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Drop the trash talk

AMA tells Health Minister: stop attacking GPs to justify Budget cuts, p7

Major report finds cost-efficient GPs crucial to containing costs, p8

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In this issue

GPs deserve praise, not abuse – especially from the Government

BY AMA PRESIDENT PROFESSOR BRIAN OWLER

We all thought that the Government's direct and indirect attacks on GPs – including being called rorters, and regularly accused of inappropriate behaviour with tests and billing – came to an end when Sussan Ley took over as Health Minister almost a year ago.

A new era of civility was ushered in. Or so we thought. The era of incivility, which began with the 2014 Federal Budget and its unprecedented assault on primary care services and public hospital funding, raged on for much of 2014 with various versions of a GP co-payment, the Medicare patient rebate freeze, and the ill-conceived policy to change Level A/B GP consultations.

> "The Government appears to have adopted a strategy of demonising GPs to sell its policies, especially the MBS Review"

We moved into 2015 with a new Minister and a new era of cooperation and consultation as the Government heeded the warnings from the profession and the community and dropped most of its bad policies.

Fast forward to the present day and the mood is somewhat different.

Almost every major health announcement from the Government – the MBS Review and the most recent Professional Services Review Report most notably – have been dropped to the media for maximum weekend news coverage (and little chance of right of reply), and characterised by overt attacks on the credibility of doctors, especially GPs.

The Government appears to have adopted a strategy of demonising GPs to sell its policies, especially the MBS Review.

They are cherry picking 'heavy traffic' elements of the MBS and then labelling the GP behaviour as 'rorting' and 'inappropriate'.

This approach was echoed by the *Four Corners* program on waste in the health system, with the finger being pointed at GPs for over-ordering and over-servicing. The approach by both the Government and *Four Corners* lacked one key thing – clinical evidence.

The Government's behaviour makes it very difficult not to conclude that its overall strategy is to cut the health budget – savings for savings sake, without a thought for the impact on patients and public health. That has been the AMA's suspicion all along.

The AMA knows that a small number of doctors do the wrong thing. And it is a very small number. But their actions should not be used by the Government to attack all Australia's hardworking GPs.

There are processes in place to identify inappropriate behaviour and punish that behaviour, MSAC and the PSR for example – both of which are actively supported by the AMA and the profession.

So it came as a shock when the Health Minister chose recently to politicise the PSR, using it to attack the credibility of GPs and promote the Government's not-so-hidden agenda to slash health funding via the MBS Review. The PSR has been above politics for a very long time. It has been a symbol of cooperation.

The real evidence about the performance – and value – of general practice is contained in the Bettering the Evaluation and Care of Health (BEACH) Reports, the latest of which was released this month.

The BEACH Report illustrated yet again that general practice is the most cost efficient part of the health system.

More than 85 per cent of Australians see their GP at least once a year. This type of quality care keeps people away from expensive hospital care. This type of quality care saves the Government money.

The BEACH reports provide undisputed evidence that general practice and GPs are the foundation of the health system. They show that the community and patients rely on their GPs, and trust them.

The Government needs to adopt a new strategy and new rhetoric for its policies. They should be praising GPs and applauding their work. They must start working cooperatively on major policies, including the MBS review. The talk must be about modernising the MBS, not cost cutting.

A Government health strategy built on attacking the credibility and value of GPs is not smart politics – especially going into an election year.

The AMA and asylum seekers

BY AMA VICE PRESIDENT DR STEPHEN PARNIS

The AMA is currently in the process of revising and updating our 2011 Position Statement on Health Care of Asylum Seekers and Refugees.

In the four years since we first released the AMA Position, the health care and well-being of those seeking asylum in Australia has changed significantly.

In August 2012, the Labor Government announced it would reopen the detention centres on Manus Island (PNG) and Nauru; while the Coalition Government reached a Memorandum of Understanding with Cambodia to take asylum seekers. While we welcome the large reduction in the numbers of children being held in detention in recent years, we lament the fact that any children are there at all, and that our nation's treatment of asylum seekers has become more harsh and covert.

The AMA Federal Council has convened an Asylum Seeker and Refugee Working Group to revise our Position in light of these and other policy changes. What hasn't changed is that the AMA continues to advocate that those who are seeking, or who have been granted, asylum within Australia have the right to receive appropriate medical care without discrimination, regardless of citizenship, visa status, or ability to pay.

The AMA position is based on a fundamental ethical principle: that all people seeking health care, including asylum seekers and refugees in Australia, or under the protection of the Australian Government, should be able to access appropriate services and be treated with compassion, respect, and dignity.

In revising the Position Statement, we are aware of mounting evidence about the serious and far reaching physical and psychological harm detained asylum seekers suffer, particularly those held in offshore detention centres.

The courageous and principled decision by Melbourne's Royal Children's Hospital doctors to refuse to discharge refugee children back into detention, and the recent protest by health staff from the Lady Cilento Children's Hospital in Brisbane, are clear indications that the medical profession demands that the Government release children from detention.

Individual doctors have agonised over allowing children to return to detention, knowing full well that the harms they presented with in the first place are going to continue.

Earlier this year, the results of an Australian Human Rights Commission inquiry were released showing that 233 assaults recorded at detention centres between January 2014 and March 2014 involved children, and there were 33 incidents of reported sexual assault.

The AMA supports a change in Federal Government policy. Now is an opportunity for the new Prime Minister, Malcolm Turnbull, to recognise that something is very wrong with the existing detention policy, and to start improving it by removing all children from these harmful environments.

This is not a new demand. The AMA has been calling for this change since 2002.

Many doctors also want to see all families seeking refugee status to be allowed to live within the community, and to access health care at a standard expected by Australians.

The AMA's position is supported by Australia's international obligations to provide appropriate physical and mental health care to all people residing in Australia, or under the protection or auspices of the Australian Government. The conventions that Australia has ratified identify our responsibilities to asylum seekers and refugees with regard to health care.

The revised Position Statement will be accompanied by a background document outlining Australia's international obligations to provide appropriate health care. It includes the *Universal Declaration of Human Rights, The International Convention on Economic, Social and Cultural Rights (ICESCR), and The Convention on the Rights of the Child (CHC).*

In late October, at its 66th Annual Assembly in Moscow, the World Medical Association issued a Resolution on the Global Refugee Crisis. It emphasised the damage to health imposed by becoming a refugee, and called on nations to play their part in providing immediate care and support for these vulnerable people.

The revised AMA Position Statement will make clear the role of medical practitioners in providing proper health care to a highly vulnerable and at-risk group, many of whom have arrived here

with a range of complex physical and mental health conditions.

That is why we have consistently called for the re-establishment of a panel of doctors and other health professionals who can provide independent advice to the Government, and who can report in a transparent manner on health-related issues in detention centres.

But instead of transparency, on 1 July we got the Border Force Act.

The revised Position Statement will take into account the restrictions contained in the Border Force Act. It is ethically imperative that doctors working with asylum seekers and refugees put their patients' health needs first. In order to do this, doctors require reasonable professional autonomy and clinical independence without undue pressure from others.

The AMA believes that doctors should be afforded the freedom to exercise their professional judgement in the care and treatment of their patients. Doctors should be able to speak out about unjust, unethical maltreatment of asylum seekers without persecution.

Prolonged, indeterminate detention of asylum seekers in immigration detention centres violates basic human rights and further damages their health. The longer a person is in detention, the higher their risk of mental illness. Detention should be used only as a last resort, and for the shortest practicable time. Solutions to prolonged, indeterminate detention must be sought as a matter of urgency.

The AMA's position is all about doctors being able to provide humane medical care. After all, we provide medical care to prisoners, and it has to be remembered that asylum seekers have committed no crime.

Detention centres are unsuitable environments for the health of all detainees, but the effects on children are far worse. These people, whatever their circumstances, are in our care. We must stop this brutal cycle of harm, especially for children, and be able to provide the best possible medical care without political interference.

Family violence and Indigenous incarceration a focus of AMA advocacy

BY **AMA SECRETARY GENERAL ANNE TRIMMER**

> "The correspondence shows how medical practitioners can sometimes let down women when they most need support, questioning the veracity of claims of violence or not providing referral or direction to agencies that could give assistance. Hopefully the toolkit will assist in addressing these issues"

Family violence and the role of the doctor has been a policy focus for the AMA during 2015.

While family violence has long been a community concern, the selection of Rosie Batty as Australian of the Year has provided a platform for public discourse on the topic. It also provided the impetus for the launch by the AMA and the Law Council of Australia of a national toolkit to be used as a resource by GPs. The toolkit is based on one that AMA NSW developed some time ago in conjunction with the NSW Women's Legal Centre.

Following the media attention given in late October to the AMA NSW campaign on the impact on children of family violence, the AMA received correspondence from women who have suffered violence, only to have their needs dismissed by their medical practitioner. The correspondence shows how medical practitioners can sometimes let down women when they most need support, questioning the veracity of claims of violence or not providing referral or direction to agencies that could give assistance. Hopefully the toolkit will assist in addressing these issues.

The AMA resources add to the recently announced funding commitment by the Federal Government, including $14 million to be used to expand the existing domestic violence-alert training program, aimed at improving the ability of hospital emergency department staff, police and others to detect signs of domestic violence, as well as to expand specialised training for GPs.

A further $15 million will be used to help legal services work with local hospitals, and to establish specialised domestic violence units providing coordinated legal, social and cultural services.

The AMA resource can be found at https://ama.com.au/article/ama-family-violence-resource.

During November, the AMA and the Law Council of Australia will launch complementary report cards on the impact of incarceration on Aboriginal and Torres Strait Islander people. The publication of the AMA's Indigenous Health Report Card is an important event in the AMA calendar. Over many years, it has been used to highlight areas of concern regarding the health of Aboriginal and Torres Strait Islander people.

This year, the Report Card will look at the health impacts of incarceration. The Law Council's report tackles the same issue from the perspective of the justice system.

For many years the proportion of Indigenous people in jail has far exceeded their representation in the general population. There are many reasons for this, not least of which is the policy of mandatory detention pursued in some states for more than a decade.

Imprisonment occurs for a range of reasons - from the impact of low literacy where a person may not hold a driver's licence and be convicted of driving without a licence, to non-payment of fines, to drug and alcohol issues. Whatever the cause, the representation of ATSI people in Australian jails is disproportionate. The AMA report card provides an extensive review of the impact this has on the lives of those imprisoned, and their families.

The report card will be launched on 25 November.

Govt slurs on doctors must stop: AMA

AMA President Professor Brian Owler has called for an end to sustained Federal Government attacks on the medical profession amid mounting evidence that GPs are playing a crucial role in keeping health costs down.

Responding to the latest salvo fired by Health Minister Sussan Ley in which she alluded to widespread misuse of Medicare among general practitioners, Professor Owler said the profession was getting "very weary" of the Minister's attacks, which he said were aimed at creating the impression GPs were rorting the system as a way to justify cuts to health spending.

"The Government tries to come out with this narrative about GPs doing the wrong thing," the AMA President told ABC radio. "We've seen this from this Government before, and I think it's about time that this Government actually started to appreciate, particularly their general practitioners, and stop painting the profession as people doing the wrong thing so that they can just find more savings in the Budget."

Professor Owler made his comments after Ms Ley seized on a report from the Professional Services Review (PSR) agency to claim that that an increase in incorrect Medicare claims by doctors may be just the "tip of the iceberg".

The agency reported a 40 per cent jump in the number of cases of suspected inappropriate practice referred to it for investigation in 2014-15, from 44 to 62, with much of the increase involving claims made for chronic disease management items.

"The MBS items and their associated rules are necessarily somewhat prescriptive," the agency said in its Annual Report. "This provides scope for less scrupulous practitioners to populate the clinical record of an attendance with copious 'generic' computer template material. PSR committees often find that these are of little apparent relevance to the particular patient."

"PSR committees frequently find that some practitioners in large practices provide [chronic disease management] services opportunistically despite the lack of clinical relevance."

