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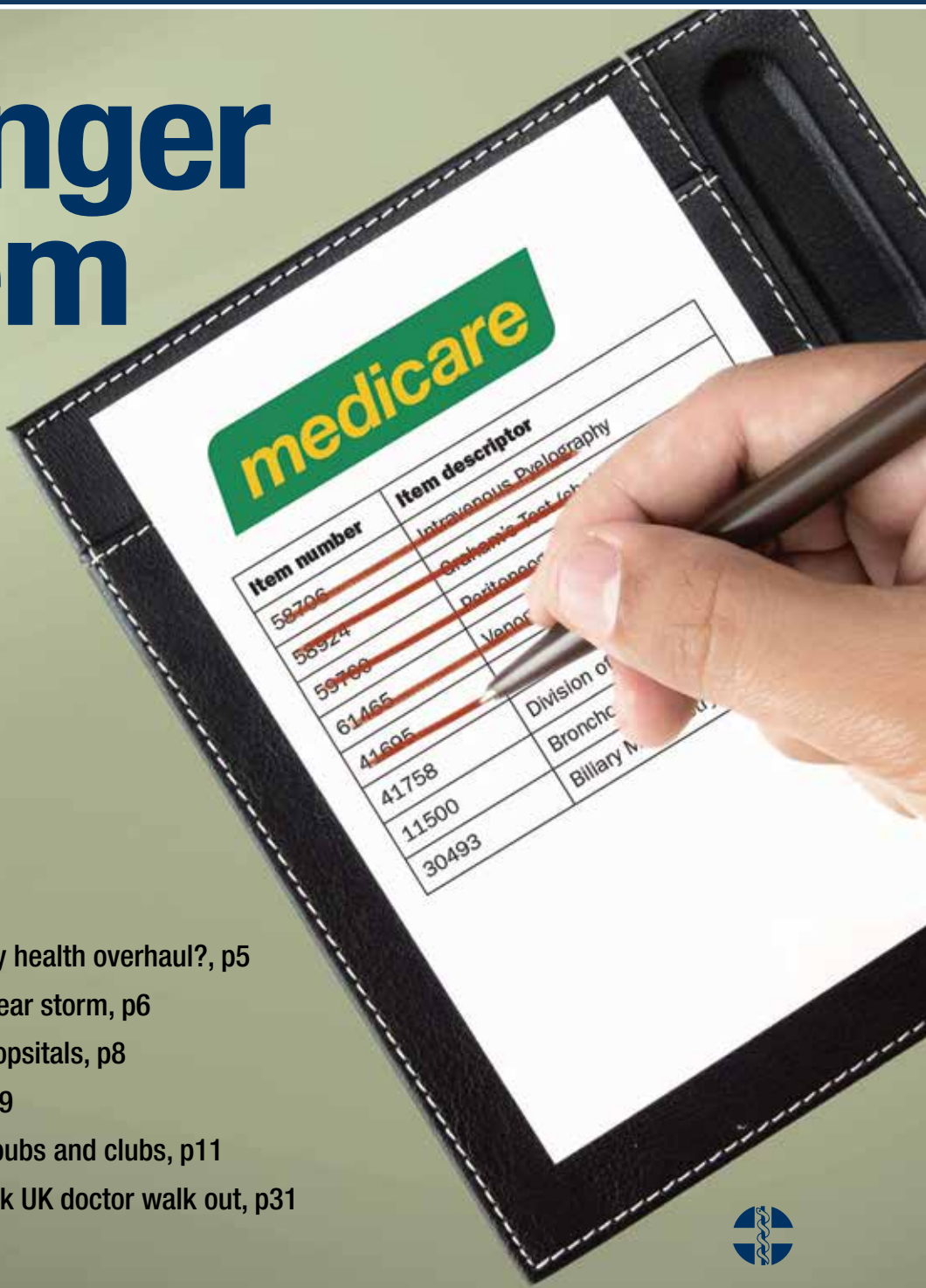
No longer an item

Govt to grab half of MBS savings, p4



INSIDE

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AMA LEADERSHIP TEAM

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Associate Professor
Brian Owler

Vice President
Dr Stephen Parnis

In this issue

Only half of MBS savings to be reinvested in Medicare

Health Minister Sussan Ley has admitted only around half of the money saved by cuts to Medicare Benefits Schedule items will be re-invested in new procedures and services, deepening concerns that the Federal Government is using the MBS review to rip more money out of health.

