

Calvary was resisting Medibank demands that it pick up the tab for treating 165 medical conditions the insurer claimed would

be caused by incompetence or neglect in the care patients received.

Medibank has argued that by insisting on a long list of exclusions, it is encouraging private hospitals to lift their standards of care. And it has received the backing of rival insurers Bupa and NIB, which argue it is time to hold hospitals to account for poor or inappropriate care.

Senior Bupa executive Dwayne Crombie told The Australian that insurers would take an increasingly hard line with private hospitals over costs: "I think you are going to see much blunter discussions. I totally support Medibank's approach, and we would think similarly".

NIB Chief Executive Mark Fitzgibbon told the same newspaper that "the trick here is to transfer the risk of poor quality to the person best placed to manage that risk, which is clearly the hospital. It's right that the hospitals take that risk".

But while the AMA accepted that hospitals should be held accountable for avoidable errors such as operations on the wrong limb or using the wrong blood type in a transfusion, Professor Owler said trying to avoid responsibility for complications like deep vein thrombosis that can and do arise despite the use of extensive preventive measures, was wrong.

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Medibank putting profits before patients, says AMA

... from p4

“what we should be doing is waiting for the evidence to come forward and then make recommendations. That is not what Medibank are doing”

The AMA President said the Australian Commission on Safety and Quality in Health Care already regulated the safety and quality of health care, and there was no evidence to support the items on Medibank’s list.

“What we should be doing is waiting for the evidence to come forward and then make recommendations. That is not what Medibank are doing,” he said.

A Medibank spokesman told News Corp the insurer rejected the criticism and said it would be rare for a hospital not to cover the cost when a mother died in childbirth, and if this did occur the insurer would “vigorously contest” the decision on behalf of its members.

“We understand it is a common industry practice not to pay for this event, because it is rarely charged,” the spokesman said.

The AMA President said the insurer’s decision to walk away from its talks with Calvary Group, which meant Medibank Private members would no longer be covered for treatment at the group’s hospitals, was in keeping with a shift in the health fund’s focus since being privatised from patient care to shareholder returns.

He said it was clear Medibank’s intention was to simply to shove costs off its books and instead dump them onto private hospitals, and would have the effect of forcing the most complex clinical cases onto the public hospital system.

Already, there is a well-established trend for private patients to be treated in public hospitals.

Figures released by the soon-to-be- abolished Private Health Insurance Administration Council show that public hospital admissions of privately insured patients surged from 20.9 per cent in 2003 to 28.8 per cent last year, and patient volume growth in public hospitals outstrips that in the private sector.

Professor Owler warned the Calvary hospital stoush was part of an aggressive and unwelcome push by Medibank to have a much greater say in the provision of care.



He said the nation had been well served by a private health insurance system which was open to all, regardless of health status. Under industry rules, patients can join the health fund of their choice even if they have a pre-existing condition, and they cannot be denied coverage (the principle known as community rating).

But the AMA President expressed concern that Medibank was trying to drag the system down a path toward US-style managed care, in which insurers were able to dictate what doctor a patient saw, and what sort of treatment they received.

“A US-managed care system is a system that places an enormous administrative burden on the patients and on the practices,” he said. “It actually increases costs and, at the end of the day, the only one that wins is the insurer. We don’t want to go down that system.”

“[But] I am concerned that as Medibank Private, given its float and new direction, that we are slowly heading towards that direction.”

While the private health insurance sector was not uniform, and mutual funds operated to benefit members, Professor Owler said Medibank’s relentless cost-cutting could create competitive pressures that would undermine the ability of other insurers to maintain their level of coverage and services.

Mr Crombie said that although Bupa did not have shareholders, it was facing cost pressures similar to those driving Medibank.

ADRIAN ROLLINS

Doctors 'obliged' to speak out on asylum seeker health

AMA President Professor Brian Owler has accused the Federal Government of trying to intimidate doctors and other health workers from speaking out about the treatment of asylum seekers being held in immigration detention centres.

The AMA President has mounted a strongly-worded attack on controversial provisions in the Government's Border Force Act aimed at gagging whistleblowers amid mounting claims that many detainees – including children – have been sexually and physically abused while in custody.

As doctors, we have an ethical and moral obligation to speak out if we have concerns about the welfare of our patients, whether it be the treatment of an individual or whether it be at a system level

Professor Owler said doctors were ethical and morally obliged to advocate for the welfare of their patients, and the new laws – which threaten up to two years imprisonment for unauthorised disclosures – placed them in an invidious position.

“As doctors, we have an ethical and moral obligation to speak out if we have concerns about the welfare of our patients, whether it be the treatment of an individual or whether it be at a system level,” he said.

Asked if the AMA was advising doctors to refuse to work in detention centres under these conditions, the President said that it “wouldn't matter what I said, I suspect. I think doctors would vote with their feet and they would go and provide health care to asylum seekers, because that's what they do”.

“Doctors will always go and look after the patient, and they will put their own interests second.”

The apparent attempt to gag critics has come against the background of ongoing reports of abuse and assault at detention centres.

The independent Moss review of allegations of abuse at the Nauru detention centre, released in March, found evidence of

rape, the sexual assault of minors, and guards trading marijuana for sexual favours from female detainees.

Despite this, a separate Senate committee inquiry heard last month that no detention centre staff accused of abusing children have been charged.

Transfield, which has a \$1.2 billion contract to operate the Nauru and Manus Island detention centres, said that of 67 allegations, just 12 had been referred to police.

In other testimony, a former senior doctor with Immigration Department contractor International Health and Medical Services, Dr Peter Young, told the Senate committee that medical staff were directed not to report mental health problems.

Dr Young, who was director of mental health for IHMS, said he was told several times not to report that asylum seeker mental health had been harmed by being detained at the Nauru detention centre.

Separately, the Government-appointed Council on Asylum Seekers and Detention has been told that detainees begin to suffer serious mental health problems within three months of incarceration.

Immigration Minister Peter Dutton has sought to provide assurances that health workers who spoke out would not be prosecuted under the Act, but Professor Owler said much more was needed.

“The AMA has been concerned about the provision of health care to asylum seekers, particularly those in the offshore processing centres of Nauru and Manus Island,” he said. “Legal advisers have confirmed that the Act provides penalties, including potential imprisonment for doctors, nurses and other health workers who speak out about abuse or the wellbeing of asylum seekers.”

Professor Owler said that if medical whistleblowers were not liable for prosecution, then “it should be clearly and directly spelt out in the legislation”.

“We call for this exemption because, for a doctor, an asylum seeker is no less a patient than any other patient. If we are willing to compromise the rights of doctors and patients for one group, how can we ensure that other groups will not be compromised in the future?” he said.

ADRIAN ROLLINS

'Fix this funding mess', leaders told



The nation's political leaders are considering increasing the GST, raising the Medicare levy or extending Medicare to encompass hospital treatment to help bridge an annual \$35 billion health funding gap.

Victorian Premier Daniel Andrews and his Tasmanian counterpart Will Hodgman have been directed to examine "more durable revenue arrangements" to meet future health costs following a leaders' retreat convened by Prime Minister Tony Abbott to consider the future of the Federation.

The 22 July retreat, and a subsequent Council of Australian Governments meeting, was warned of a growing Commonwealth and State revenue shortfall that was likely to reach \$45 billion a year by 2030 – at least \$35 billion of which would be due to increasing health expenditure.

But AMA President Professor Brian Owler said that, while high-level discussions about how to fund future health care were welcome, the options on the table were a "modest summation" of what was needed and lacked vision.