The Agency reported that action was taken in 70 per cent of cases referred to it, including ordering 24 doctors to repay $2.6 million of Medicare benefits, fully or partially disqualifying 13 practitioners from Medicare for anything up to 12 months, and issuing six reprimands. A further $1.57 million was refunded in negotiated settlements.

Ms Ley said she was deeply concerned that grey areas and ambiguities in Medicare rules that made it hard to track and prove abuses by less scrupulous practitioners could mean many more instances of misuse and rorting may be going unreported.

"These findings show the importance of having clear, strong rules around the use of individual Medicare items to ensure they are clinically relevant and reflect contemporary practice, but also aren't misused for financial gain," the Minister said.

The attack came just weeks after Ms Ley echoed claims that around 30 per cent of services and procedures provided by doctors through the Medicare Benefits Schedule were unnecessary or potentially harmful.

But Professor Owler said the number of practitioners found to have engaged in some form of wrongdoing by the PSR was a tiny fraction of the 100,000 registered doctors working in the country, and it was wrong Ms Ley to attempt to "politicise" the Review.

"The Government has been too eager to use the inappropriate behaviour of a small number of doctors – which the AMA does not condone – to tarnish the reputation of all GPs," he said.

A major study (see page 8) has found that GPs, far from being a drag on the health system, are playing a crucial role in keeping patients healthy and out of expensive hospital care, and should be a focus for Government investment.

Professor Owler said the results showed that the Government should be praising, rather than bagging, GPs, and, at the very least, should be removing the freeze on Medicare rebates.

"Instead, the Government is regularly engaging in criticism of hardworking GPs, calling them 'rorters' in its efforts to sell its cost-cutting MBS review model and in its unbalanced portrayal of the latest Professional Services Review (PSR)," he said.

ADRIAN ROLLINS

Cost-effective GPs a health saving

A major study has found that the nation's GPs are playing a vital role in holding health costs down, calling into question the Federal Government's push to gouge money out of primary care to boost the Budget bottom line.

Sydney University health researchers have found that GPs are playing a crucial role in caring for aging patients with multiple and complex health problems, helping them lead longer and healthier lives at a fraction of the cost of other health systems, particularly the United States.

The conclusion is politically awkward for the Federal Government, which has targeted the health budget for cuts, claiming that Medicare expenditure is out of control.

The Government has imposed a four-year freeze on Medicare rebates, and Health Minister Sussan Ley has directed a review of the Medicare Benefits Schedule to achieve savings that can be ploughed back into general revenue.

The latest report from the long-running Bettering the Evaluation and Care of Health (BEACH) study being undertaken by the Family Medicine Research Centre backs AMA warnings that the Government's attack on primary health care funding is misguided and will cost both patients and the country dearly.

The BEACH report found that the aging of the population is imposing an increasing burden on the health system.

While less than 15 per cent of all Australians are aged 65 years or older, they are twice as likely to see a GP, have a pathology test, see a specialist and be on medication as the rest of the population.

This is due, to a large extent, to the fact that they tend to have multiple chronic health complaints – the study found 60 per cent of them had three or more health problems, and a quarter had five or more.

And the health demands of older Australians are growing quickly – their use of GP time, diagnostic tests, medicines and referrals is expanding much more rapidly than their numbers would imply.

But, despite this, Australia's total health spending as a proportion of GDP is on a par with countries such as Britain, Canada and New Zealand while achieving among the longest life expectancies in the world – and is far better than the United States, which spends double the amount but whose life expectancy is four years shorter.

The BEACH researchers attributed this world-class result to the work of the nation's GPs and central role they play in the health system.

"One of the biggest differences between the health care systems in Australia and the United States is that primary care is the core of Australia's system, with GPs acting as 'gatekeepers' to more expensive care," they said. "If general practice wasn't at the core of our health care system, it is likely the overall cost of health care would be far higher."

The BEACH researchers said that the early diagnosis of health complaints and increasing life spans meant people were living longer with complex conditions, adding greatly to health costs: "This is the price Australia pays for good health, but we would argue this price is very reasonable".

GPs are central to holding costs down, in large part because of the work they do in co-ordinating the care provided by hospitals, specialists, allied health professionals and community and aged care services.

The BEACH researchers said this coordinating role was crucial because it cut down on duplication of tests and helped ensure continuity of care – both considered vital in sustaining health and holding down costs.

They found that 98.6 of older patients had a general practice they usually attended – a de facto 'medical home'.

"If our Government wants to make our health care system sustainable, it should invest in primary care to improve the integration of, and communication between, these different parts of the health system," the researchers said.

"Further strengthening the role of general practitioners will reduce unnecessary interventions in the secondary and tertiary health sectors."

ADRIAN ROLLINS

More patients, more complex problems, more often: the lot of GPs

Patients are seeing their GP more often, and taking up more of their doctor's time seeking help with an increased array of health problems, adding weight to medical practitioner complaints about the inadequacy of the Medicare rebate.

A long-running study of general practice has found that the proportion of older patients being seen by GPs has increased as the nation's population has aged, bringing with them multiple health problems that require more time-consuming and complex care.

The Bettering the Evaluation and Care of Health (BEACH) study, which involves a random sample of 1000 GPs each year, found that between 2005 and 2014 the proportion of patients 65 years or older seen by GPs increased from 27 to 31 per cent.

At the same time, the number of consultations claimed through Medicare climbed 36 per cent to more than 137 million and the number of problems managed per 100 encounters rose from 146 to 155.

Together, these results mean that 65 million more problems were managed by GPs in 2014-15 compared with 2005-06 – underlining concerns that doctor remuneration through Medicare has failed to keep pace with the volume and complexity of the work GPs undertake.

The AMA has condemned the Federal Government's decision to freeze the Medicare rebate until mid-2018, warning the measure is likely to drive some GPs out of practice and cause many more to cease bulk-billing, potentially deterring the sickest and most vulnerable from seeking care.

While the rebate is stuck, the complexity and multiplicity of problems that GPs are treating has meant a blow-out in the time they spend with each patient. Consultation time has increased from a mean of less than 14 minutes a decade ago to 14.7 minutes last financial year – and the increase in time taken could be accelerating. The BEACH study found that in the last two years alone, the median consultation has increased from 12 to 13 minutes.

While hypertension, check-ups, coughs and colds remain the common reason to see a GP, in the past decade there has been a sharp increase in other types of complaints – particularly those chronic in nature.

Last financial year, GPs has 23 million more consultations for chronic complaints than in the mid-2000s, including many more for depressive disorders, oesophageal disease, heart problems, chronic back pain and other, unspecified, chronic pain.

Not only has the type of patients and the problems they have changed in the past decade, but so has the way GPs operate.

The BEACH study found that GPs now were less likely to prescribe medicine, particularly antibiotics and anti-inflammatories, than they were 10 years ago.

Instead, they were likely to order more pathology and imaging tests, and more readily referred their patients to a specialist.

ADRIAN ROLLINS

'Extreme' GST on health makes no sense

The sickest and most vulnerable in society would be hit hardest if the Federal Government moved to impose a consumption tax on health care, AMA President Professor Brian Owler has warned.

The Turnbull Government has initiated a wide-ranging discussion on tax reform that has included suggestions the Goods and Services Tax be raised to 15 per cent or be expanded to include health care, education and fresh food.

Treasurer Scott Morrison has sought to distance the Government from what he has described as more "extreme" proposals, and it has been reported that health and education will remain exempt because of complexities in applying the indirect tax to these services.

But Professor Owler said it was nonetheless important to discuss why health should remain GST-exempt.

He said imposing a consumption tax on health would have a "very significant impact" on the cost of health care, particularly for the most unwell and chronically ill.

Consumption taxes, because they apply across the board, are seen as inherently regressive, and Professor Owler said that was particularly the case when they were applied to health.

"It doesn't get much more regressive [than] when it comes to health care, because this is going to be a tax on the sickest, most unwell people in our society; those who can least afford to pay a significant increase in health care costs," he said.

Professor Owler said Australian patients already paid among the highest out-of-pocket costs in the world for their health care, and adding a GST would exacerbate the situation, to the particular detriment of the poorest and sickest.

It has been suggested that the impact of a GST on health could be offset by compensation payments, but Professor Owler questioned the practicality of the idea, particularly in directing it to those who most need it.

He said if fresh food was to be kept GST-exempt, so should health care: "We are talking about excluding fresh food, presumably because we want to preserve people's health. So it makes no sense, then, to apply the GST to health care when people are actually sick and when they can least afford it".

ADRIAN ROLLINS

Domestic violence victims urged: talk to your doctor

AMA President Professor Brian Owler and Vice President Dr Stephen Parnis talk with Australian of the Year Rosie Batty at the launch of the *Share your story* campaign

Women suffering violence at the hands of their partners are being encouraged to speak with their family doctor amid concerns that many are failing to get the support they need.

AMA President Professor Brian Owler has joined with Australian of the Year Rosie Batty and AMA New South Wales President Dr Saxon Smith in launching the *Share your story* campaign to encourage victims of domestic violence to speak with their GP.

Professor Owler said doctors were at the domestic violence frontline, and saw the consequences of the physical and emotional abuse of women and children as part of their daily work.

"I remember when I started as a neurosurgeon at the Children's Hospital at Westmead, I was shocked - and in fact still am shocked - , at the number of cases that we deal with, the proportion of our work that is taken up with severe head injuries, devastating consequences of domestic violence," the AMA President said. "Some of them die in hospital; the vast majority end up with severe disability and are in need of lifelong care".

Ms Batty said the nation needed to do more to protect children from family violence.

"How does a child recover from the trauma of injury, psychological abuse, sexual abuse? How do they lead a life as adults when they are permanently affected by the trauma of being impacted by violence in their families?" she said. "The children are the future, and we are not doing a good enough job.

Ms Batty said that doctors had a big role in helping women in need.

Professor Owler said familiarity with the family doctor often made them the first port of call for those suffering abuse at home, even more so than specialist care.

"Everyone knows where to go if they want to see a doctor, but that's not always the case with domestic violence services," he said. "Domestic violence services are certainly there and ready to help, but they can be less visible than doctors in the community."

The *Share your story* campaign is complemented by a program to assist family doctors in identifying and supporting patients suffering domestic violence. Earlier this year the AMA joined with the Law Council of Australia in producing a guide for doctors in how to broach the issue of domestic violence with their patients, both victims and perpetrators, as well as canvassing legal obligations and detailing support services.

The AMA President said that the ability to provide support and find appropriate help was "a vital role that doctors, nurses, care workers play, both in helping to identify, but also in trying to support victims - whether they're women or children or anyone else, that are victims of this scourge in our community".

At the launch, Professor Owler sought to draw particular attention to the plight of children, who he said often suffered lifelong effects of domestic violence.

"We see large numbers of children that present through our hospitals that unfortunately are victims of domestic violence, and they have a range of injuries, including head injuries, eye injuries and fractures, [that can] have a devastating impact on the rest of their lives," the AMA President said.

He said non-accidental head injury, usually resulting in bleeding on the brain, was "very common" among children growing up in abusive households, and could lead to severe disability or other life-long impediments such as epilepsy and poor emotional control.

"The other side of this is...that we have children that are just exposed to domestic violence or abuse, and that can have significant consequences as well, particularly from psychological perspectives."

Between 2008 and 2010, 29 children were killed by a parent or step-parent, and Professor Owler said abuse by a parent or step-parent was the third most common cause of injury in children, after car accidents and accidental drowning.

ADRIAN ROLLINS

Holding children in detention 'a form of abuse': AMA President

AMA President Professor Brian Owler has condemned holding children in immigration detention as a form of Government-sanctioned child abuse and has praised the actions of Royal Children's Hospital doctors in refusing to discharge patients facing return to lock-up.

"Having children in detention is a form of abuse," Professor Owler said. "This is a systematic abuse of children that is sanctioned by the Government. There is no reason why we should have children in detention."

RCH doctors are refusing to discharge patients they believe will be returned to detention, putting them on a collision course with the Federal Government, which shows no signs of backing down from its controversial detention policy.