Ms Ley said that although some of the funds freed up by cutting items from Medicare would be spent on new listings, much will go on shoring up the Budget.

"I've said to doctors right from the beginning, I see this as roughly investing half for sustaining Medicare, and half for new items," the Minister told ABC Radio National. "But the intention of this process is not a savings exercise."

In the first instalment of her plan to review all 5700 items on the MBS, Ms Ley announced late last year that 23 items covering 52,500 episodes of care in 2014-15 had been identified as obsolete or unnecessary and, subject to further consultation, would be removed from the Schedule.

"This first stage of work has provided recommendations about the immediate removal of lower-volume MBS items in some specific specialties where there is clinical consensus that they are obsolete and no longer represent clinical best practice," Ms Ley said in a statement released on 28 December, and added that "it is important to understand that this is not by any means a comprehensive or complete list of final findings about the final makeup of the MBS."

The Government expects to save almost $7 million a year if the recommended cuts are approved.

AMA President Professor Brian Owler responded cautiously to the announcement, reiterating the peak medical group's support for the MBS review, but only so long as it was clinician-led and evidence-based, and was not simply a cost-cutting exercise that harmed patient care.

"The AMA has supported the MBS Review right from the outset," Professor Owler told ABC Radio National. "But it was on the proviso that there weren't going to be cuts in terms of access to patient services. We want to be able to make sure that patients can still access all the services that they need, and that it wasn't just a cost cutting exercise."

Professor Owler said the Government's recent track record on health policy was not reassuring, citing its unsuccessful attempts to introduce a GP co-payment and its savage cuts to public hospital funding.

"It's not a secret that this is about trying to find savings in the health system," the AMA President said. "We've just had the Government announce over $600 million of cuts to pathology and diagnostic imaging in terms of bulk billing incentives.

"When we look at the Government's form on trying to cut costs in health care, I think [patients] can be a little bit anxious about the Government's motives."

But Ms Ley has sought to allay concerns. She said the review was not merely focused on removing items, and may also add new procedures and services "where appropriate", as well as tightening up rules around MBS item eligibility and use.

"My number one priority for this MBS review has always been, and remains, building a healthier Medicare for Australian patients, health professionals and taxpayers, and I am determined to deliver it," the Minister said.

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Only half of MBS savings to be reinvested in Medicare

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Professor Owler said the AMA was "not just going to oppose cuts for the sake of it. Where it can be supported by evidence, and where there's general agreement in speciality groups then absolutely, there's no problem with that. But what we don't want to do is just see cuts for the sake of it."

The Government has portrayed the review being led by Sydney University Medical School Dean, Professor Bruce Robinson, as a much-needed shake-up of a moribund MBS, amid claims that almost no items have been subjected to evidence-based assessments.

> "The scheduling's all about the patient's rebate, it's about what they get back from Medicare…when they undergo a procedure or test" - Professor Owler

But Professor Owler said there was "nothing new" about MBS reviews, pointing out that since 2009 the AMA has taken part in 26 of them.

And he rubbished attempts to call the legitimacy of many items into question because they had not been subject to a formal evidence-based assessment process.

"Many of the items that are on the MBS of course might not have been through the MSAC [Medical Services Advisory Committee] process.

"But we don't need to go through that process to say that general anaesthetic, for instance, when undergoing a major surgical procedure, needs to have new evidence to support it being maintained on the MBS.

"I think when people get carried away about saying that things haven't been through an evidence-based process on the MBS. You've got to remember that not all of the items actually need time to go through that process."

He said the greater concern was that, in axing items from the MBS, the Government may be removing rebates for part of a procedure, increasing out-of-pocket costs for patients who undergo a particular treatment.

"The scheduling's all about the patient's rebate, it's about what they get back from Medicare...when they undergo a procedure or test," Professor Owler said. "Now, there are some proposed changes which will essentially mean that items can't be used in conjunction with various procedures, and that may well raise the out-of-pocket costs that patients are charged."

The MBS items the Robinson review has recommended be removed include seven diagnostic imaging tests, nine ear, nose and throat surgery procedures, five gastroenterology items, one obstetric item, and one thoracic medicine procedure.

The MBS Taskforce appointed by the Minister reported that in many cases more clinically appropriate and efficient technologies and procedures were already listed on the MBS, and retaining the older items was an unnecessary duplication that could compromise patient safety.