Professor Owler said every delay in improving hospital funding added to the toll of pain and suffering of patients, causing great distress for them, their families and their doctors.

"The funding of our public hospital system is not an argument for the abstract," he said. "I want our leaders to know that the hardworking and dedicated doctors in our public hospital system are...very frustrated. You get to the point that you stop seeing patients because you don't want to add any more to the waiting list."

The AMA President said patients were being forced to wait up to three years for surgery, including for cancer and life-threatening conditions, and in the meantime were often unable to work, and left debilitated and in pain.

His concerns have been highlighted by research showing the deadly consequences of hospital overcrowding.

An Australasian College of Emergency Medicine study found patients forced to wait more than four hours to be transferred to a hospital bed after receiving emergency care were 51 per cent more likely to die than those with shorter waits.

Professor Owler said the message for the nation's leaders was to "sort this mess out. Fund our public hospital system properly, and don't keep leaving the sick and the suffering behind".

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'Fix this funding mess', leaders told ... from p7

While the leaders discussed the need for greater "efficiencies" in current health spending, they agreed to canvass ways to boost revenue to bridge the fiscal gap, including increasing the GST and raising the Medicare levy.

"Clearly, we can do things in terms of efficiencies...but on current projections, there is undoubtedly a requirement for some revenue," NSW Premier Mike Baird said. "So, we'll be undertaking work both looking at the GST and the Medicare levy in detail, with various options for this group to consider."

The Federal Government, which precipitated the funding crisis by announcing the withdrawal of \$57 billion of Commonwealth funding from public hospitals in the next decade, has been keen for the States to take the lead in addressing the funding shortfall – particularly the political opprobrium that might accompany an increase in taxes.

Mr Abbott welcomed Mr Baird's public advocacy of an increase in the GST because it was, he said, a relatively efficient tax.

"I'm not ruling things in, I'm not ruling things out, but my preference would be to consider GST issues rather than Medicare levy issues," the Prime Minister said. "The GST is, if you like, a joint exercise by the Commonwealth and the States, whereas the Medicare levy is simply a Commonwealth tax."

But several State leaders have rejected an expansion of the GST and have instead argued for an increase in the Medicare levy or an extension of the Medicare system to include hospitals.

South Australian Premier Jay Weatherill said it was an appealing idea because "there isn't an incentive for one side that's running the primary health system, another side that's running the public hospital system to actually cost shift to each other, we could run a more efficient system, but also a better system for patients and people looking to get their health care needs met," he said.

Alongside these potential changes, Mr Abbott incongruously flagged a possible shift in the basis of Commonwealth funding to hospitals to be more closely aligned to outcomes – having dumped the activity-based funding model last year.

"If the Commonwealth's contribution to public hospitals looks like it's aligned to the delivery of good services at the best price rather than simply a block grant handed over to a bureaucracy, that would be a big step in the right direction," he said.

Similarly, in primary health, he said health care plans should be designed to give GPs incentives to keep patients with complex and chronic conditions out of hospital.

ADRIAN ROLLINS

Taxing health a costly exercise

Expanding the GST to include health services and fresh food would undermine access to care and hamper efforts to combat obesity and encourage healthier eating, AMA President Professor Brian Owler has warned.

Though Professor Owler said it was not up to the AMA to tell governments how to raise the revenue needed to adequately fund public hospitals, he cautioned that a knee-jerk broadening of the GST could create more problems than it solved.

Increasing the GST is one of the options being considered by the nation's leaders looking to plug a gap in revenue, possibly including getting rid of current exemptions for fresh food and health care.

But in a nationally-televised speech, he told the National Press Club that slugging fresh food with a GST would be at odds with attempts to encourage people to eat healthier diets, while adding 10 to 15 per cent to the cost of seeing a doctor would make health care less affordable and accessible.

Professor Owler also expressed concern about how any extra revenue raised might be used.

"Whether it's through a Medicare levy, whether it's through the GST, whether it's through income tax, it's still all going to the Federal Government," he said. "The issue is actually how we allow States to actually share in that revenue, and even actually allow them to raise the revenue themselves."

"Suffice to say that the money needs to go into the public hospitals at the end of the day, and make sure that we stop this blame game between the States and the Commonwealth about where the money comes from."

ADRIAN ROLLINS

Plan for future, no more piecemeal cuts: Owler

The foundations of the nation's health system are being undermined by a dangerous period of policy drift characterised by piecemeal approaches to major challenges, AMA President Professor Brian Owler has warned.

In a major televised speech, Professor Owler bemoaned a lack of vision and resolve among the nation's political leaders on health, and called for the formulation of an overarching National Health Strategy.

He said that too often, the slogan that health care should be about the 'right care, right place, by the right person', had become little more than code for cost shifting and responsibility ducking.

"A long-term, bipartisan National Health Strategy may be difficult to achieve, but allowing our health care system to meander risks its future, and allows its foundations to be undermined piece by piece," the AMA President said. "A National Health Strategy should guide our health policy, our decisions, and any future reform of the health care system."

Professor Owler's call received strong backing from the Australian Health Care Reform Alliance, a coalition of peak health groups, which said the AMA President's speech was "a wake-up call" on the need for national health strategy and greater focus on preventive and primary care.

"Apart from a focus on funding cuts with little evidence of their value and long-term impacts, the Government has not articulated its values and intentions to tackle the variety of urgent issues reducing the effectiveness and fairness of our health systems," AHCRA Chair Tony McBride said. "Saving money by randomly cutting services, such as funds for...public hospitals and...for NGOs appears to be the extent of the Government's vision for health."

The outlook for health has for years been clouded by unresolved Commonwealth-State tensions and disagreements over funding and lines of responsibility.

Professor Owler said a national leaders' retreat held last month to consider the division of health responsibilities and funding as part of reform of the Federation was a welcome first step, but talks limited to rearranging tasks or raising a little more revenue by themselves were not enough.

He called for a thoroughgoing reassessment and change in the way health is considered by governments.

"Health should not be an annoyance – a concerning budget line to be dealt with," he said. "Health is an essential ingredient to any economy.

"We need to see health care expenditure not as a waste, but as an investment."

The AMA President held up the Federal Government's approach to Indigenous wellbeing as an example of the muddled and ineffective policymaking that can arise in the absence of an overarching strategy.

The Commonwealth has instituted a crackdown on truancy among Aboriginal children and carrot-and-stick measures to boost Indigenous employment.

But Professor Owler said that, by neglecting health, the Government's strategy would achieve only limited success in closing the gap.

"The lack of focus on health is one of the reasons why I struggle to understand the Government's Indigenous advancement strategy," he said. "Making kids go to school, encouraging young people to get a job, and making a safer society are all noble objectives. But health must underpin these strategies, particularly when it comes to Closing the Gap."

The AMA President said a more honest and incisive assessment of the health system was needed to identify and take advantage of opportunities to achieve better and more cost-efficient care.

He said that, contrary to the claim of politicians, health spending was not out of control, though he acknowledged that scarce health dollars could be used to greater effect.

Rather than trying to hold down health spending by rationing access to care and other punitive measures, Professor Owler said a smarter approach was to drive dollars further by improving health system integration, particularly through the use of information technologies.

In addition, he said, governments should invest in general practice to help care for patients with complex and chronic conditions and to upgrade preventive health initiatives.

"Investment in general practice is essential if we are going to keep people well and in the community," the AMA President said.

"Seven per cent of hospital admissions may be avoidable with timely and effective provision of non-hospital or primary health care.

"Our family doctors are the cornerstone of chronic disease management. They need to be supported to do this work with investment, funding, and resources."