There has already been at least one stand-off between doctors and Immigration Department officials over the issue. Earlier this year, medical staff refused to discharge an asylum seeker mother and her infant without a guarantee that they would not be returned to detention.

Eventually the woman, who was suffering post-traumatic stress disorder and post-natal depression, and her child were released into the community.

The protest has since spread, with hospital staff around the country joining a Detention Harms Children campaign calling for the immediate release from immigration detention of all children and their families.

Professor Owler said it was well established that detention was harmful to health, especially for children.

"Detention centres are not suitable environments for the health of all detainees, but the effects on children are far worse," the AMA President said. "We know that many children suffer in these facilities, and are being exposed to things that no child should be exposed to. These children are being harmed, and it's going to have long-term consequences in terms of their psychological, but also physical, health."

It is believed about 200 children are currently being held in immigration detention centres – about 50 per cent of them in offshore facilities, and Immigration Minister Peter Dutton said the Government would not be changing its hardline policy regarding asylum seekers arriving by boat.

Mr Dutton told the *Sunday Herald Sun* that, while he understood the concern of doctors, "Defence and Boarder Force staff on our vessels who were pulling dead kids out of the water don't want the boats to restart".

The action by RCH doctors, which has been backed by Victorian Health Minister Jill Hennessy and RCH Chair (and former State Liberal Health Minister) Rob Knowles, follows the passage of the Border Protection Act, under which health workers and other detention centre staff who speak out about conditions face up to two years' imprisonment.

But Professor Owler said doctors had been put "in a very difficult position".

"We cannot send children back to an environment where they're going to be harmed.

"The Melbourne doctors are holding true to the ethics and principles of the medical profession in raising these concerns about the health of detained children. The AMA strongly supports them."

More than 400 RCH staff rallied on 9 October to voice their support for the doctors' actions, and to demand that children be released from detention – a call backed by the AMA.

"There is no reason why these children need to be in detention. It is not a deterrent for the boats to stop coming. This is a matter of human rights, it's a matter of stopping systematic abuse of children that is sanctioned by the Australian Government," Professor Owler said.

ADRIAN ROLLINS

Insurers put on notice amid spike in 'bill shock'

Private health funds are coming under increased scrutiny for possible misleading conduct and breaches of consumer protection laws amid mounting complaints about rising premiums and dud cover.

In findings that echo AMA concerns about the proliferation of what President Professor Brian Owler has labelled "junk" health policies, the competition watchdog has found that misleading, incomplete and unnecessarily complex information is hindering the ability of consumers to make an informed choice, leaving many unintentionally under-insured and at risk of so-called "bill shock".

> "Everything is going to be on the table in terms of how people might want the system to look or how they may want it not to look, what changes they may support and what changes they may not like"
> - Susan Ley

The focus on industry practices has been further sharpened by Health Minister Sussan Ley, who has announced the Federal Government will seek public comment on insurer behaviour, and has appointed former Australian Competition and Consumer Commission Chair Professor Graeme Samuel to advise on regulatory changes and other reforms "to enhance the inherent value proposition" of private health insurance.

"Consumers are becoming increasingly concerned with the value for money – or lack thereof – they are currently receiving from their private health insurance products," Ms Ley told the National Press Club.

The Minister said the Government would also conduct industry consultations to identify "inefficiencies and unnecessary regulatory burdens in the system that will free up private health providers to offer consumers the best value services available".

"Everything is going to be on the table in terms of how people might want the system to look or how they may want it not to look, what changes they may support and what changes they may not like," Ms Ley said, adding that changes to the regulatory burden could "free up private health providers to offer consumers the best-value services available".

But Professor Owler urged caution, warning of the risk that removing controls, particularly regarding insurer involvement in primary health, could lead to the introduction of US-style managed care.

"It does concern me when the Minister starts to talk about health funds being too tied up with regulation," Professor Owler told *Medical Observer*. "They're tied up in regulation because we know that without regulation we could have open slather, and we will go down the US managed care path, which is much more expensive and much less effective in terms of outcomes for patients."

Over-promise, under-deliver

His warning came as the Australian Competition and Consumer Commission gave notice that it will be "closely reviewing" the actions of health funds, including providing misleading and incomplete information that might leave consumer without the cover they expect, or facing surprise medical bills.

"Current trends in the private health insurance industry warrant a closer examination," the watchdog said in a report presented to the Senate on 20 October, warning of a "significant disconnect between consumers' expectations of the services and rebates they are entitled to receive under their policy, and the reality of the benefits their policy provides".

The watchdog said that although insurers appeared to be operating within the letter of the Private Health Insurance Act, some were making representations to consumers that, "when intertwined with policy variations, may be at risk of breaching the consumer laws".

The warning has come amid a surge in policyholders downgrading their cover in the face of rising premiums and the introduction of a means test for the private health insurance rebate.

While the private health insurance market is dominated by just five providers, there has been a massive proliferation in the number of policies on offer, with more than 20,000 on the market that include a huge range of benefits, exclusions, excesses, co-payments and waivers.

In a speech to the health insurance industry earlier this year, Professor Owler complained that all too often patients were unaware of exclusions and limitations in their health cover, and

he attacked the growth of "junk" policies that were designed simply to avoid the Medicare levy surcharge.

"The AMA would prefer to see a private health insurance market that does not have exclusion insurance products," he said. "Too often, my members see patients who think they have cover, but don't, because they purchased a cheaper product several years ago. Sometimes treatment is planned and surgery is booked, only to be cancelled shortly beforehand because the hospital's health fund check reveals that the patient is not covered."

Mind the gaps

The ACCC said the complex array of insurance policies on offer, combined with the intentionally obscure way in which many were presented and the frequent failure of insurers to adequately communicate policy changes to existing customers, meant many were unaware of the extent of their cover.

While 52 per cent of insurance policies had exclusions in 2012-13, more than half of policyholders were unaware what, if any, exclusions were in their own cover.

The ACCC said that at least part of this complexity and obfuscation arose from the incentive for the big insurers to present information in a complex and confusing manner to help deter policyholders from switching funds.

It found that while almost half of policyholders contemplated changing to a different insurer, only 14 per cent actually carried through on the idea.

Much of this is because of the difficulty in trying to compare policies between insurers, who often use different terms and definitions for their products.

Instead, the ACCC found that, faced with a blizzard of options, consumers were increasingly being forced to rely on price as the only readily comparable factor between policies.

Though acknowledging that price was a legitimate consideration for consumers, the watchdog warned that such a narrow focus could be risky.

Insurers have responded to the increase price-sensitivity of consumers by introducing policies that trade off lower premiums for multiple exclusions, bigger excesses and other carve-outs that often go unrecognised by their customers, leaving them "unintentionally under-insured".

Increasingly, consumers caught out like this are turning to the Private Health Insurance Ombudsman, who has seen a big spike in consumer complaints, particularly regarding inadequate information and unexpected expenses.

The Ombudsman received 3427 complaints in 2013-14 – a 16 per cent jump from the previous year, and in the March quarter 2015 they were up 23 per cent from a year earlier. A large proportion related to unexpected out-of-pocket expenses and "bill shock".

ADRIAN ROLLINS

PRIVATE HEALTH INSURANCE by the numbers

47 per cent of Australians have hospital cover

55 per cent have extras cover

$21 billion – total revenue in 2014-15

$29 billion – projected total revenue in 2019-20

6.4 per cent – estimated annual revenue growth

$1.5 billion – total annual profit

$970 million – total annual industry wage bill

34 - number of insurers

The top five insurers dominate the market:

medibank For Better Health	29.1% market share
Bupa	26.7% market share
HCF	10.7% market share
nib	7.7% market share
hbf	7.4% market share

Forcing GPs to adopt half-baked e-health record a dud idea: AMA

The AMA has criticised Federal Government plans to force doctors to adopt its MyHealth Record e-health system before fundamental shortcomings have been fully addressed.

The Government has proposed that GP Practice Incentive Program e-health payments be tied to doctor use of the MyHealth Record (MyHR) system being developed to replace the $1 billion Personally Controlled Electronic Health Record scheme. The PCEHR has been dumped amid dismal take-up rates among patients, doctors and medical practices.

But AMA President Professor Brian Owler said the MyHR system was far from fully developed, so using PIP incentives to get doctors to sign up was ill-considered and premature.

"The MyHealth Record is not at a stage where it can be adopted by practices, so it should not be linked to the PIP scheme," Professor Owler said. "There are fundamental issues with the design of the MyHR that are yet to be fully addressed."

The AMA has detailed a long list of problems with the current version of the system in a submission to the Health Department, including:

- the ability of patients to remove information from view, making the record potentially incomplete and of no clinical value;
- no flags to indicate if information has been removed from view;
- radiology or pathology results are not yet included;
- the shared health summaries are not automatically updated, rendering them quickly out-of-date; and
- inaccuracies occur in the upload of data.

In addition MyHR, in its current iteration, remains an 'opt-in' system.

The reliance on patients to sign up for an e-health record was seen as a fatal weakness of the PCEHR, and a three-person review of the system recommended that MyHR be an opt-out scheme.

But Health Minister Sussan Ley has indicated that the opt-out approach will first be trialled next year before being adopted.

The Minister told the National Press Club that about one million people living in the Nepean-Blue Mountains region and far north Queensland would take part in an "all-inclusive" trial of MyHR early next year.

"It's important that all Australians are signed up to ensure we have a functioning system, and trialling an opt-out model means we can do it carefully, methodically and ensure the appropriate protections are in place to give patients peace of mind," Ms Ley said.

"If automatic registration for a digital health record in the opt-out trials leads to higher participation in the MyHealth Record system, the Government will consider adopting opt-out on a national scale."

But Professor Owler said that until these and other problems with MyHR are adequately addressed, GPs should not be expected to adopt it.

"Until the problems with the MyHR have been rectified, so that it is easy to use and offers real clinical benefits for patients, it is unreasonable to expect GPs to actively use it," the AMA President said."The AMA has been a strong advocate for a well-designed and governed e-health record which can deliver real benefits for patients, but the current MyHR model has well-known flaws that must be fixed."

The AMA has recommended the Government focus on rectifying problems with MyHR rather than trying to force GPs to use a system that is cumbersome and incomplete.

Even when the system is complete and fit for use, the AMA has argued that, instead of using the existing e-PIP incentive, the Government instead create a Medicare Benefits Schedule item and a Service Incentive Payment scheme to promote its use.

To help establish MyHR, Ms Ley has announced the appointment of former National Mental Health Commission Chief Executive Robyn Kruk to head an 11-member eHealth Implementation Taskforce Steering Committee.

The Committee, which includes Dr Hambleton, will design, implement and oversee the establishment of the Australian Commission for eHealth.

For its part, the Commission will oversee the operation and development of e-health systems, including operating the MyHealth Record system.

Revised eligibility requirements for the e-Health Incentive are due to be announced in November 2015, and to commence from 1 February 2016.

The AMA submission can be viewed at: at https://ama.com.au/submission/ama-submission-proposed-changes-pip-ehealth-incentive

ADRIAN ROLLINS

A health record for all to share

Patients will have full access to use and share their electronic health record as they see fit, including sharing with retailers and IT developers, under a radical proposal outlined by Health Minister Sussan Ley.

Ms Ley said it was time Government "got out the way" and allowed consumers to have open-source access to all their health data, enabling them to use and share it as they liked.

"What if we, as Government, got out the way and gave consumers full access to their own personalised health data and full control over how they choose to use it?" she said. "It's a revolutionary concept in health – but it shouldn't be – given it's already happening with industries like finance across the globe," the Minister told the National Press Club.

But a parliamentary committee on human rights has already raised concerns about possible privacy breaches around the storage and use of health records uploaded to the central database of the MyHealth Record system.

The committee, chaired by former Howard Government Minister Philip Ruddock, said the proposed system raised significant privacy concerns – particularly the proposal that a person's electronic health record be automatically uploaded to the database unless they actively opted out of the arrangement.