For example, invasive tests to diagnose lower leg blood clots and gall bladder problems have been superseded by the use of non-invasive ultrasound technology, the Minster said.

Professor Owler said the AMA supported the review process as long as it did not reduce patient access to services: "we want to be able to make sure that patients can still access all the services that they need and that it wasn't just a cost cutting exercise".

While reviews of MBS items are not new, the process initiated by Ms Ley is the biggest yet undertaken.

So far, just six working groups have been established, but around 80 are expected to be formed during the life of the two-year exercise.

Professor Owler said that, to be conducted properly, each recommendation made by a working group will have to be reviewed by the relevant specialist society or college. Their input, along with that of the AMA, will be provided to the Health Department and the Taskforce, which will then make its final recommendations to the Minster.

He said the AMA supported the review as long as it followed this process.

ADRIAN ROLLINS

Fears over big plans for PHNs

There are growing concerns the Federal Government wants to sideline GPs and divert Medicare rebates to Primary Health Networks to purchase and ration health services, repeating many of the mistakes made by Labor in its botched Medicare Locals scheme.

Just days after Health Minister Sussan Ley announced funds would be directed to the nation's 31 Primary Health Networks (PHNs) to provide tailored care packages for mental health patients, the AMA has warned of the risk that under these arrangements PHNs could end up dictating the care patients receive, disrupting GP services and undermining health outcomes.

In its *Position Statement on Primary Health Networks 2015*, the AMA cautioned against allowing PHNs to develop in ways that are "inimical to good health provision" by turning them into fundholding bodies that directly purchase GP services and giving them scope to interfere with and ration care.

AMA Vice President Dr Stephen Parnis said the Government's mental health reforms and some of the preliminary work undertaken by the Primary Health Advisory Group seemed to involve a larger and more controversial role for PHNs in funding primary care.

"There are worrying signs that the Government is ignoring the lessons of the failed Medicare Locals experiment, as well as diverting significant amounts of Medicare funding to PHNs, potentially establishing new models of care for some population groups that could interfere in the GP clinical care role, restrict patient choice, and ration access to health services," Dr Parnis said.

He said it was unclear whether the Government wanted PHNs to act as fundholders for GP services, and called on it to immediately rule out such a possibility.

The AMA said universal access to patient rebates was a key foundation of Medicare, and "any move to divert rebate entitlements as bundled payments to GPs or to PHNs to fund the provision of...medical services [must be rejected]".

The Government is still in the process of establishing the planned network of PHNs, which Dr Parnis said remained "seriously underdeveloped nationally".

The Government announced the formation of PHNs to replace Labor's Medicare Locals, which were widely disliked by doctors because they sought to operate in competition with GPs, were overly bureaucratic, and were seen to pay little heed to the advice or opinions of local practitioners.

The AMA has backed the need for PHNs to improve the integration of health services and coordination between hospitals and primary health providers.

But it said they needed to focus on supporting primary health services and identifying and addressing gaps in local care.

Dr Parnis said PHNs had an important role to play in ensuring health services were tailored to local needs and, in addition to supporting general practice, could have "a strong impact" on aged care services, mental health outcomes, chronic disease management, Indigenous health services and care for the disadvantaged.

"PHNs should focus on population health, building general practice capacity, and engaging with Local Hospital Networks or Districts to ensure there is continuity of care," he said.

In order to effectively fulfil such a role, the AMA said general practice needed to be "at the heart" of PHNs – local GPs should be on PHN boards, clinical advisory bodies must be GP-led, and they should be assessed on their ability to engage with local GPs.

"GP leadership and input is vital to the success of any PHN in targeting service gaps, supporting continuity of care, and facilitating access to appropriate services," the AMA Position Statement said. "[PHNs] must have strong processes in place for effectively engaging and consulting with grassroots GPs on issues affecting patient care."

In addition to having strong GP involvement and representation, the AMA said PHNs "must not compete with general practice service provision, and should only be allowed to provide clinical services where there is a demonstrable market failure".

ADRIAN ROLLINS

Govt faces storm over cuts to pap smear payments

Women face being charged to get their pap smear results under Federal Government plans to axe bulk billing incentives for pathology services.

Calculations by the AMA show the Government's contribution to the cost of a pap smear will be cut by 12 per cent to $23.55 from 1 July, a $3.20 reduction. There were almost 1.8 million pap smears conducted in 2014-15, suggesting the cut will save the Government around $5.7 million a year.