Mr McBride said that the Government should search for efficiencies before resorting to rhetoric and fearmongering about "unsustainable" health expenditure: "This means being smarter about what services we fund, not just cutting them."

ADRIAN ROLLINS

Rebate freeze an 'attack on GPs'



The medical profession has stepped up the pressure on the Federal Government to dump its controversial Medicare rebate freeze amid reports medical practices are abandoning bulk billing and hiking patient out-of-pocket charges.

As the Government faces the prospect of backlash from patients hit with higher costs to see their GP or specialist, AMA President Professor Brian Owler told the National Press Club that the freeze was a "direct attack on general practice".

He said the four-year clamp on GP rebates that came into effect last year left family doctors with little choice but to pass the increasing cost of providing a health service – including rising staff wages, rent, utility charges and maintenance costs – onto patients, with inevitable consequences for affordability and equitable access to care.

The Government has attempted to dismiss the medical profession's outcry as a cash grab by greedy doctors, but Professor Owler said it was a false argument.

"It is important that people understand that the Medicare rebate is the rebate to the patient," he said. "Only in the case of bulk billing does that rebate go directly to the doctor."

Instead, he said, what was at stake was the viability of medical practices, particularly in socially disadvantaged areas.

As reported in the 21 July edition of *Australian Medicine*, numerous GPs have reported to the AMA that they have had to abandon bulk billing, increase patients charges – and, in at least one instance, close down – as a direct result of the rebate freeze.

Dr Emil Djakic said his north-west Tasmania practice, which

had been bulk billing 75 per cent of patients, had been forced to introduce a charge of at least \$30 for all patients because of the financial squeeze caused by the rebate freeze.

Meanwhile, a small practice in Redfern has been forced to shut down because the increasingly inadequate Medicare rebate, combined with the limited capacity of most patients to pay, meant it could no longer afford to operate.

Professor Owler said that the rebate freeze had been implemented for purely budgetary reasons without taking into account the consequences, including reduced access to care for patients.

The situation confronting specialists is in many respects even more pressing – Medicare rebates for specialist services were frozen in 2012 and have not increased since.

Professor Owler said this was having a significant effect on the affordability of specialist services, and the effect was most profound for patients in need of psychiatric, cardiothoracic or dermatological care.

"In many instances, these will be patients with chronic and complex diseases," he said. "They need the care of many specialists."

He said the freeze was starting to undermine the effectiveness of the private health insurance system, because many insurers were refusing to index their benefits until the Government does likewise.

"As a result, there is likely to be a growing number of doctors who choose not to participate in the known gap schedule, and instead charge a gap," the AMA President said. "It may actually lower the costs for the fund substantially, but it will that patients in that fund are likely to be subject to much higher out-of-pocket expenses."

He said this would have significant knock-on effects for the health system.

"Government measures that reduce the value of private health insurance by increasing out of pocket expenses - or putting upward pressure on health insurance premiums - undermine our private sector.

"This puts more pressure on our public hospital system - and that's not good for anyone.

"It is essential that the freeze is lifted [and that] the attack on general practice ceases."

ADRIAN ROLLINS

Worrying trends in MBS review

There are mounting concerns about the direction of the Federal Government's far-reaching overhaul of the Medicare Benefits Schedule amid indications up to 100 review groups will be established to examine specialist items.

The AMA has cautiously welcomed the MBS review, led by Sydney University Medical School Dean Professor Bruce Robinson, and has undertaken to help organise and coordinate the input of clinicians.

But AMA President Brian Owler has convened a meeting of medical profession leaders for the later this month to discuss worrying aspects of the Government's approach to the review, including excluding specialist colleges and societies from direct involvement, opaque processes for the selection of review members that raised the risk of influence by individual vested interests, and a lack of transparency regarding the work of review groups and their decision-making.

Professor Owler warned the Government that it risks jeopardising the medical profession's support for the process if it turns out to be just a cost-cutting exercise that lacks transparency and excludes clinical input.

"Doctors are not afraid of change and reform. We will willingly participate in reform where it is in the best interests of our patients," he told the National Press Club last month.

He said the MBS, which list treatments and procedures for which the Government will provide a Medicare rebate, was due for an update because of improvements in medical technology and innovations by doctors to provide better and more effective treatments.

"However, our support is predicated on this review not being aimed at cutting the funding to health," Professor Owler said. "We agree with not paying for procedures that don't work for certain indications, but we also need to ensure that we don't deprive people of important services."

He voiced concern that the Government might use the review mostly to remove items from the MBS, rather than ensuring the schedule was up-to-date and reflected advances in care and medical practice.

"The MBS review cannot be a cost-cutting exercise," he said. "If there are clearly savings that are identified and the evidence is there that supports those savings, then fine. But we also need to make sure that we have the ability to introduce new items onto the MBS. This cannot be about just taking items off."

The AMA President said there were a lot of procedures and services currently not covered by the MBS that should be

included, and lamented that currently the process for getting new items on the schedule was lengthy and costly.

He said an important aspect of the review was the opportunity to add new items and make the MBS "modern".

The AMA is convening a meeting of medical colleges, associations and societies later this month to discuss to MBS review, including concerns over its structure and direction

"What we need to do as part of this review is ensure that we can actually add new things on and make sure that we do actually come up with a modern MBS," the AMA President said. "If we get the sense that this is a cost-cutting exercise, then AMA support and, I suspect, the support of the whole medical profession, will be jeopardised."

The MBS review meeting being convened by the AMA later this month will be addressed by Professor Robinson.

In his letter to college and society leaders inviting them to the meeting, Professor Owler detailed a number of issues regarding the Government's approach to the review, including that:

- it had not articulated a strategic vision for the health system to guide the review's outcomes;
- that it had not been given specific and quantifiable aims;
- that specialist colleges and societies were excluded from direct involvement;
- that the criteria to be used to select review members was unclear; and
- there was a lack of transparency around individual reviews as they progress, and the decisions that will come from them.

"Any review of this nature must bring the profession along with it," the AMA President wrote in his letter. "In the absence of a Government process that facilitates that, it is very important for the medical profession to be collaborative and coordinated."

ADRIAN ROLLINS

National action on bullying, harassment

The AMA has commenced work with the peak advisor to the nation's health ministers to ensure doctors and interns nationwide have access to effective procedures for complaints regarding bullying and harassment.

AMA President Professor Brian Owler has held talks with the Chair of the Australian Health Ministers' Advisory Council, David Swan, about establishing or improving policies and processes regarding workplace bullying and harassment in each State and Territory.

Professor Owler said rules and procedures varied greatly across the country, and it was vital to ensure that all medical staff – no matter where or for whom they worked – felt confident and comfortable in reporting instances of bullying and harassment.

"We need to make sure that it is safe for people to actually come forward without fear of reprisal, without fear for their careers," the AMA President told the National Press Club last month.

He said that for many junior doctors, their employer was the relevant Health Department, rather than a medical college or senior practitioner.

"What we need to do is make sure that the policies and procedures [regulating acceptable workplace behaviour and handling complaints] are in place. [At the moment] they vary right across the country," he said. "[We] need to make sure that those procedures are set up right across the country, and we're working through AHMAC to make that happen."

A number of states are examining the work done by the NSW Ministry of Health on workplace bullying and sexual harassment, and Mr Swan said AHMAC was keen to collaborate with the medical profession on the issue.

Professor Owler applauded the work being undertaken by the Royal Australian College of Surgeons on the issue, and said a complaints process being developed by the College should be replicated across the profession.