Mr Ruddock questioned whether such an approach justified the potential breach to privacy.

He told Parliament that there need to a be substantial concern, not simply pursuit of a desirable outcome, to justify limiting human rights.

Ms Ley said consumers already had control of personal data in industries like finance and banking, and patients should be similarly able to use their personal health information to create a portfolio of products and services specifically tailored to their health needs.

"What if you, as a consumer, were able to take your personal Medicare and Pharmaceutical Benefit Scheme data to a health care service; to an app developer; to a dietician; to a retailer and say how can you deliver the best health services for my individual needs?

"Why can't we allow someone's doctor to use an app developed on the free market to monitor their patient's blood pressure at home following an operation, or keep a real time count on their insulin levels?

"The answer is – we can, and allowing consumers open-source access to their health data is the way to do it," the Minister said.

Ms Ley said this was an area she was "keen to explore" as a way to give patients greater control over their health.

ADRIAN ROLLINS

Car technology can make zero road toll a reality: AMA President

AMA President Professor Brian Owler calls for mandatory fitting of autonomous emergency braking at the Australasian Road Safety Conference

Advances in car safety technology mean achieving a zero road toll is now within the nation's grasp, AMA President Professor Brian Owler has told a road safety conference.

Urging government and consumers to demand that the latest life-saving equipment be fitted as standard to all new cars, Professor Owler told the Australasian Road Safety Conference on the Gold Coast that although motorists needed to drive with greater care, the widespread adoption of proven technologies that improved car safety and mitigated human error was "the future of road safety".

"It is the game changer that mitigates our human faults," he said. "It is the tool we have to truly move towards zero fatalities and serious injuries on our roads."

Earlier this year the AMA and the Australian New Car Assessment Program (ANCAP) jointly called for autonomous emergency braking (AEB) – in which the brakes are automatically applied if the driver fails to take action to avoid an impending collision – to be fitted to all new cars.

Evidence indicates the technology cuts the incidence of rear-end collisions by more than 38 per cent.

Professor Owler, who is the public face of New South Wales' successful *Don't Rush* road safety campaign, told the Conference that developing safer cars did not lessen the need to improve driver behaviour.

He took particular aim at what he saw as societal acceptance of risky behaviour on the roads.

"There are cultural issues, and even rites of passage, that make some young people think that speeding and disobeying the road rules is something tough, something cool or something to be admired.

"There are no survivors of road trauma who think this way."

The AMA President said compulsory seatbelt and drink-driving laws, complemented by education and awareness campaigns, had shown that modifying driver behaviour was possible, though the process was lengthy and difficult.

And, he added, improving driver behaviour and choices did not eliminate the capacity for human error, which contributed to 90 per cent of crashes.

Professor Owler said people should not die, or endure life-long pain and impairment, because of a split-second mistake, which was why there should be widespread adoption of proven life-saving technology in cars.

Car companies are fitting AEB as standard equipment in Europe, the United States and Japan, and the AMA President said there was no reason why Australia should be left behind.

There have been objections that making AEB mandatory will increase the cost of new cars – industry estimates an additional cost of up to $200 per vehicle.

But Professor Owler said this was little price to pay for technology that would save lives, and asked why Australian life should be valued any less than one in Europe or North America.

"Australians," he declared, "should be driving the safest vehicles on our roads".

ANCAP aims to pressure car companies to fit AEB in Australia vehicles by making it impossible from 2018 for a car to get a five-star crash rating without the technology.

Professor Owler said consumers needed to exert similar pressure.

"The fastest way to have vehicles with these features as standard is through consumer demand," he said, urging large fleet purchasers in particular to demand advanced life-saving equipment as standard in their vehicles.

The AMA President said it was not good enough to aim simply at reducing road fatalities and injuries.

Advances in technology meant the elimination of road trauma was a practical goal.

"There is no acceptable number of deaths, as there is no acceptable number of serious injuries," he said. "Towards zero is not an aspirational target. For Australia, we must make zero the reality. We have the ability to do this."

ADRIAN ROLLINS

Govt's 10-year plan to achieve Indigenous health goals

Cutting smoking and boosting vaccinations and child health checks are among 20 specific goals set out by the Federal Government as part of a 10-year plan to close the gap in Indigenous health.

In a much-anticipated announcement, Rural Health Minister Fiona Nash has detailed a series of targets to help guide the implementation of the National Aboriginal and Torres Strait Islander Health Plan released two years ago.

Among the goals, the Government has committed to trebling the proportion of Indigenous toddlers who have a least one health check in their first four years of life to 69 per cent by 2023, raising the immunisation rate among one-year-olds to 88 per cent (from 85 per cent) and increasing the proportion of Aboriginal youth who have never smoked from 77 to 91 per cent.

Senator Nash said these and 17 other goals covering areas including the incidence and management of diabetes and the health of pregnant women will be used to measure progress in Indigenous health under the National Plan.

The document, developed in consultation with Indigenous groups including the National Health Leadership Forum, also sets out changes needed to make the health system more comprehensive and responsive to the needs of Indigenous people.

Senator Nash's announcement followed a call from the AMA for the Federal Government to make improved Indigenous health a whole-of-government priority.

The peak medical body has issued a Position Statement in which it urges the Government to take concrete steps to close the health gap, including working with Indigenous people on standards for the provision and access of Aboriginals and Torres Strait Islanders to all Government services, boosting funding for Indigenous primary health care services, and more training places to address the shortfall in health professionals providing Indigenous care.

AMA President Professor Brian Owler said the targets set by the Government to reduce health inequalities were "admirable", but genuinely collaborative action was needed to achieve meaningful improvement.

Professor Owler said it was unacceptable that the substantial health gap between Indigenous Australians and the rest of the community continued to persist.

"It is tragic that, as a wealthy nation, we still struggle to provide adequate health care to 3 per cent of our population," Professor Owler said, and argued that a whole-of-government approach was need to close the gap.

"All current and future policies addressing education, employment, poverty, housing, taxation, transport, the environment and social security should be assessed according to their impact on health and equity," he said. "Equal health outcomes will not be achieved until economic, education and social disadvantages have been eliminated."

While Senator Nash has won plaudits for announcing the health targets, the strength of the Government's commitment to improving Indigenous health has been clouded by a number of recent funding cuts, including to anti-smoking programs in Indigenous communities and the decision to slash $596.2 million from the Health Flexible Funds, many of which have been used to finance health programs for Aboriginal and Torres Strait Islander people.

Professor Owler said these cuts had affected targeted programs aimed at reducing the health gap, improving responses to communicable diseases and providing substance abuse treatment services.

Professor Ian Ring, Professorial Fellow at the Australians Health Services Research Institute at the University of Wollongong, said that Senator Nash's announcement of a strategy to implement the National Aboriginal and Torres Strait Islander Health Plan was "potentially a game changer".

Professor Ring said the strategy, for the first time, addressed the question of what services and workforce is required to close the gap, and identified those areas with the poorest health, with a view to making them a priority in building capacity.

Writing in *The Canberra Times*, he said the goals set out by Senator Nash were achievable, "but require high quality services delivered in the right way".

And he warned that setting targets in and of themselves was not a solution.

"The targets identified in the [plan] seemed to have been framed to present predictions from current trajectories and rather miss the point," Professor Ring wrote. "A target is an aspiration, not a prediction, and needs to bear a logical relationship with the overall goal."

He said the scale of health gains to be achieved was "closely linked" to the extent of service enhancements.

"For this reason, the critical targets at this stage are those for service provision," he added.

ADRIAN ROLLINS

Never-ending intern, training crisis looms again

> "... modelling by the former Health Workforce Australia indicated the nation was facing a shortfall of 569 first-year advanced specialist training places by 2018, increasing to 689 places in 2024 and 1011 places in 2030"
>
> - Professor Brian Owler

Hundreds of medical graduates and junior doctors face missing out on vital training places in the next two years without urgent investment by Federal, State and Territory governments, the AMA has warned.

As aspiring doctors and specialists scramble to secure internships, prevocational and vocational positions, the Association has urged governments to honour existing training funding commitments and lift their investment in specialist education if the country is to avoid a looming shortage of doctors.

Medical graduates in South Australia are facing uncertainty following indications the State Government is preparing to renege on its commitment to fund internships for all SA medical graduates.

The AMA has warned that, on current projections, 22 SA medical graduates will miss out on an internship in the State in 2017, rising to 39 in the following year.

Further along the training pipeline, the AMA has told a Health Department review of the Specialist Training Program (STP) that the number of places provided under the scheme will increasingly fall short of what the nation needs.

AMA President Professor Brian Owler said modelling by the former Health Workforce Australia indicated the nation was facing a shortfall of 569 first-year advanced specialist training places by 2018, increasing to 689 places in 2024 and 1011 places in 2030.

He warned this would have knock-on effects throughout the medical training pipeline, and there are concerns it could leave the nation short of the specialists it needs to meet future demand.

HWA predicted general practitioners, psychiatrists and anaesthetists, in particular, could be in short supply by 2030, and the problem will be especially acute in rural and regional areas.

Professor Owler said the Government should boost the size of its well-regarded STP program from 900 to 1400 places by 2018, and to 1900 places by 2030.

"We should now be trying to improve the distribution of the medical workforce and encouraging future medical graduates to train in the specialties where they will be needed to meet future community need for healthcare services," he said.

Until now, much of the growth in training opportunities has been at the undergraduate level. In the past decade there has been a 150 per cent jump rapid expansion in the number of medical school places, and currently there are 3736 students enrolled nationwide.

But the AMA and the Australian Medical Students' Association have warned that much of this investment will be wasted without a commensurate increase in intern, pre-vocational and specialist training places.

Modelling undertaken for the *Australia's Future Health Workforce* identified an emerging mismatch between trainees and the number of vocational training places, with a shortfall of around 1000 places by 2030.

Professor Owler said this was particularly concerning because the pressure on intern places nationwide meant there was no guarantee that SA graduates unable to secure a place locally would be offered an internship interstate.

In its submission to the STP review, the AMA urged that the

program be used to help address current and developing workforce shortages in particular specialties and regions.

It said the program could make an important contribution to relieving shortages in the specialist workforce in rural areas by increasing the priority given to providing training positions in rural and regional areas.

Already, 41 per cent of STP training positions are in rural Australia, but the AMA has argued this should be increased, in part by shifting away from the current emphasis on one-year placements to a structure that instead supports clear and co-ordinated pathways for trainees interested in pursuing rural careers.

It said STP funding could support the establishment of regional training networks - vertically integrated networks of health services and regional prevocational and specialist training hubs – which the AMA has proposed as a way of remedying chronic rural workforce issues by enhancing generalist and specialist training opportunities and supporting prevocational and vocational trainees to live and work in regional and rural areas.

"Medical training does not stop at the gates of the medical school," Professor Owler said. "We have seen a massive investment in extra medical school places, which must not be allowed to go to waste.

"It is important that all governments look beyond the intern year. With medical workforce planning data showing shortfalls in specialist training places, we need investment across the medical training pipeline," he said.

ADRIAN ROLLINS

INFORMATION FOR MEMBERS

Changes to National Standard

Changes to national standard for user-applied labelling of injectable medicines, fluids and lines.

New labelling standards assisting health professionals to identify injectable medicines and fluids removed from their original packaging have been released by the Australian Commission on Safety and Quality in Health Care.

The National standard for user-applied labelling of medicines, fluids and lines replaces the *National recommendations for user-applied labelling of injectable medicines, fluids and lines* released in 2012.

Key changes to the revised labelling standard include:

- Principles to develop standardised, pre-printed labels for injectable medicines and fluids in closed practice environments, including the operating room, procedure rooms and interventional cardiology and radiology.
- Improved identification of anticoagulants.
- Enteral container and line labels to help prevent errors associated with inadvertent delivery of enteral medicines via the parenteral route.
- Catheter lock label to help prevent errors caused by inadvertently administrating medicines held as a lock in a central venous access device.
- Inhalation label to prevent medicines intended for nebulisation drawn up by syringe being injected in error.