Pathology providers, who have had no increase in the Medicare rebate for their services for almost two decades, have warned that many labs will not be able to absorb the cut and will instead have to pass it on to their patients.

The amount charged to patients is likely to increase above $3.20 to account for the additional administrative costs of billing individuals, including processing payments and chasing up amounts owing.

Royal College of Pathologists of Australasia Chief Executive Debra Graves told Sydney radio station 2SER FM that most pathology labs would have to reduce the rate at which they bulk bill patients, meaning many will be forced to make a co-payment.

The issue has alarmed doctors and pathologists because of concerns that out-of-pocket costs will convince many patients to forego a pap smear, reducing the chances of early detection of cervical cancer.

AMA President Professor Brian Owler condemned the bulk billing incentive cuts at the time they were announced, describing them as "a co-payment by stealth".

"Cutting Medicare patient rebates for important pathology and imaging services is another example of putting the Budget bottom line ahead of good health policy," Professor Owler said. "These services are critical to early diagnosis and management of health conditions to allow people to remain productive in their jobs for the good of the economy."

Health Minister Sussan Ley has tried to head off a social media campaign on the issue by arguing that the Government has not touched the Medicare rebate it pays for pap smear tests, and the bulk billing incentive was an "inefficient" payment to pathology companies.

In its Mid-Year Economic and Fiscal Outlook statement, the Government estimated that axing the incentive for pathology services and reducing it for diagnostic imaging would save $650 million over four years.

But the AMA said that the bulk billing incentive had been used by successive governments to help offset the fact that the Medicare rebate for pathology services, including pap smears, had not been increased in 17 years, and the net effect of axing the incentive was a cut in the Government's contribution to the cost of a pap smear.

An online petition objecting to the change, which is due to come into effect from 1 July this year, had collected more than 181,000 signatures at the time of publication.

Those signing the petition claim the cuts are unfair and will lead to the late detection of illness, which would end up costing the health system more.

Professor Owler said the AMA strongly opposed the changes and would be working to convince the Senate to disallow them.

ADRIAN ROLLINS

Pap smear scare a warning

As the Federal Government embarks on an election year, Health Minister Sussan Ley has had a sobering lesson in the power of social media.

When a story was posted on website Mamamia early on 6 January claiming women would be charged $30 for a pap smear because of the Federal Government's cuts to pathology and diagnostic imaging bulk billing incentives, it sparked a storm of protest.

A petition on change.org protesting the cuts rapidly gained momentum. By late that morning, it had garnered more than 10,000 signatures.

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Pap smear scare a warning

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It was not until almost midday that Ms Ley responded, going on Twitter to argue that there had been "no cut 2 $ value of Medicare Rebate YOU receive 4 pap smear/test or your access to it as falsely claimed 2day".

> "The message that women would for the first time likely to be charged out-of-pocket expenses for a pap smear had spread far and wide through Twitter, Facebook, and other social media, and was being picked up by mainstream news outlets"

But by then the horse had well and truly bolted.

The message that women would for the first time likely to be charged out-of-pocket expenses for a pap smear had spread far and wide through Twitter, Facebook, and other social media, and was being picked up by mainstream news outlets.

As the day wore on, the Minster posted more tweets trying to calm the storm, and her office issued a statement attacking what it said were misleading claims.

In it, her spokesperson said there had been no shift in the cost of having a pap smear or the Medicare rebate.

The sole change, the spokesperson said, was to scrap the incentive paid directly to pathology providers, worth between $1.40 and $3.40 for each pap smear.

"It is therefore not part of the patient's Medicare rebate, as some have tried to claim," the spokesperson said, and Ms Ley has insisted that competitive pressures in the pathology industry mean providers will have to absorb the cost rather than pass it on to patients – an assertion the sector disputes.

The Government has struggled to gain traction on the issue.

Its complex and nuanced argument has been drowned out by the simple message being broadcast far and wide on social media that women will be charged for a pap smear.

The scale of the Government's problem has been laid bare by the fact that, despite numerous media interviews and statements rebutting the $30 pap smear claim, by mid-Friday the petition was closing in on 200,000 signatures.

The episode is a salutary lesson for the Minister and the Government in the perils of blindsiding health groups and the public with unheralded cuts and changes.