Mr Swan said AHMAC was keen to see the outcomes of the RACS work, which he said could provide a good basis for future collaboration between states and the medical profession.

Professor Owler said that, vital though it was to ensure there were effective bullying and harassment policies and complaint procedures in place, the real issue was to stop such behaviour in the first place.

"The most important thing is that we do need to change the culture," he said. "The vast majority of senior doctors are very supportive of junior doctors but we know that that is not always the case. So where we do see a problem...we need to speak out and make sure that we don't allow that to happen. And as leaders, as senior doctors within the profession, the responsibility is on us to make that happen."

ADRIAN ROLLINS



Your AMA Federal Council at work

WHAT AMA FEDERAL COUNCILLORS AND OTHER AMA MEMBERS HAVE BEEN DOING TO ADVANCE YOUR INTERESTS IN THE PAST MONTH:

Name	Position on council	Activity/Meeting	Date
A/Prof Jeff Looi	AMA Federal Councillor, Representative for Psychiatrists	MBS Reviews Workshop	8/7/2015
Dr Andrew Mulcahy	AMA Federal Councillor, Representative for Anaesthetists	MBS Reviews Workshop	8/7/2015
Dr Andrew Miller	AMA Federal Councillor, Representative for Dermatologists	PBS Authority medicines review reference group meeting	24/7/2015
Prof Geoff Dobb	AMA Board Member	Health Star Rating Advisory Committee	17/7/2015

Intern system needs upgrade, not overhaul



Calls to dump the current medical intern training system and replace it with a two-year prevocational program or absorb it in the final year of medical school are ill-considered and unnecessary, the AMA has told a Government inquiry.

In a submission to the Council of Australian Governments' Health Council National Review of Medical Intern Training, the AMA argued that although aspects of the current intern system could be improved, any changes should be incremental and underpinned by evidence.

AMA President Professor Brian Owler and AMA Council of Doctors in Training Chair Dr Danika Thiemt told the review there was nothing to show that a wholesale overhaul of existing arrangements was warranted.

"It is hard for us to agree that the current internship model is flawed when there is so much variety and flexibility across Australia, and when the calibre of doctors in training emerging are world-class and are regarded as such," they said. "That is not to say there is no room for improvement, but we do not believe this has to take the shape of frame-breaking change, and any change should be informed by a strong evidence base."

The COAG review is being conducted amid expectations a growing number of medical graduates will miss out on an internship place this year as Federal and State governments squabble over funding and responsibility.

A national audit found that there was a shortfall of 366 intern places this year, and Australian Medical Students' Association President James Lawler said anecdotal reports indicated there would not be enough places in 2016.

"This is a bittersweet time for medical students around the country, with excitement at their internship offers conflicting

with the fact that they are now competing for training places in a system that is already overwhelmed," Mr Lawler said.

The review has been asked to examine four options, ranging from leaving the system as-is, to increasing intern term periods, establishing a two-year UK-style prevocational training program or drawing internship-like duties back into the final year of medical school.

In their submission, Professor Owler and Dr Thiemt argued strongly against the latter two options.

"The AMA believes there is no evidence to support radical changes to the structure of the internship along the lines suggested in [these] options," they wrote. "These options are unrealistic, would require a significant investment of resources, including cost and additional supervisor input, and may result in unintended negative consequences. In any case, it is unlikely that cash-strapped jurisdictions would be in any position to fund them."

The AMA leaders said the UK-style model might be superficially attractive, but there was no evidence that it would deliver any improvement on current arrangements, while the type of learning gained through university education was "very different" from that provided in a workplace, where interns are required to make decisions about care, albeit under supervision.

"There is no evidence to show that the current model of internship in Australia is 'broken', or that radical changes to its structure are required," Professor Owler said. "The current model of intern training in Australia has served the community well. Instead of sweeping changes, we need to build on what works."

But he said the review had highlighted a lack of data surrounding the quality and effectiveness of the intern year in preparing junior doctors for independent practice, and the AMA has proposed that remedying this be a priority.

"The AMA believes the review must propose new systems to provide better information on the quality of medical intern training, the transition from medical school to intern training, and in the remaining prevocational and vocational training years," the AMA President said.

The AMA has recommended there be a national survey of medical training, similar to the survey that the General Medical Council undertakes in the United Kingdom.

ADRIAN ROLLINS

IT investment key to health savings



Penny-pinching governments should invest in information technology to improve health quality while cutting waste and reducing inefficiency, AMA President Professor Brian Owler has said.

As the Federal Government pushes ahead with an overhaul of the much-maligned Personally Controlled Electronic Health Records (PCEHR) system, Professor Owler said policymakers and health system administrators needed to invest in the use of information technologies in providing health services.

He said doctors and hospitals had embraced IT in their everyday practice, but there was not the unifying structure to unify and integrate these systems to ensure patients received seamless, well-coordinated and cost-effective care.

“Doctors have embraced IT in practices, particularly our GPs,” the AMA President said. “The problem is that all of these systems have been built up as silos, rather than allowing people to communicate and talk to each other. What we need to do is develop the ability to link that IT with the hospital.”

The previous Labor Government’s much-vaunted PCEHR was intended to provide part of that link, giving patients and their doctors access to medical records, wherever and whenever they were needed.

But its adoption has fallen far short of expectations amid concerns from the AMA and others that the ability of patients to edit their record had fatally compromised its usefulness as a clinical tool.

An Abbott Government-commissioned review called for an overhaul of the system to make it opt out and to curb the extent to which it could be altered by patients.

The AMA President said that, over time, the PCEHR had morphed into a “sort of grandiose plan” as people pushed for more and more features, and in the end it outgrew any usefulness.

“What we need to do with the PCEHR is scale it back, allow it to be the vehicle that allows us to do what we need to do - provide the clinical information between doctors, allow that doctor-to-doctor communication, so that we can actually know what people are saying to each other. That’s the sort of direction the PCEHR needs to go down.”

Professor Owler lamented that \$1 billion had so far been wasted on the scheme, but said that should not deter governments from investing in IT for the health system.

He said the ability to quickly and seamlessly share information would not only improve the efficiency of the health system, but also reduce unwanted clinical variation, delivering improved health outcomes for patients and reducing costs through more effective treatment.

The AMA President said that on a trip to the United States last year, he had seen first-hand how hospitals in Chicago and Washington DC equipped with advanced IT systems were able to use sophisticated techniques like predictive analytics to improve the quality and efficiency of the care they provided.

“They can actually predict for a patient with certain characteristics, what should be done to prevent that patient from developing a disease, or they can predict if that patient is likely to get into trouble within the next few months. And so they’re more pro-active about trying to intervene,” he told the National Press Club.

“That’s the sort of direction, that’s the...smarter way, that we need to be heading.

“Unless we have that sort of infrastructure that is being developed that reduces the waste, that reduces unwanted clinical variation, then we are always going to continue to struggle.”

Professor Owler said there was “no reason” similar systems could not be used in Australia.

“There’s no reason why, in a country of 24 million people, we can’t do this. There are regions in the United States where they have systems that cover a population that’s larger than that,” he said. “So, there’s no reason why this cannot be done. It just needs some resolve, and it needs to focus on what we need to do to make the system work.”

ADRIAN ROLLINS

A change of circumstance for Pompe

Australians suffering from an extremely rare genetic disorder have been given subsidised access to a life-saving treatment following a \$40 commitment from the Federal Government.

In a decision greeted with relief by 28 adults living with little-known Pompe's disease, Health Minister Sussan Ley has announced that from 1 September they will have cost-free access to the drug Myozyme through the Life Saving Drugs Program.