For more information about the updated labelling standard visit http://www.safetyandquality.gov.au/our-work/medication-safety/safer-naming-labelling-and-packaging-of-medicines/user-applied-labelling/

KIRSTY WATERFORD

Dedicated service major advance in doctor health

AMA Vice President Dr Stephen Parnis urges doctors to attend to their own well being at the Australasian Doctors' Health Conference 2015

The AMA is on target to establish a national network of dedicated doctor health services by the end of 2016, Vice President Dr Stephen Parnis has revealed.

In a major speech to the biennial Australasian Doctors' Health Conference, Dr Parnis said the establishment of the network was a "very significant and positive initiative" that would boost the level of support to the profession.

Focus on the health of doctors, particularly their mental wellbeing, has intensified in recent years amid mounting concerns around very long and disruptive work hours, substance abuse, and workplace bullying and harassment.

The issue of workplace bullying and harassment has come in for particular attention in recent months after vascular surgeon Dr Gabrielle McMullin complained that female trainees were being pressured for sex by senior surgeons.

A survey of 3500 people subsequently conducted by the Royal Australasian College of Surgeons found about half of surgeons, trainees and international graduates had suffered some form of abuse. In all, around 60 per cent of women reported they had been bullied and around 30 per cent said they had been sexually harassed.

Dr Parnis told the Conference that he had personal experience of the many serious stressors doctors face during their working life, and the growing willingness to acknowledge and address them was a welcome development.

"I have been an advanced trainee in surgery, and I have had personal experience of some of the issues uncovered this year," the Vice President said.

"I have sought the advice and care of medical colleagues when I have found the pressures of my career overwhelming [and] I have grieved for friends and colleagues who have harmed themselves or taken their own life."

Dr Parnis told the Conference that, rather than indulging in a culture of finger-pointing and blame, the medical profession needed to promote good health and health lifestyles for its members.

He said the establishment of a national network of dedicated doctor health services was an important part of this process.

The Medical Board of Australia is providing the AMA $2 million a year, indexed to inflation, to establish and oversee a nationally consistent suite of health, advice and referral services for doctors and medical students available in all states and territories.

To deliver this, the AMA has created Doctors' Health Services Pty Ltd, a wholly-owned subsidiary, to co-ordinate the delivery of services that are at arm's length from the Medical Board.

An Expert Advisory Council, chaired by Dr Kym Jenkins of the Victorian Doctors' Health Program and including representatives of existing health services, medical students and doctors in training, will help guide its development and operations.

Dr Parnis said the development of the national service was "progressing well, and the programs are on target to be operational by the end of next year".

"We will all end up being a patient at times during our career, and the challenge is to practise what we preach to our own patients," the Vice President said. "We need to be honest, to be open to uncomfortable advice from our doctors, and to recognise our own limitations."

He said the development of the national doctor health service was "a very significant and positive initiative" that would boost the support available to doctors.

"To care for one's colleagues is not an easy thing, because it entails significant risk," Dr Parnis said, "but there are real rewards and satisfaction for those who do."

ADRIAN ROLLINS

General practice accreditation framework close to reality

BY DR BRIAN MORTON, CHAIR, AMA COUNCIL OF GENERAL PRACTICE

Over the last 12 months, the AMA has been part of consultations being undertaken by the Australian Commission on Safety and Quality in Health Care (the Commission) on the future of general practice accreditation.

This has, in turn, informed work being undertaken by the Commission and the Royal Australian College of General Practitioners (RACGP) to develop a governance and reporting framework for general practice accreditation in Australia. This work was commissioned by the Department of Health.

> Throughout this process the AMA has maintained its support for a model of general practice accreditation that is profession-led

Throughout this process the AMA has maintained its support for a model of general practice accreditation that is profession-led.

We have highlighted how the costs of accreditation are a barrier to greater participation, and how these costs could be reduced through a more integrated and streamlined process. In particular, practices involved in teaching and training are subject to multiple accreditation processes which often look at the same accreditation criteria.

Most stakeholders believe that accreditation has played a role in driving improvements in safety and quality in general practice.

The AMA believes, however, that rather than just being a measure of conformance at a particular point in time, it is important that accreditation encourages self-directed improvement. Feedback from accrediting agencies about a practice's performance against RACGP Standards for General Practice is essential for driving further improvement.

The practice accreditation scheme the Commission has proposed will include the following key elements:

1. a governance framework to provide national coordination of general practice accreditation;
2. approval of accrediting agencies to enable the coordination of agencies

performing assessments to the RACGP Standards; and

3. the collection of accreditation data and evaluation of accreditation outcomes information.

The AMA voiced significant concerns with the Commission's initial proposal, particularly regarding the breadth of proposed scheme and the potential for greater Government control over accreditation.

What the Commission proposed went well beyond the bounds of earlier Australian National Audit Office recommendations that said the Health Department needed to develop a means to inform itself about the quality of general practice accreditation.

As part of the Commission's proposed governance framework, a Coordinating Committee would be established to provide oversight of the coordination of general practice accreditation, and the data to be collected and reported. It would also review and interpret accreditation outcomes data, provide input into the accrediting agency approval process, report on de-identified general practice accreditation outcome information, and provide oversight for any appeals process. AMA advocacy has ensured that, contrary to the Commission's initial proposal, the Department will not be part of the Coordinating Committee.

The General Practice Accreditation Scheme should provide practices with more information about their accreditation assessment. Also, it provides a mechanism for raising concerns about the application of standards, and to progress complaints and appeals regarding accreditation decisions through an independent body.

The Scheme will facilitate the development of resources and support that practices may need, as well as ensuring greater consistency in the standards of accrediting agencies and the skills of their surveyors.

The Commission is currently working towards finalising the framework and intends preparing a communication strategy for implementation. The AMA will be consulted further on this early in the New Year.

Evidence alone won't change what doctors do

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

> "… if you want people to make wise decisions, you need to make it easy for them – making healthy choices easy choices. Otherwise not much will change"

In the ABC *Four Corners* program 'Wasted', broadcast on 28 September, presenter Norman Swan drew attention to the lack of evidence of effective contribution to care of four procedures: x-rays of the lower back, arthroscopies for knee pain, the investigation of chest pain and PSA testing for prostate cancer. Hundreds of millions of dollars go to pay for these procedures which, on aggregate and as assessed using clinical trials, add nothing to health. The tests can also cause damage.

A 13-member review taskforce, announced in April well before Four Corners, is now working to assess the current list of 5500 Medicare items. The list has grown since the 1950s with little critical review. Seventy per cent of the 5500 items have not been apprised since inclusion. The background to the review is well explained at http://www.health.gov.au/internet/main/publishing.nsf/Content/MBSReviewTaskforce.

That such a gap exists between the data from trials as to what constitutes effective care, and what we actually do in practice may suggest perversity and stubbornness on the part of practitioners. This implication has provoked vocal pushback to the *Four Corners* program. Surely, the argument runs, the doctor should be the one to decide what tests to do for a patient and what therapy to prescribe. It is almost certainly untrue in my opinion.

We know from health promotion efforts to encourage people to adopt a healthy lifestyle, be it restrained drinking or avoidance of fatty foods, that a focus on the individual goes only a short distance towards success.

The social context in which people live contains major forces that determine their choices. Individual resolution and intention will not save us, either with regard to our diet or medical practice.

We should not expect evidence alone to change the behaviour of individual doctors, any more than dietary advice to weighty individuals will set them on a path to slender normality.

A program in the US designed to encourage physicians to restrict their use of interventions that are of unproven value does not appear to be going well (see Rosenberg A, Agiro A, Gottlieb M, et al. Early trends among seven recommendations from the Choosing Wisely campaign. JAMA Intern Med 2015; published online 12 Oct, doi:10.1001/jamainternmed.2015.5441.

http://archinte.jamanetwork.com/article.aspx?articleid=2457401).

As summarised in the *British Medical Journal* (BMJ 2015;351:h5437 doi: 10.1136/bmj.h5437, published 13 October 2015), the study included several million enrolees in the Blue Shield and Blue Cross insurance schemes.

The seven services listed in 2012 that the *BMJ* reported were targeted for reduced use were "imaging tests for headache with uncomplicated conditions; cardiac imaging in patients without a history of cardiac conditions; preoperative chest x-rays when history and physical examination results are unremarkable; low back pain imaging for patients without a history of cancer or fever; human papillomavirus (HPV) testing for women under 30; antibiotic use for acute sinusitis; and prescription of non-steroidal anti-inflammatory drugs for patients with chronic conditions that can be worsened by these drugs, such as hypertension, heart failure, or chronic kidney disease."

The researchers looked at trends in claims for these seven interventions and found nothing much had changed despite the Choosing Wisely campaign. Information alone did not alter their use in general practice. Why this should be so is not clear, and until the power of the context in which the practitioners are exposed to the rhetoric of the Choosing Wisely campaign is better understood, there is no explanation.

To revert to the analogy with health promotion, if you want

people to make wise decisions, you need to make it easy for them – making healthy choices easy choices. Otherwise not much will change.

Clearing the MBS of items that have no evidence of effect might be a good move to modify the environment, so that if patients insist that they want a test for which no evidence of benefit exists, they pay for it. But on its own not much is likely to happen.

The BMJ article quotes comments from Ralph Gonzales, Associate Dean for Innovation in the medical faculty at University of California, San Francisco, and Adithya Cattamanchi, a Professor of Medicine from the same institution, who wrote a paper recently entitled, Changing clinician behaviour: when less is more (Oct,doi:10.1001/jamainternmed.2015.5987), in which they reported that awareness of guidelines is insufficient to change clinicians' behaviour.

"The Choosing Wisely recommendations—even though created and distributed by trusted professional societies—are only a starting point," they wrote. "To actually reduce wasteful medical practices, delivery systems and clinician groups must (1) accept and commit to the Choosing Wisely challenge, and (2) develop and implement strategies that make it easier for clinicians to follow Choosing Wisely recommendations."

I take the second of those points most seriously. I doubt that we will see big shifts in medical practice as a result of evidence alone. To achieve those alterations requires change management at a level of sophistication that we have not yet seen in this land. We should stop kidding ourselves.

Those tightly bonded to the value of evidence in deciding which tests are good value should extend their interest to include evidence-based assessments of how to change medical practitioners' behaviour.

INFORMATION FOR MEMBERS

AMA LIST OF MEDICAL SERVICES AND FEES

The 1 November 2015 edition of the AMA Fees List is now available both in hard copy or electronic format.

Members listed as being in private practice or with rights of private practice, and salaried members who have requested a hard copy should have received their AMA Fees List Book by 31 October 2015.

The AMA Fees List is available in the following electronic formats; a PDF version of the hard copy book, a CSV file for importing into practice software, as well as an Online database where members can view, print or download individual items or groups of items to suit their needs.

The PDF and CSV versions of the AMA Fees List are now available to all members via the Members Only area of the AMA website http://www.ama.com.au/resources/fees-list. The Fees List Online Database has been updated as of 2 November 2015.

To access this part of the website simply enter your username and password by clicking on the symbol in the right corner of the blue task bar at the top of the AMA homepage and follow these steps.

1) From the home page hover over **Resources** at the top of the page. A drop down box will appear. Under this, select **Fees List**.
2) *For the PDF and CSV* - Select first option, **AMA List of Medical Services and Fees - 1 November 2015 (Members Only)**.
3) Download either or both the **CSV** (for importing into practice software) and **PDF** (for viewing) versions of the AMA Fees List.
4) *For the Fees List Online Database* - **Select AMA Fees List Online Database (Members Only)**
5) Click on the link to open the AMA Fees List Online Database, or alternatively the database can be accessed directly via http://feeslist.ama.com.au.

Also available to members is the AMA Fees Indexation Calculator, this allows you to calculate your own fee increase based on your individual cost profile. To access the AMA Fees Indexation Calculator, follow these steps:

1) From the home page hover over **Resources** at the top of the page. A drop down box will appear. Under this, select **Fees List**.
2) Select AMA Fees Indexation Calculator (Members Only)

Members who do not currently have a username and password should email their name, address and AMA member services number to **memberservices@ama.com.au** requesting a username and password.