"Pompe disease is a rare and severe medical condition, affecting only a very small number of Australians every year," Ms Ley said. "However, it is a very expensive treatment, costing several hundred thousand dollars, putting it out of reach for many Australians."

Pompe is an inherited and often fatal disorder caused by a mutation in the gene responsible for producing the enzyme responsible for breaking down glycogen in the body. Over time it causes muscles to break down, reducing mobility and eventually leading to respiratory failure.

Myozyme works by replacing the missing enzyme. It is supplied free of charge to children – there are eight currently being treated for Pompe disease – but not adults.

According to Australian Pompe's Association, there are 28 adults with the condition, several of whom rely on a charitable access program to be able to afford the treatment.

But the program was closed to new patients in 2012, and the Association said eight adults were currently receiving no treatment.

Association President Raymond Saich said the Minister's announcement was cause for celebration.

"We are incredibly grateful to the Minister and her Department in making the life-changing decision to make treatment available for this devastating disease," Mr Saich said. "While there are only a small number of Australians living with Pompe disease, they are mothers, fathers, sisters, brothers, sons and daughters.

"Treatment can halt the progression of the disease – allowing us to live our lives to the full as active members of the community."

Ms Ley said patients already receiving Myozyme will be immediately eligible for the subsidy, while newly-diagnosed patients will have to undergo clinical assessment first, plus annual checks to ensure its use remains clinically appropriate and effective.

ADRIAN ROLLINS



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Cannabis meds? Follow the evidence, says AMA



AMA President Brian Owler has called for a considered, evidence-based approach to the use of cannabis for medicinal purposes as the clamour for its legalisation as a treatment for conditions such as cancer, epilepsy and multiple sclerosis grows.

Professor Owler told the National Press Club that marijuana's use as a recreational drug should not be allowed to cloud the assessment of its potential medical applications.

But likewise, he warned against a wholesale embrace of cannabis as a treatment without proper scientific evaluation of its effectiveness for a wide variety of maladies.

"It's not about the fact that it's cannabis. It's actually about the fact of how effective it is," he said. "There are some conditions where it clearly may be beneficial, and perhaps we don't need to have an in-depth trial on those sorts of indications. But there are clearly others where the evidence is actually not there."

His comments came as Federal Labor intensified the pressure on the Federal Government over the issue after the ALP National Conference passed a motion calling for reform of existing regulations governing the use of cannabis.

Already, several states are taking significant steps toward the use of cannabis for medicinal purposes. New South Wales has initiated a series of clinical trials, and Victoria and Queensland have reached an agreement to let their citizens who are suffering terminal or life-threatening conditions to take part.

But Labor's Shadow Assistant Health Minister Stephen Jones said the participation of the Commonwealth was vital to allowing its medicinal use.

"The truth is, neither State nor Commonwealth governments can go it alone," Mr Jones said. "We need Commonwealth leadership to deal with the complex overlay of State and Federal laws that deal with registration of medicines [and the] cultivation, supply and use of prohibited drugs."

He said Labor believed in a national approach based on medical science.

"Cannabis should be treated like any other medicinal product," Mr Jones said. "There is evidence to show that medicinal cannabis can reduce the pain and nausea associated with cancer treatment. It may also help with controlling epileptic fits [and] multiple sclerosis.

"But right now cannabis medicines can't be prescribed by doctors. We need scientific verification and approval by the Therapeutic Goods Administration."

Prime Minister Tony Abbott last year said that he had "no problem with the medical use of cannabis, just as I have no problem with the medical use of opiates".

"If a drug is needed for a valid medicinal purpose...and is being administered safely, there should be no question of its legality. And if a drug that is proven to be safe abroad is needed here it should be available," the Prime Minister said.

While there is growing clamour to legalise medicinal cannabis, Professor Owler said it was nonetheless important to take a cautious and well-informed approach.

"We need to have proper trials and regulate it as a medication just like any other medication," he said. "It's not about trying to deny access to the drug, but we also want to make sure that we don't do any harm. We want to make sure that people are actually getting the drug for the right reasons, and that it's actually going to benefit them in the future."

ADRIAN ROLLINS

OBITUARY

Emeritus Professor Pricilla Kincaid-Smith



When world-renowned medical expert and pioneering doctor Pricilla Kincaid-Smith died last month, it brought to an end a remarkable career marked by numerous firsts.

But it almost might never have happened.

Among the numerous obstacles Emeritus Professor Kincaid-Smith had to overcome were the arcane social mores of post-war Australia. When she moved here in 1958 after marrying her husband Ken Fairley, the laws of the time dictated that she would not be allowed to work.

It won't surprise anyone who knew her that she was not about to let that stop her.

Within a year of arriving in the country (and having already established her credentials in the UK as a dual-qualified physician and pathologist), she had joined the AMA and managed to secure research positions at the Baker Institute and in the University Department of Medicine, as well as being an Honorary Physician at the Queen Victoria Hospital. Within a decade she was appointed Director of Nephrology at the Royal Melbourne Hospital in 1967.

Equipped with such ability and determination, it is not surprising Professor Kincaid-Smith went on to achieve world-wide renown, taking on breakthrough roles with the University of Melbourne, the Australian Medical Association (AMA) and World Medical Association, and discovering the link between headache powders and kidney disease.

Just as she became a leader in her chosen specialty nephrology, so she also blazed a trail for Australian women to hold leadership positions in Australia's medical community.

It all began in Johannesburg, South Africa where Professor Kincaid-Smith was born in 1926, one of four children.

She was a talented hockey player and swimmer and reports indicate that she was more interested in sport than attending classes, but despite this, she started university at just 16.

Originally wanting to study physical education, she was deemed too young and ended up in medical science, where she topped most of her classes and discovered her passion for medicine.

After two years working in South Africa, Professor Kincaid-Smith moved to London where she spent six years training in pathology and cardiology - nephrology, her major speciality, did not exist as a speciality at the time.

It was following this that she moved to Australia with her husband.

Professor Kincaid-Smith achieved many firsts in her life. She was the first female Professor at the University of Melbourne in 1975, first female President of the Royal Australasian College of Physicians in 1986, first female chair of the AMA in 1990 and the first female, and first Australian, chair of the World Medical Association in 1994.

While she joined the AMA soon after arriving in Australia, it was not until the 1980s that she became more directly involved, driven by a strong sense that doctors should actively engage with Government in the delivery of health services.

During her time on AMA Federal Council, she served on numerous committees, including making major contributions to the workforce committees. Dr Kincaid-Smith was, appropriately, the first recipient of the AMA's Woman in Medicine Award.

In addition to all these amazing achievements, as part of a team with her husband, Professor Kincaid-Smith discovered the link between the overuse of headache powders Bex and Vincents and kidney disease in the early 1960s.

She then actively lobbied for restrictions on the availability of the analgesics, and was heavily involved in setting up the renal transplant unit at the Royal Melbourne Hospital.

Dr Kincaid-Smith published more than 480 original papers in refereed scientific journals, 103 chapters in books, wrote three herself and edited a further 10.

Dr Kincaid-Smith made remarkable contributions to medicine, both in Australia and internationally. She worked long and hard for the profession and will be remembered for her passion and dedication.

KIRSTY WATERFORD



AMA in the news

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

PRINT/ONLINE

Patients set to pay in Medicare impasse, *Courier Mail*, 21 July 2015

AMA President Professor Brian Owler warned there would be a sharp rise in the number of visits in which patients would be hit with out-of-pocket fees unless the Government lifted its freeze on Medicare rebates.