If you did not receive your hard copy of the 1 November 2015 AMA List of Medical Services and Fees or would like one, please contact the AMA on 02 6270 5400 or email feeslist@ama.com.au.

The universal truths of medical training

BY DR DANIKA THIEMT, CHAIR, DOCTORS IN TRAINING COMMITTEE

It is a truth universally acknowledged that a Government in possession of a valued health care system must be in want of a sustainable, locally-trained medical workforce.

A truth so universally acknowledged that, in 2006, the states and territories were granted extra medical school places by the Commonwealth on the condition they guaranteed to provide intern-training places for domestic medical graduates. Of course, everyone happily agreed.

> "Perhaps most worryingly, rather than scrambling to ensure the ongoing development of a robust medical workforce, it appears that South Australia is instead going to breach the COAG agreement, leaving 22 graduates without jobs"

As medical graduate numbers continued to rise, this agreement became harder and harder to uphold.

Bound to the agreement, the states and territories continue to provide internships to their local graduates in the hopes of securing that ever-coveted sustainable workforce.

But, as time goes on, truths change.

Last month, we saw reports from South Australia suggesting that up to 22 locally-trained domestic graduates will miss out on an internship from 2017. These numbers look set to rise in 2018, up to 39.

Perhaps most worryingly, rather than scrambling to ensure the ongoing development of a robust medical workforce, it appears that South Australia is instead going to breach the COAG agreement, leaving 22 graduates without jobs.

While we may be speaking about small number in the greater scheme of medical training we, as a profession and a society, have made a significant investment in the training of these 22 graduates. Without the ability to complete an internship, these individuals will be unable to join our workforce and serve our community.

Not only is this a waste of incredible talent, but would also be short-changing the Australian people. We cannot afford to waste the significant investment we make in any of our nearly 4000 medical graduates each year.

Logically, a shortage in intern places is merely a precursor of what is to come further along the medical training pipeline.

Work by the now-disbanded Health Workforce Australia projected a shortfall of 569 vocational training places by 2018, rising to 1011 places by 2030.

This means that doctors in training will be soon be without the opportunity to progress to specialist practitioners, leaving the Australian people without access to doctors in the areas and specialities that they need the most.

In short: the training crisis is not coming, it is already here. We seem to be in the middle of it before we even knew it had begun.

The South Australian Government needs to be held to account over its failure to commit to providing medical internships to domestic graduates from local medical schools.

Additionally, the AMA calls on all states and territories to re-affirm past COAG commitments.

We know that there are a sufficient number of graduates making their way through the training pipeline.

However, graduates require vocational training to progress and, without adequate investment into training places, we will never build the health workforce we need.

There needs to be Federal leadership regarding the expansion of vocational training.

We call on all Health Ministers to work closely together in the funding, planning, and coordination of medical training places. Medical training needs to be a priority agenda item not only for our Federal leaders, but also for all states and territories.

Not only is Australia in want of a well-trained and sustainable medical workforce, we deserve one - and are within reach of establishing one.

Now, we just need to separate the universal truths from the politics.

To view the letter the AMA has sent to Health Minister Sussan Ley on the issue, visit: https://ama.com.au/media/medical-training-must-be-priority-health-ministers

#InternCrisis worsens

BY JAMES LAWLER

In the early 2000s the Federal Government began funding new medical schools in response to reports of an increasing shortage of doctors in Australia.

This was the obvious policy response and, at the time, every new medical school (including several established while Tony Abbott was Health Minister) was lauded as a success. As a result, the number of medical graduates has nearly doubled in the past ten years.

Soon enough, the attention shifted from medical student numbers to the availability of internships and training positions at some undefined point in the future. There seemed to be little interest from decision makers in the problem, since a) it was poorly understood, b) it seemed some years away and c) it's a difficult problem to solve – universities educate medical students with federal funding, but hospitals, colleges and state governments train the graduates. The Council of Australian Governments did, however, guarantee internship positions for all domestic medical graduates.

In late 2012, the problem seemed to come to a head, and pressure from AMSA, the AMA and other groups led to increases in training positions from State governments, as well as a $10 million commitment from the-then Labor Government, to find more positions.

The incoming Coalition government committed to a Commonwealth Medical Internship Initiative in 2013, to fund up to 100 extra internships each year for four years in non-traditional settings such as private hospitals and rural areas.

Despite the best efforts, the bureaucracy of the current system has been an issue.

While applications were submitted, in most instances, in May, and offers began to be released in July, there are still hundreds of students waiting for positions, with a significant number of positions still remaining.

The states have done their best to eliminate the confusion caused by students accepting offers in two places, and by the practice of taking students who have accepted offers in one State and placing them somewhere else. But, until there is a nationally co-ordinated system for internship allocation, we will continue to lose graduates overseas while they wait for the states to sort out their processes.

A new development occurred in South Australia this year. A ministry official from SA Health met with some student representatives to politely inform them that up to 10 per cent of the domestic graduates who had trained in South Australia would have to look to other states for internships. A subsequent bunch of questions from journalists to the South Australian Health Minister had Jack Snelling promising that there would be internships for South Australian graduates. But it isn't clear how long that guarantee will last for, or if those jobs will be in South Australia.

The universities must share some of the blame. The only students to miss out on internships so far have been international students. These students had a medical degree promoted to them, and came out to this country with high hopes of starting a career. Their fees help fund medical education for universities as a whole. However, most of them were not aware that internships might not be available upon their graduation.

While the situation for those seeking internships is somewhat perilous, spare a thought for those prevocational doctors who are applying for specialist positions – not only are positions limited, but there is very little data to show what the state of affairs actually is.

Ultimately, something will have to give – either universities will need to be more tightly regulated regarding their student numbers; State governments, colleges and hospitals will have to make more training room, or students and young doctors will give up and work elsewhere.

We need leadership. The Council of Australian Governments needs to come together and work on a plan for medical training in Australia, and finish what was started more than a decade ago.

To treat or transport?

BY DR DAVID MONASH IS A GP BASED IN SALE, VICTORIA

> "The key component of regional care that is missing is specialist services, and the allied health support services that come with them"

In 2002, the Department of Human Services Victoria commissioned the development of a Cancer Services Framework. Following this, in 2008, Victoria implemented the Cancer Action Plan, which recommended that Tumour Streams be developed to reduce unwanted variation in practice.

This resulted in the establishment of centres of excellence for patient care based principally in the metropolitan areas.

Hospitals being supported financially to comply with the requirements of the Optimal Pathways of Care (OPC) determined where these centres would be located.

Have health outcomes in Gippsland improved as a result of this work? No.

The Regional Health Status Profile Report (Gippsland 2012) reveals that in the 10 years since the development of optimal treatment pathways, the health outcomes for Gippslanders have actually deteriorated and remain the worst in Victoria.

This report reveals that rates of diabetic complications, heart disease, renal failure and dialysis, cancer diagnoses, avoidable deaths (including deliberate self harm) and respiratory disease are significantly worse than other regions in Victoria. This is despite primary care being in relatively good shape - the number of GPs per capita in Gippsland is only slightly below the level of other regions of Victoria.

The key component of regional care that is missing is specialist services, and the allied health support services that come with them. The level of specialists per capita in Gippsland is one-third the average number in Victoria. This is a direct result of the decisions made regarding OPCs.

Because local hospitals are starved of funds and effectively prevented from providing the resources needed to comply with OPCs, there is no alternative but to transport patients to Melbourne for treatment.

The increase in patient transport from the Gippsland region to Melbourne hospitals has been dramatic, and has been reflected in our clinic - arranged patient transport by clinic staff has increased five-fold in the last five years.

This development has been demonstrated most clearly by the establishment in many towns of patient transport firms not previously seen in Gippsland.

Unfortunately, many patients elect not to proceed with transport to distant centres for treatment not available locally, or even at the so-called 'hub' or 'base' hospital positioned in Traralgon. They accept poor health outcomes as a consequence of these decisions.

Sending complex patients from the region for treatment has starved Gippsland of specialists and their support service providers. This has left a devastating hole in the gamut of services available, and has forced local doctors to transport sick people to Melbourne. Health outcomes in the region continue to deteriorate as a consequence.

Transport and not treat has resulted, and is continuing to result in, the loss of essential medical services in Gippsland. This has adversely affected health outcomes for the local population. We need local health services for local people, and an end to this failed, poorly conceived and resourced strategy.

Mapping differences in care

BY AMA PRESIDENT PROFESSOR BRIAN OWLER

The AMA's Health Financing and Economics Committee (HFEC) considered the issue of healthcare variation at its meeting on 10 October.

Members of the Medical Practice Committee joined the meeting to receive a briefing on the nation's first Australian Atlas of Healthcare Variation, which is due to published by the Australian Commission on Safety and Quality in Health Care this month.

Associate Professor Anne Duggan, who chaired the committee advising the Commission on the Atlas, told the meeting its purpose was to inform the development of strategies, resources and tools to identify and reduce unwarranted health care variation, and to drive further investigation into variation at the local area level.

The HFEC and its predecessor, the Economics and Workforce Committee, have had a longstanding interest in health care variation, particularly how it reflects the impact of healthcare financing and funding arrangements on the delivery of health care. These are both key terms of reference for the Committee.

In its first iteration, the Atlas will be in hard copy, though later editions may be published in an interactive online format. Internationally, this is not new ground. Both the United Kingdom and New Zealand have published their own atlases of health care variation.

At its simplest, health care variation relates to the gap between what is known to be effective, based on the best available evidence and research, and what actually happens in practice.

Of course, there may be good reasons for variation across areas. When these factors are taken into account, what is left is often referred to as unwarranted variation - differences that cannot be explained by patient factors including illness or medical need, or by the evidence-based medicine that should apply.

How should we, as clinicians, approach the issue of health care variation and the Atlas?

Clinicians have a direct interest in understanding variation in the health care they provide. Knowing the results of the care we provide, how well this meets patient needs, and how these results compare (fairly and accurately) with care for other patients in other locations and from other health care providers, is an inherent part of clinical care. This is essential information for delivering effective health care and for continuing improvement as part of clinical stewardship.

As clinicians, and with and on behalf of our patients, we clearly have the most direct interest in data on health care variation. If clinicians do not engage with this issue, what is assumed to be unwarranted variation, and the actions taken to address it, will be decided by others.

But engaging with the data doesn't mean slavish acceptance. When publications such as the Atlas are released, our first responsibility is to carefully and critically consider the data. This is essential to determine what is warranted, as opposed to unwarranted, variation.

Members of the Committee said it was important to consider why particular areas have been selected, and whether they reflect preconceptions and existing agendas about variations.

It is also important to understand what data sets have been used to provide the health care data, and whether they have particular limitations that affect comparisons across areas, such as different treatment protocols or different approaches to providing services in or out of hospital.

It should also be recognised that atlases of health care variation are unlikely to address some important factors, such as how the preferences of patients can influence the nature and location of care provided.

Overall, the Atlas should serve as a conversation starter. The data it presents (taking into account necessary qualifications) should be used to explore the amount of, and possible reasons for, variation. That is, it should be used to help inform the start, but not the end, of the health care story.

2015: a year of action on many fronts

BY AMA VICE PRESIDENT DR STEPHEN PARNIS

> "The AMA, along with its associated body, the Australian Salaried Medical Officers Federation, is developing a Position Statement on sexual harassment in the medical workplace to give doctors a framework for appropriate behaviour and responses to harassment"

It has certainly been a year of pressing issues for the Council of Salaried Doctors. Some we've been directly involved in, others we've observed with interest. There are too many issues to cover in detail, but here are the highlights:

Bullying and harassment in the medical workplace

You can't be precious when you work in a medical workplace. People say things in the heat of what is frequently a tense health care moment that may shock those from other environments. At other times, staff need firm direction, even performance management. Australian workplace law recognises that "reasonable management action" is not harassment.