AMA calls for no GST on GP visit, *Courier Mail*, 22 July 2015

Patients face paying GST on doctors' visits if the tax is broadened. AMA President Professor Brian Owler called on the Government and the states to rule out broadening the GST to include health care.

Medibank blasted for cost-cutting, *The Age*, 23 July 2015

AMA President Professor Brian Owler warned Australia was heading toward a US-style health care system, saying the cost-cutting behaviour of private insurance giant Medibank was offensive.

Medibank's offensive stand lacks insight: AMA head, *Australian Financial Review*, 23 July 2015

AMA President Professor Brian Owler said Medibank Private's hardball negotiating demands are offensive and misunderstand the motivations of health professionals. Professor Owler said one of the highly preventable adverse events that Medibank has said it would not pay for was maternal death associated with childbirth.

GPs could have seen to hospital visits: survey, *The Australian*, 24 July 2015

Almost a fifth of emergency department visits by the elderly are for problems that could have been managed by their GPs. AMA Vice President Dr Stephen Parnis said it was hard to differentiate when the best care should be provided by a primary care physician or an emergency department.

AMA President's wrong diagnosis on budgets, *The Australian*, 28 July 2015

AMA President Professor Brian Owler is calling for an urgent recognition of the costs of providing high quality care. Professor Owler told the National Press Club it was not the AMA's job to say where the funding should come from.

Medibank Private ready for scrap with hospitals, *Weekend Australian*, 25 July 2015

Medibank Private is ready for a long battle with private hospitals. AMA President Professor Brian Owler said negotiations between hospitals and private insurers had become increasingly aggressive and he warned that Medibank's patients would no longer be fully covered for treatment in a Calvary hospital.

RADIO

Professor Brian Owler, 2UE Sydney, 21 July 2015

AMA President Professor Brian Owler talked about health funding. Professor Owler said that, when it comes to public hospital funding, the states and territories are the ones that have the responsibility to get the job done, but they rely on Commonwealth funding.

Professor Brian Owler, 2GB Sydney, 22 July 2014

AMA President Professor Brian Owler talked about the dispute between the AMA and Medibank Private. Professor Owler said that Medibank Privates decision to list 165 conditions for it will not provide insurance cover was not common practice.

Professor Brian Owler, 2UE Sydney, 23 July 2014

AMA President Professor Brian Owler discussed Medibank wanting to change its maternity coverage so that if the mother dies during child birth they don't have to pay. Professor Owler said it was "offensive" that anyone could think that a financial penalty was needed to motivate hospital staff to prevent deaths during child birth.

Dr Stephen Parnis, 5AA Adelaide, 27 July 2015

AMA Vice President Dr Stephen Parnis discussed alcohol advertisements. Dr Parnis said foetal alcohol syndrome was a serious problem in Australia and that sometimes warning labels on packaging were used as an excuse for not taking more significant action.

TELEVISION

Professor Brian Owler, ABC, 22 July 2015

Acknowledging the political and economic realities that confront governments, AMA President Professor Brian Owler outlined the practical, affordable, and achievable policies and actions that the AMA believes will best serve the health needs of the Australian population.

Why doctors won't cop legislated silence

BY MICHAEL VAGG, CLINICAL SENIOR LECTURER, DEAKIN UNIVERSITY SCHOOL OF MEDICINE

This article first appeared in *The Conversation* on 29 June, 2015 and can be viewed at: <https://theconversation.com/why-doctors-wont-cop-legislated-silence-43993>

Two Australian doctors have taken to the pages of the prestigious journal, the *BMJ* to make their international colleagues aware of the extraordinary assault on medical ethics contained in the recently enacted *Border Force Act 2015*.

I have also received an email, on behalf of the President of the Royal Australasian College of Physicians Professor Nick Talley, to all members of the College and its Chapters and Faculties calling the Act "unacceptable to physicians". They join the AMA and other peak health organisations in publicly warning the Government about trying to prevent doctors advocating for vulnerable patients.

The essence of opposition from medical groups is not political, but ethical. The paramilitary nature of the *Border Force* that has been created is reinforced by the grotesque oath pledging loyalty to the organisation's interests.

Doctors regard themselves as having loyalty first and foremost to their professional ethics, and not to any employer. When I was a military medical officer, I was subject to the *Official Secrets Act* but also to the Geneva protocols regarding my obligation to remain a non-combatant and provide medical care based on need rather than political allegiance.

If I was witness to any war crimes or other unconscionable acts, I would have felt obliged to speak out on behalf of the victims, even if that meant I might have to answer for a security breach.

Drawing attention to the condition of detainees in immigration detention does not affect national security in the same way as military matters. Publicising the plight of patients suffering permanent harm in immigration detention cannot give comfort or operational intelligence to an enemy.

Professor Talley is correct to point out that punishing whistleblowers with a gaol term is placing them in an impossible position ethically. He adds that the Act "fails to understand... that the contribution made by health professionals who speak out about healthcare in situations such as detention centres is invaluable".

I'll repeat that. It is regarded by the RACP as invaluable. Not illegal. Not seditious. Invaluable.

Invaluable because the Immigration Health Advisory Group

(IHAG) which oversaw these issues has been disbanded by the Government. There is nobody to report substandard care to any more.

When experts in paediatrics and psychiatry have lined up to condemn the failure of successive Governments to provide even the barest mental and physical health care to asylum seekers, the politicians should take note. They have been told by the profession that what they are doing is reckless with the lives of these benighted people.

This is not political point-scoring. It is the caring profession using its advocacy to protect the vulnerable to whom we owe a duty of care that transcends partisan politics. Some humanitarian and civic duties transcend the party system. Surely there must be some within the major parties who agree that doctors must be free of intimidation to advocate for their patients. Such a law is unprecedented in Australian medicine.

This Government has attempted to roll over doctors' concerns about vulnerable patients previously, with the ill-conceived GP tax. This mandatory silence is a direct attack upon the ancient obligation of medical practitioners to speak out on behalf of their patients. A situation where doctors are required by law to report suspected child abuse in routine practice, but are now apparently forbidden to report proven child abuse in detention cannot be allowed to stand.

Instead, the *Border Force Act 2015* seeks to make it illegal to voice discontent at disgraceful health outcomes, and legislates compulsory non-disclosure for any health worker who is compassionate and courageous enough to want to work in the face of such hamfisted intimidation.

That sinister oath would stick in the throat of any decent doctor.

If the Government insists on refusing doctors the freedom to advocate on behalf of their patients, I expect they will face an organised campaign from the profession. The signs are that they will. It is unusual for such a conservative body as the RACP to take such public steps in disagreeing with a political policy. There is widespread incredulity in the profession that this is being attempted. This will turn to anger soon enough, if our warnings are ignored. And not just doctors, but nurses and paramedical staff would feel exactly the same.

The Abbott Government would surely not be foolish enough to pick a fight over ethics with the whole healthcare workforce.



Health on the hill

POLITICAL NEWS FROM THE NATION'S CAPITAL

Not nanny state, just good sense



AMA President Professor Brian Owler has rejected criticism of smoking bans, pub lock-outs, bicycle helmets and other public health measures that are the target of a Senate inquiry into so-called 'nanny state' laws.

Cross-bench Senator David Leyonhjelm, who advocates strongly libertarian views, has taken aim at Commonwealth laws, policies and guidelines he claims restrict personal choice, including restrictions on the sale and use of tobacco, alcohol, marijuana and pornography, as well as bicycle helmet laws, and other measures he considers to be paternalistic.

The Liberal Democrat has won Senate backing to chair a broad-ranging one-year inquiry into what he says is a burgeoning 'nanny state'.

"[What you do is] not the Government's business, unless you are likely to harm another person," the Senator said. "Harming yourself is your business, but it's not the Government's business."

But Professor Owler said such an exceedingly narrow view failed to take account of the effect a person's actions had on others.

"I agree that the Government should not be interfering with choices and behaviours of individuals without reason," the AMA President said. "But, as individuals, we live in a society. As such, the choices and behaviours that we make as individuals affect those around us."

For example, he said, laws against using a mobile phone while

driving were considered by some as an intrusion on their individual rights.

But he said people who drove while on their mobile were four times more likely to be involved in an accident, possibly killing or maiming someone else. He said, even if only they were injured, the rest of society still picked up the tab for their hospitalisation, treatment and rehabilitation.

Among Senator Leyonhjelm's targets are pub lock-out laws introduced in King's Cross and the Sydney CBD following an escalation of deadly alcohol-fuelled attacks in the city's major entertainment districts.

"There's no question it's a sort of collective punishment for the guilt of individuals," he told Fairfax Media. "It was a classic moral panic."

But Ralph Kelly, whose son Thomas was killed after being punched in the head in a random attack in King's Cross in 2012, said Senator Leyonhjelm's claim was "absolute rubbish".

Mr Kelly, who with his wife addressed the AMA National Conference last year about their work raising awareness of alcohol-related violence, said the lock-out laws were working to make Sydney safer for revellers.

Professor Owler, who was at the forefront a calls for Government action following to spate of violent street attacks earlier this decade, said doctors saw first-hand every day the tragic effects on people of their behaviour and the actions of others, which was why they were "unashamed champions" for public health.

"Government does have a role to play in making this country a safer and healthier society," Professor Owler said. "It does have a role in regulating and modifying the behaviour of individuals so that the rest of us can be confident that we won't be run over by someone distracted by talking on their mobile phone, or run off the road by a drink driver."

The AMA President said the attack on sensible laws and regulations was dismaying, and added that it was "very concerning" sufficient Federal MPs shared Senator Leyonhjelm's extreme views to enable him to launch his inquiry.

"The existence of this Committee is a distraction from the real discussion of preventive health care and injury prevention that we should be having," he said.

"There should be a clearly articulated approach to prevention.

Continued on p21 ...



Health on the hill

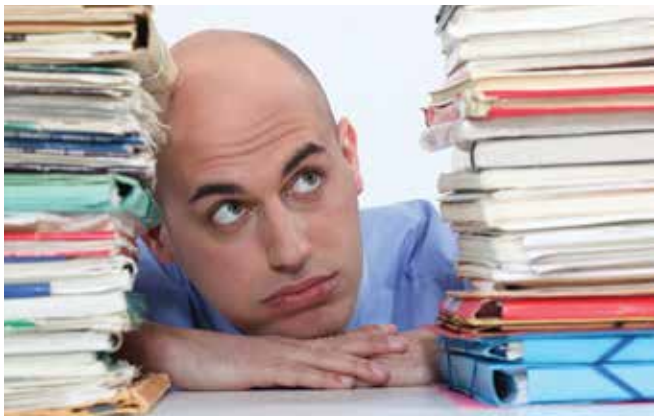
POLITICAL NEWS FROM THE NATION'S CAPITAL

... from 20

“More importantly, we need all those who have a responsibility for prevention, governments at all levels, to live up to their responsibilities for prevention.”

ADRIAN ROLLINS

Doubt cast on Govt commitment to cut red tape



The Federal Government has been put on notice to significantly increase its engagement with the medical profession if it is genuine in its ambition to cut medical red tape.

In a scathing assessment of current Government initiatives, AMA Secretary General Anne Trimmer said deregulation work being undertaken by the Health Department and the Health Ministerial Advisory Committee was not informed by the practical experience of doctors and appeared to be of little relevance or value.

The Australian National Audit Office (ANAO) is conducting a review of the Government's implementation of its deregulation program, and has sought the AMA's input.

Surveys of GPs conducted by the AMA have shown that red tape is a major burden on medical practice, with estimates that general practitioners spend, on average, 4.6 hours a week on compliance activities. Across the profession, that was the equivalent of 15 million standard consultations a year.

Ms Trimmer said the AMA had identified and promoted four simple measures that could achieve real reductions in red tape

without compromising care, including:

- scrapping PBS authority prescription requirements;
- assigning doctors a single Medicare provider number;
- streamlining Centrelink and Department of Veterans Affairs forms; and
- putting third party forms into electronic format.

Despite this, the Department of Health in its *Health Portfolio Annual Deregulation Report 2014* had nominated a set of initiatives the AMA Secretary General said would have “very little meaningful relevance to our membership, or are of limited value”.

She said many initiatives did not appear to be genuinely linked to the deregulation program, such as the replacement of Medicare Locals with Primary Health Networks, and none of the numerous ongoing consultations between the Department and the AMA specifically related to deregulation.

“To the extent that advice may have been sought on some of the initiatives, this was not sought on the basis of tackling red tape,” Ms Trimmer said. “The AMA has not been asked by the [Department] to put forward ideas on red tape reduction, and it would appear that the deregulation program is being managed by the [Department] with very minimal stakeholder involvement or input.”

She said similar concerns applied to the deregulation work being undertaken by the Health Ministerial Advisory Committee (MAC).

The AMA official told the Audit Office there was “a very low level of awareness of the MAC, and no apparent mechanism through which it interacts with stakeholders or seeks their views”.

In particular, she said the committee did not include representatives of small to medium-sized medical practices, which bore much of the red tape burden.

“This, and the absence of organisational representation, makes it difficult to understand how the MAC can be expected to provide the type of robust policy advice the Government needs on red tape reduction,” Ms Trimmer said, adding that clinical input was “critical” for the development of effective deregulation policies.

The ANAO is due to table its report in the first half of 2016.

ADRIAN ROLLINS

Health on the hill

POLITICAL NEWS FROM THE NATION'S CAPITAL

Future Fund controversy shadows top research body appointments

The man charged with heading the Federal Government's review of the Medicare Benefits Schedule has been appointed to a three-year term on the National Health and Medical Research Council.

Sydney University Medical School Dean Professor Bruce Robinson is among 13 people appointed to the NHMRC by Health Minister Sussan Ley to provide expert advice on health, research ethics and funding.

"The new Council provides an impressive cross-section of high-level skills and experience which will be extremely valuable for this key organisation," Ms Ley said.

The appointments come soon after a change of leadership at the NHMRC helm following the replacement of long-serving chief executive Professor Warwick Anderson with Professor Anne Kelso.

Changes at the top of the NHMRC have come at a sensitive time, with accusations the Government has sidelined the research body from a central role in helping set the direction for the controversial Medical Research Future Fund.

The Federal Government was accused of setting the \$20 billion MRFF up as a slush fund after it was revealed that, instead of having the central role in deciding how MRFF funds would be allocated, the NHMRC will now be just part of a Government-appointed expert advisory committee.

AMA President Professor Brian Owler said the arrangement was concerning.

"We don't want to see this money being used at the whim of the Finance Minister," Professor Owler said.

Shadow Health Minister Catherine King said that, "as it stands, the Bill is creating what could very likely become another Government slush fund: \$20 billion in funding with no independent oversight of how the earnings from that money is to be spent," she told Parliament.

But Ms Ley said the strategy for the MRFF would be developed with reference to the NHMRC's strategy for medical and public health research, and the priorities it set.

"The Medical Research Future Fund is being set up to deliver national projects and priorities, and it will naturally work hand-in-hand with the NHMRC and other areas of Government to deliver that," the Minister said.