The key thing for us is to recognise when things can go too far, or when there is deliberate sexual or other harassment of a staff member. That is not acceptable, and we must speak out about it. The AMA, along with its associated body, the Australian Salaried Medical Officers Federation, is developing a Position Statement on sexual harassment in the medical workplace to give doctors a framework for appropriate behaviour and responses to harassment.

End of Life/ palliative care

Demand for palliative care is increasing as our population ages. Patients and their families are seeking access to services to provide relevant care to people who are actually dying from their chronic and complex conditions.

Gaps remain, as our health system is not always able to offer the care that is sought. In an ideal world, governments would work together to provide the necessary funding, as well as a strong legal framework within which patient-centred palliative care can be conducted with dignity and certainty. We intend to keep this important issue in our sights.

Employment issues

Once again, the medical workforce has faced challenges to its structures and ability to cope, particularly related to teaching, research and substitution.

The China-Australia Free Trade Agreement may allow Australian health care providers to set up private clinics in China, but its effect on pharmaceuticals and other areas of health care in Australia are, as yet, undetermined.

Activity-based funding has created a situation where funding models may not adequately compensate hospitals in certain areas, leaving salaried doctors to do more work with fewer resources.

The appearance of hospitalists has been considered by the Committee and the Industrial Coordination Meeting (ICM). There aren't many yet, but numbers are likely to increase, so we are monitoring the situation, and there will be an update of our Position Statement. We don't want the hospitalist role to usurp that of either Visiting Medical Officers or Doctors in Training.

Safety of doctors in the workplace

The AMA has highlighted evidence that doctors are at greater risk of stress-related problems than the general population. This is why doctors' health services are vital to both the profession and the public good.

Doctors need physically safe workplaces. They need to be sure that they are safe from hostile patients. Sound policy and proper funding are vital to this. The AMA is reviewing its Position Statement on Personal Safety and Privacy for Doctors, and the Committee is providing valuable input.

The Australian Border Force Act (ABF Act)

The ABF Act threatens two years' jail for health workers who speak out against conditions in immigration detention centres. Despite this, more than 400 Royal Children's Hospital Melbourne staff have refused to discharge patients who face being returned to detention, and have demanded that all children be released from detention. The ABF Act is an outrage to medical independence, clinical judgment and the industrial wellbeing of those involved in treating asylum seekers. We will continue to make representations to the Government on this issue.

Alterations to salary packaging arrangements

The Government announced in its 2015-16 Budget that it would introduce a cap of $5000 for salary sacrificed meal entertainment allowances from April 2016. A consultation process saw more than 64 submissions received, AMA included. This change affects salaried doctors more than any other group of doctors. We are greatly concerned about its potential effect on the ability of hospitals to attract and retain staff, especially struggling rural hospitals. Let's hope the Government recognises the value to hospitals of this small incentive, though to date senators appear unmoved on the issue.

Medicare Benefits Schedule Review

On 22 April, the Government announced a review of the more than 5500 items on the MBS. What this will mean for rights of private practice (RoPP) in public hospitals is not clear yet, but various governments have in the past targeted RoPP with outrageous and unsubstantiated claims of impropriety. Let's hope we're not facing another witch hunt, and that the benefits of RoPP will not be overlooked.

This is the final report from the Committee for the year, so I bid you farewell until next year. Enjoy a well-earned break as we prepare for another, doubtless hectic, year ahead. Best wishes for the Festive Season.

INFORMATION FOR MEMBERS

AMA INDIGENOUS PEOPLES MEDICAL SCHOLARSHIP 2016

Applications for the AMA Indigenous Peoples Medical Scholarship 2016 are now open.

The Scholarship, open to Aboriginal and Torres Strait Islander people currently studying medicine, is worth $10,000 a year, and is provided for a full course of study.

The Scholarship commences no earlier than the second year of the recipient's medical degree.

To receive the Scholarship, the recipient must be enrolled at an Australian medical school at the time of application, and have successfully completed the first year of a medical degree (though first-year students can apply before completing the first year).

In awarding the Scholarship, preference will be given to applicants who do not already hold any other substantial scholarship. Applicants must be someone who is of Aboriginal or Torres Strait Islander descent, or who identifies as an Australian Aboriginal or Torres Strait Islander, and is accepted as such by the community in which he or she lives or has lived. Applicants will be asked to provide a letter from an Aboriginal and/or Torres Strait Islander community organisation supporting their claim.

The Scholarship will be awarded on the recommendation of an advisory committee appointed by the AMA's Indigenous Health Taskforce. Selection will be based on:

- academic performance;
- reports from referees familiar with applicant's work regarding their suitability for a career in medicine; and
- a statement provided by the applicant describing his or her aspirations, purpose in studying medicine, and the uses to which he or she hopes to put his or her medical training.

Each applicant will be asked to provide a curriculum vitae (maximum two pages) including employment history, the contact details of two referees, and a transcript of academic results.

The Scholarship will be awarded for a full course of study, subject to review at the end of each year.

If a Scholarship holder's performance in any semester is unsatisfactory in the opinion of the head of the medical faculty or institution, further payments under the Scholarship may be withheld or suspended.

The value of the Scholarship in 2016 will be $10,000 per annum, paid in a lump sum.

Please note that it is the responsibility of applicants to seek advice from Centrelink on how the Scholarship payment may affect ABSTUDY or any other government payment.

Applications close 31 January 2016.

The Application Form can be downloaded at: file:///C:/Users/arollins/Downloads/Application-Form-and-Conditions-for-AMA-Indigenous-Peoples'-Medical-Scholarship-2016.pdf

The Indigenous Peoples' Medical Scholarship Trust Fund was established in 1994 with a contribution from the Australian Government. The Trust is administered by the Australian Medical Association.

The Australian Medical Association would also like to acknowledge the contributions of the Reuben Pelerman Benevolent Foundation and also the late Beryl Jamieson's wishes for donations towards the Indigenous Peoples' Medical Scholarship.

Health on the hill

POLITICAL NEWS FROM THE NATION'S CAPITAL

A lifetime of jabs to be on the record

The birth-to-death vaccination details of every Australian will eventually be held in a single national register under new laws passed by Federal Parliament.

In a strong show of bipartisan support for the importance of vaccination, the Labor Party on 12 October backed Coalition legislation calling for the establishment of an Australian Immunisation Register to document all the vaccinations received by Australians under the National Immunisation Program.

Under the new laws, the current Australian Childhood Immunisation Register will, from 1 January next year, be renamed the Australian Immunisation Register and expanded to collect vaccination records for all Australians 20 years or younger.

From next September, the Register will be further enlarged to encompass all age groups including, for the first time, 70-year-olds receiving the Zostavax shingles vaccine provided under the National Immunisation Program.

These changes will be complemented by the transformation of the National Human Papillomavirus Vaccination Program Register into the Australian Schools Vaccination Register, which from 2017 will document all vaccinations given to schoolchildren under the National Immunisation Program.

The legislation will also enable the Federal Government to implement its No Jab, No Pay policy by allowing for the sharing of vital Centrelink data.

Assistant Treasurer Kelly O'Dwyer said the changes would remedy serious shortcomings in the nation's immunisation record which have left some dangerously exposed to serious infections.

"The changes made in this Bill will help to increase national immunisation rates," Ms O'Dwyer told Parliament. "There are a number of vaccines administered in schools that are not adequately recorded and, as a result, immunisation rates for adolescents in Australia are not well known."

The Minister said this included information about vaccination for potentially extremely serious diseases such as chicken pox, tetanus, diphtheria and whooping cough.

Ms O'Dwyer said the registers, which will eventually be consolidated into a single, life-long vaccination record, would help identify areas where vaccination rates were low, allowing targeted action.

"The…registers will give vaccine providers the data they need on areas where immunisation rates are low, and it will allow them to send out the necessary reminder letters," she said.

Shadow Health Minister Catherine King said the legislation would not only help ensure children were being fully immunised, but also adults.

"It is about ensuring adults have information they need to ensure the protection they receive as children continues long after their schooling ceases," Ms King said. "Diseases like tetanus, diphtheria and, of course, whooping cough, are not confined to children. Adults who travel or come into contact with others who do not keep their immunisations up-to-date are just as much at risk as those who have refused to be vaccinated."

"Having a register rof people and knowing their vaccination status is an important way to ensure that people can remain vaccinated."

ADRIAN ROLLINS

Australian-made cannabis no free-for-all

Access to cannabis for medicinal purposes will be tightly controlled and subject to rigorous scientific assessment even as the country moves to legalise and license its cultivation.

Health Minister Sussan Ley has confirmed that medical cannabis will only be available by prescription, and its use will be subject to approval by the Therapeutic Goods Administration.

Advocates have welcomed Federal Government plans to introduce legislation allowing the controlled cultivation of cannabis for medical and scientific purposes by the end of the year.

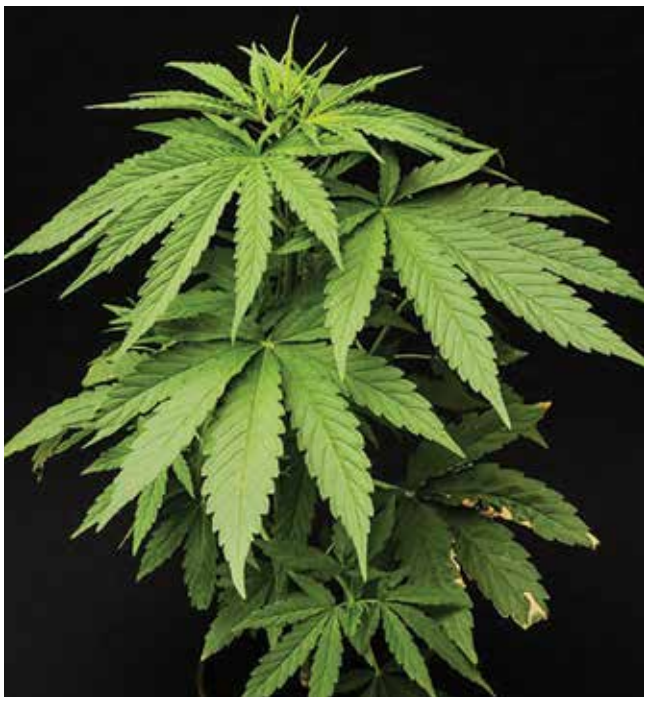
But Ms Ley cautioned that although the new laws, which have the support of Labor, would legalise and regulate the production of medicinal cannabis, any potential application would need to be approved by the medicines watchdog based on evidence as to safety and efficacy.

"It's important we maintain the same high safety standards for medicinal cannabis products that we apply to any other medicine," the Health Minister said. "I'm sure Australians would be concerned if we allowed medicinal cannabis products to be subject to lower safety standards than common prescription painkillers or cholesterol medications."

The AMA has argued that cannabis should be regulated in the

Health on the hill

POLITICAL NEWS FROM THE NATION'S CAPITAL



same ways as other therapeutic narcotics, and be subject to rigorous testing to assess its clinical safety and effectiveness for various conditions.

AMA President Professor Brian Owler said last year that the efficacy of medicinal cannabis for treating symptoms of multiple sclerosis was well established, but other applications should be subject to the same rigorous assessment process as applied to other medicines.

"The way that we regulate medicines in this country for clinical indications is through the TGA, and I think we need to keep using those mechanisms...to regulate the availability of cannabis - not crude cannabis that can be grown at home, but the pharmaceutical preparations that are actually already available, and even looking at putting those on the PBS for particular indications," the AMA President said.

The Health Minister said medicinal cannabis would not be made available over the counter, except through a doctor's prescription or as a result of evidence gained through clinical trials.

"At the end of the day, cannabis is classified as an illegal drug in Australia for recreational use and we have no plans to change that," Ms Ley said. "In many cases the long-term evidence is not yet complete about the ongoing use of various medicinal cannabis products, and it's therefore important we maintain the role of medical professionals to monitor and authorise its use."