Among those appointed, or re-appointed, to the NHMRC are Professor Sandra Eades, Adjunct Professor Graeme Samuel, Professor Ian Olver, Professor Brendan Crabb, Professor Sharon Lewin, Professor Kathryn North, Professor Michael Kidd and Professor Sharon Lewin.

ADRIAN ROLLINS

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



Busting the myths on eating disorders

Kate Moss's infamous quote that "nothing tastes as good as skinny feels", will be put under scrutiny as university researchers dispel myths and educate high school students on eating disorders and fad diets.

Eating disorders affect nearly one million Australians, or around 9 per cent of the population, with young people most at risk. The incidence of eating disorders has increased worldwide over the past 30 years, and some estimates are that it costs Australia more than \$69 billion annually.

High school students will have the chance to ask a team of leading researchers about negative body image, obesity and eating disorders as part of an interactive workshop following the production of the stage play, *What is the Matter with Mary Jane?*

The play is the autobiographical, one-woman account of a 15-year battle with anorexia and bulimia nervosa. It has become a classroom staple since it debuted at the Sydney Theatre Company in 1995.

Professor Stephen Touyz from University of Sydney, a participant in the workshop, said that the events were a great learning tool and a provided a new approach to teaching on the issue.

"Instead of showing someone a video, you're presenting them a story told in a real live production, which makes the impact a lot stronger. Immediately afterwards, we'll be there to stimulate discussion and answer any lingering questions the play might raise for students," Professor Touyz said.

Professor Touyz said that interactive forums like workshops were critical for opening an early dialogue with young people facing eating disorders, which still tended to be glamoured in the media and popular culture.

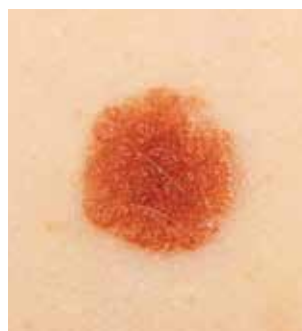
The themes of the play and workshops will continue into a free, public Sydney Ideas forum, 'Eating Disorders: New Approaches for treatment and Management', on Thursday 6 August.

The production *What is the Matter with Mary Jane?* Runs until 8 August, with support from The University of Sydney's Charles Perkins Centre, Eating Disorders Victoria and The Butterfly Foundation.

For more information visit: <http://www.seymourcentre.com/events/event/what-is-the-matter-with-mary-jane/>

KIRSTY WATERFORD

Breakthrough – new method for detecting melanoma



A Queensland scientist has discovered new markers for melanoma that could allow the potentially deadly disease to be accurately monitored through routine blood tests.

The clinical tool could be available in two years, and is a major breakthrough in testing for one of Australia's deadliest cancers.

Michael Stark, from the QIMR Berghofer Medical Research Institute, found seven new melanoma markers which can be detected in blood.

Mr Stark said that a blood test could detect early signs of disease progression that are not picked up in scans.

"The panel of markers could be useful in tracking melanoma progression or recurrence in patients being monitored by their treating physician," Mr Stark said.

"They are highly sensitive and specific, and are significantly better than markers currently being used."

More than 11,000 Australians are diagnosed with melanoma each year, which causes 1500 deaths annually.

Mr Stark said better monitoring of the disease may improve a patient's chance of survival by detecting melanoma progression before metastatic disease is clinically evident, allowing for treatment to start sooner.

"Survival rates for patients with metastatic melanoma differ greatly depending on the extent of spread," Mr Stark said.

The blood test would look for elevated levels of the markers, which are microRNAs - tiny molecules which regulate the amount of protein a gene can produce.

The study compared samples from 255 melanoma patients with those of 102 patients with no evidence of melanoma at the time of collection. It was found that in stage four patients, the new biomarkers confirmed tumour progression in 100 per cent of cases.

The work was supported by the NHMRC, QUT, and the Queensland Government's Smart Futures Fund.

KIRSTY WATERFORD

Trade deal concerns high despite US shift

Health groups remain concerned the massive Trans-Pacific Partnership trade deal will push up the cost of medicine and hamper public health initiatives despite claims United States negotiators have given ground on controversial intellectual property protections.

While the future of the controversial trade pact is clouded following the failure of officials from 12 nations to seal an agreement in Hawaii last week, reports emerged that the US had backed down on demands that clinical data for biologic medicines be subject to a 12-year exclusivity clause in order to delay competition from cheaper generics. The proposal had become a major sticking point.

On the eve of the Hawaii talks, Trade Minister Andrew Robb told Fairfax Media he was pushing for the data exclusivity period to be slashed to five years, and it is understood the United States' chief negotiator, US Trade Representative Michael Froman, was prepared to accept a reduction to seven years.

The secretive nature of the talks has meant that most observers have had to rely on information gained by websites like Wikileaks for information about the direction of negotiations on the deal which, if concluded, will encompass about 40 per cent of the global economy.

Mr Robb has sought to allay fears about the agreement, which he said had "transformational promise" for the countries involved.

The Trade Minister said negotiations were at a "very advanced stage, and we are pushing to ensure we can secure major gains and opportunities for Australians business and for our economy".

Just before going into the Hawaii round of talks, Mr Robb admitted the treatment of biologic medicines was one of the "really difficult" issues still outstanding: "You've got to set a balance somewhere between people getting a return on innovation on investment, and enabling competition to bring prices down for the rest of the community".

Biologic medicines are derived from biological sources, and though they comprise only a fraction of drugs listed on the PBS, they are usually very expensive – accounting for a quarter (\$2.3 billion) of PBS spending in 2013-14.

While the US may have given ground on access to biologic data, the AMA and other health groups remain concerned that other clauses in the proposed trade deal, including provisions allowing pharmaceutical companies to "evergreen" drug patents and giving investors scope to block governments taking public health measures, could undermine health care.

The AMA Federal Council has called on the Federal Government

to reject "any provisions in trade agreements that could reduce Australia's right to develop health policy and programs according to need".

The Association said it was concerned that aspects of the proposed TPP could be used to attack key health policies and measures including the PBS and the cost of medicine, food labelling and tobacco control laws, restrictions on alcohol marketing, the operation of public hospitals and the regulation of environmental hazards.

Among the most controversial provisions are investor-state dispute settlement (ISDS) procedures that would enable corporations to mount legal action against government policies and laws they felt harmed the value of their investment or future profits.

Tobacco giant Philip Morris Asia used just such provisions in a 1993 investment agreement between Australia and Hong Kong to challenge Australia's world-first tobacco plain packaging legislation in the courts and seek compensation, arguing that the policy undermined the value of its investment by 'expropriating' its trademarks and branding.

In addition, the TPP includes proposals demanding the removal of technical barriers to trade – provisions which companies have used to challenge regulations such as alcohol warning labels, alcohol excise, and front-of-package food labelling.

There are also concerns market access rules in the TPP may be used to restrict government support for public hospitals and other health services by requiring that there be competitive neutrality between such entities and private health providers.

Medical charity Medecin Sans Frontieres is also apprehensive about the deal.

It said that without major changes in the Hawaii talks, the deal would have a "devastating impact" on global health.

MSF was particularly concerned about provisions it warned would "strengthen, lengthen and create new patent and regulatory monopolies for pharmaceutical products that will raise the price of medicines and reduce the availability of price-lowering generic competition".

It said some of the most concerning provisions centred on patent evergreening, which would force governments to grant drug companies additional patents for changes they made to their medicines, even if these were of no therapeutic benefit.

ADRIAN ROLLINS

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