The Government has proposed the Health Department operate a national licensing scheme to allow the controlled cultivation of cannabis, providing what Ms Ley said was the critical "missing piece" in enabling a sustainable domestic supply of safe medicinal cannabis for Australian patients.

While there are already systems in place to license the manufacture and supply of medicinal cannabis products, local production is currently illegal, and patients and carers trying to obtain them have been forced to try illegal suppliers or to overcome numerous barriers to access on international markets.

"Allowing the cultivation of legal medicinal cannabis crops in Australia under strict controls strikes the right balance between patient access, community protection and our international obligations," Ms Ley.

The Government will consult with Labor, the Australian Greens, crossbench senators and the states and territories before introducing a final version of the proposed legislation to Parliament by the end of the year.

Ms Ley said the proposed Commonwealth licensing scheme would set out universal obligations and a common legislative framework for states looking to allow medicinal cannabis cultivation.

"It's imperative we have a clear national licensing system to ensure we maintain the integrity of crops for medicinal or scientific purposes," she said. "It allows us to closely manage the supply of medicinal cannabis products from farm to pharmacy. We also want to make sure that this approval and monitoring process for cultivation isn't fragmented across different jurisdictions and provides regulatory consistency."

But the Greens, though welcoming the Government's move, argued that it did not go far enough.

Greens leader Dr Richard Di Natale said the proposed legislation did nothing to remove the "bureaucratic barriers" he argues will prevent it from being prescribed like other medicines.

ADRIAN ROLLINS

Health on the hill

POLITICAL NEWS FROM THE NATION'S CAPITAL

... from p33

Freedom of choice a weighty problem

Governments will have little choice but to tighten food and marketing regulations and possibly increase taxes on unhealthy products if the nation's waistline continues to bulge, the AMA has warned.

The peak medical representative organisation told a Senate inquiry into so-called "nanny state" laws that unless Australians improved their diets and increased physical activity, rates of overweight and obesity would continue to climb and the consequent social and economic costs could force governments to act.

While not calling for a sugar tax, the AMA warned that simply giving people information for them to make informed choices may not, by itself, be enough.

"If people continue to make poor choices, and the number of adults who are overweight or obese continues to increase, Government will have little choice but to regulate," it said, suggesting this might extend to include "restricting... advertising, increasing price, and reducing access, to products known to have a negative impact on health".

Its views were echoed by ACT Chief Health Officer Dr Paul Kelly, who told *The Canberra Times* that although he did not advocate a sugar tax, government needed to be "part of the solution" to obesity.

"Just telling people [about healthy food choices], and asking them to make their own decision, is insufficient," Dr Kelly said. "We know that the majority of the work we do in the hospital system is related to chronic diseases, many of which, if not caused by, are at least made worse by people being overweight or obese. And that's a real cost to the whole community."

The AMA made its warning in a submission to the Senate inquiry being led by Liberal Democratic Party Senator David Leyonhjelm, who objects to what he sees as unwarranted Government constraints on freedom of choice, and has taken particular aim at public health measures such as tobacco controls, alcohol restrictions and bicycle helmet laws.

"It's not the government's business, unless you are likely to harm another person. Harming yourself is your business, but it's not the government's business," Senator Leyonhjelm said. "So bicycle helmets, for example, it's not a threat to other people if you don't wear a helmet; you're not going to bang your bare head into someone else."

ADRIAN ROLLINS

Hospitals, health workers increasingly targeted as conventions break down

> "These violations have become so routine there is a risk people will think that the deliberate bombing of civilians, the targeting of humanitarian and health care workers, and attacks on schools, hospitals and places of worship are an inevitable result of conflict"

A wave of deadly attacks on hospitals and health workers in Middle East conflicts has fuelled fears that basic conventions against targeting medical and humanitarian services in war zones are breaking down.

United Nations Secretary General Ban Ki-moon has denounced what calls "the brazen and brutal erosion of respect for international humanitarian law."

"These violations have become so routine there is a risk people will think that the deliberate bombing of civilians, the targeting of humanitarian and health care workers, and attacks on schools, hospitals and places of worship are an inevitable result of conflict," he said.

Mr Bann called for action to be taken against those responsible.

"International humanitarian law is being flouted on a global scale," Ban said. "The international community is failing to hold perpetrators to account."

A senior Medical charity Medicins Sans Frontieres (MSF) official has warned that the concept of international humanitarian law may be "dead" after a hospital operated by the organisation was destroyed in a bombing attack by Saudi-led forces operating in Yemen – the second such attack in less than a month.

MSF said that on 26 October its hospital in Haydan was destroyed by air strikes carried out by the Saudi Arabia-led coalition fighting against Houthi forces in the war-torn Middle East country. Multiple casualties were only avoided by the rapid evacuation of patients and medical staff.

The attack came just weeks after United States forces bombed an MSF hospital in north-east Afghanistan, killing 22 people including 12 medical staff.

And the charity has reported that at least 35 patients and medical workers have been killed, and 72 wounded, following an escalation of air bombing raids in northern Syria.

It said 12 hospitals have been hit in the Idlib, Aleppo and Hama governorates in the past month, causing six to close and destroying four ambulances.

Head of MSF operations in Syria, Sylvain Groulx, said calls for an immediate halt to such attacks had so far fallen on deaf ears.

"After more than four years of war, I remain flabbergasted at how international humanitarian law can be so easily flouted by all parties to this conflict," Mr Groulx said. "We can only wonder whether this concept is dead."

Pressure is mounting on the United States Government to agree to an independent inquiry into its attack on the MSF hospital in the Afghan city of Kunduz.

The International Humanitarian Fact-Finding Commission (IHFFC), established under the Geneva Conventions, has written to both the US and Afghanistan governments to offer its services for an independent inquiry following a complaint from MSF.

US President Barack Obama has issued a public apology for the bombing, and his Government has initiated its own inquiry. But Mr Obama has been steadfast in resisting calls for arms-length investigation, and is considered unlikely to accept the Commission's offer.

Neither the US nor Afghanistan are member states of the Commission, which has no power to compel their participation.

"It is for the concerned Governments to decide whether they wish to rely on the IHFFC," the Commission said. "The IHFFC can only act based on the consent of the concerned State or States".

President Obama has assured that his Government would conduct a "transparent, thorough and objective" inquiry into the tragedy.

But MSF claims the attack could amount to a war crime and must be investigated independently.

Hospitals, health workers increasingly targeted as conventions break down

... from p33

"We have received apologies and condolences, but this is not enough. We are still in the dark about why a well-known hospital full of patients and medical staff was repeatedly bombarded for more than an hour," said Dr Joanne Liu, MSF International President. "We need to understand what happened and why."

Dr Liu said her organisation was determined to uncover how the attack had occurred, and to hold those responsible to account.

"If we let this go, as if it was a non-event, we are basically giving a blank cheque to any countries who are at war," Dr Liu said. "If we don't safeguard that medical space for us to do our activities, then it is impossible to work in other contexts like Syria, South Sudan, like Yemen.

Saudi authorities have denied responsibility for the Yemen hospital attack, though it has been reported that Saudi Arabia's ambassador to the UN has blamed MSF for providing incorrect GPS coordinates to the Saudi-led coalition – a claim the charity denies.

MSF said it provided Saudi-led armed forces with details of the hospital's location on multiple occasions, including just two days before the strike that destroyed the facility.

President Obama called Dr Liu to apologise for the attack after the US military admitted responsibility.

The Kunduz hospital attack occurred despite the fact that MSF had given all warring parties the GPS coordinates of the hospital.

Outrage over the attack was heightened when the US initially appeared to claim it was a necessary and legitimate use of force, before later characterising it as a mistake.

MSF said that "any statement implying that Afghan and US forces knowingly targeted a fully functioning hospital – with more than 180 staff and patients inside – razing it to the ground, would be tantamount to an admission of a war crime," MSF Australia President Dr Stewart Condon and Executive Director Paul McPhun said. "There can be no justification for this abhorrent attack."

"Medecins Sans Frontieres reiterates its demand for a full, transparent and independent international investigation to provide answers and accountability to those impacted by this tragic event."

ADRIAN ROLLINS

INFORMATION FOR MEMBERS

SUPER MADE EASY – SUPERSTREAM

The ATO will be assisting general practice, dental and specialist business industry over the coming weeks to transition over to SuperStream.

Small business owners with 19 or fewer employees need to start paying super contributions and sending member information electronically through SuperStream.

The process which came into effect 1 July provides a consistent and simplified way for employees to make super contributions on behalf of their employees.

Under the system – those responsible for paying super guarantee for general practice, dental and specialist business will be able to pay super to multiple super funds through one channel.

The ATO is holding a webinar to help practice managers, employers, accountants, BAS agents, bookkeepers and anyone responsible for paying superannuation for general practice, dental and specialist businesses on Tuesday 20 October.

The ATO has an employer checklist can help employers prepare visit www.ato.gov.au/SuperStreamChecklist

KIRSTY WATERFORD

Hyundai i30 Active

BY DR CLIVE FRASER

It's been 40 years since Hyundai made its first all-Korean car called the Pony.

The fledgling brand sold better than initially expected, and has gone on to become the fourth largest auto manufacturer world-wide.

But it was a bumpy road to success.

The Hyundai Excel, launched in Australia in 1995, soon developed a reputation for poor quality and unreliability.

The competition from established Japanese brands was stiff, and repeat business was minimal.

Hyundai's selling point was that their cars were cheaper than the competition, but they weren't good value when reliability and re-sale were factored into the deal.

Back then, a 1.5 litre Hyundai Excel LX automatic would set you back $19,750 + ORC.

Fast forward 20 years and things have certainly changed.

Hyundai's i30 is now regularly Australia's top-selling car.

There's a five-year unlimited kilometre warranty, and the quality is as good as anything from Japan.

And 20 years after the Excel LX was launched, a new Hyundai i30 Active automatic can be purchased for $19,620 drive-away, according to my local dealer.

I took one on a 500 kilometre road test that took me from the Sydney CBD to Katoomba and then on to Bathurst, before returning.

From the outset, I was pleasantly surprised by the Hyundai i30.

It looked and felt like a more expensive vehicle.

There was enough power and comfort so that, after a whole day behind the wheel, my ageing body still felt fine.

I particularly liked the comfortable ride around town - the i30 is even quieter than some luxury diesel cars.

While the Mazda 3 has a more powerful (and more frugal) engine, the Hyundai i30 was not disappointing.

With a six-speed automatic transmission, it got along quite nicely.

Economy was as specified, at 7.3 litres per 100km.

The i30 has two 12-volt sockets in the front centre console, to charge all those devices we now can't live without, and another socket in the boot where I believe all mobile phones should be placed when driving.

The cabin is spacious, and the back seat comfortably accommodates two adults or three children.

There's also plenty of room in the boot, and a full-size spare tyre.

For buyers looking for more bling there is an Active X model with alloy wheels and partial leather, and a Premium model with Sat Nav, heated/ventilated seats, rain-sensing wipers and Xenon headlights.

The quality of the competition highlights what a tough sector of the market this is.

And, with a nuclear-armed neighbour run by a despot to its north, and Russia and China nearby, South Korea has to punch above its weight to survive.

Somehow, countries ripped apart by warfare seem to go on to make some great cars.

Hyundai i30 Active

Engine: 1275cc 4 cylinder OHV

For: Affordable, better than expected.

Against: Mazda 3 engineering still leads the pack.

This car would suit:
Medical administrators because they like to save money.

Specifications: 1.8 litre 4 cylinder DOHC petrol
107 kW power @ 6,500 rpm
175 Nm torque @ 4,700 rpm
6 speed automatic
10.3 l/100 km (city)
5.5 l/100km (highway)
7.3 l/100km (combined)

Price: $19,620 drive-away at my local dealership (or $20,990 drive-away on Hyundai's web-site).

Fast facts:
In 2012 Hyundai (and Kia) compensated 900,000 US owners when they over-stated fuel economy figures.

The June 2015 Popemobile was a Hyundai Santa Fe.

Safe motoring,

Doctor Clive Fraser
doctorclivefraser@hotmail.com

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