There was no consultation prior to the announcement in the Mid Year Economic and Fiscal Outlook on 15 December of $650 million cuts to the bulk billing incentive for pathology and diagnostic imaging services, and little subsequent detail about the measure, leaving a virtual vacuum in which confusion and apprehension could quickly develop.

In the febrile atmosphere of a Federal Election, where the pressure for instant judgement calls and responses is intense, issues can quickly spiral out of any political control.

It could be a very long year for the Government unless it changes tack on how it does business.

ADRIAN ROLLINS

Hospitals get just $1 more

The Coalition Government spent just an extra $1 for each man, woman and child in the country on hospital funding in 2013-14 as it screwed down hard on its health budget.

As the nation's leaders met in December for the last Council of Australian Governments meeting of the year, figures compiled by the Australian Institute of Health and Welfare showed that Commonwealth funding for hospitals reached $892 per person in 2013-14, which was a $132 increase from a decade earlier, but just $1 more than in 2012-13.

The miserly increase has contributed to a big shift in the burden of hospital funding from the Commonwealth to the other levels of government.

In the 10 years to 2013-14, spending by the states, territories and local governments on hospitals grew at virtually double the rate of the Federal Government.

Over that time, they expended an extra $10.3 billion on hospitals, after inflation – a 69 per cent increase.

During the same period, the Commonwealth's contribution grew by just $5.7 billion – a 38 per cent increase.

The result provides a sobering backdrop to the tax reform debate.

Weak growth in GST revenues in recent years has intensified the strain of health spending on State and Territory budgets, driving calls by premiers and chief ministers for access to a more dynamic revenue base. One proposal has been to push the GST to 15 per cent and direct the funds to the Commonwealth. In return, the states and territories would get a share of income tax revenue.

But the Commonwealth flagged it is not interested in increasing the GST and is instead pressuring the states to change their own tax mix.

At the same time that the Federal Government has been paring back on hospital funding, it has been pulling back on its share of primary health spending, which dropped to 36.7 per cent in 2013-14, from 37.3 per cent the previous year.

Instead, it has picked up its spending on other health goods and services, particularly referred medical services, and to a lesser extent research and health administration.

In the 10 years to 2013-14, Commonwealth spending on these services jumped from $11.6 billion to $19.3 billion – including $12.2 billion on referred medical services alone.

Indicating the increasing importance of this type of spending, in 2003-04, it was 8.4 percentage points lower than Commonwealth spending on hospitals. Ten years later, it was just 2.3 percentage points lower.

The figures underline AMA concerns that the Commonwealth is dumping an increasing share of the health funding burden onto the states and territories, intensifying the strain on public hospitals, which have already reported a downturn in performance.

The Commonwealth's backsliding on primary health funding also lends weight to fears that the reviews it has initiated into primary care, particularly the MBS Review, are being driven by a cost-cutting agenda.

ADRIAN ROLLINS

Anti-vax dodge a dubious legal ploy

Doctors are being urged not to sign a form being circulated by anti-vaccination campaigners attempting to circumvent new 'No Jab, No Pay' laws.

The AMA's senior legal advisor John Alati said the form, which asks doctors to acknowledge the 'involuntary consent' of a parent to the vaccination of their children, used unusual, confusing and misleading wording, and was of dubious legal status.

"This is not a Government-issued form, and there is no legal obligation whatsoever on a doctor to sign it, or even consider it," Mr Alati said. "It is likely to be meaningless in the legal sense."

The form has been circulated among anti-vaccination groups ahead of the 2016 school year following Federal Government welfare changes aimed at denying certain welfare payments to parents who refuse to vaccinate their child.

Under the No Jab, No Pay laws, from 1 January this year parents of children whose vaccination is not up-to-date will not be eligible for the Family Tax Benefit Part A end-of-year supplement, or for Child Care Benefit and Child Care Rebate payments. The only exemption will be for children who cannot be vaccinated for medical reasons.

The new laws are aimed at penalising parents who claim a conscientious objection to vaccination, and to provide an incentive for parents who have neglected their child's vaccination to bring it up-to-date.

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Anti-vax dodge a dubious legal ploy

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The new laws were introduced amid mounting concern that vaccination rates in some areas were slipping to dangerously low levels, increasing the risk of a sustained outbreak of potentially deadly diseases such as measles.

The Australian Childhood Immunisation Register shows there has been a sharp increase in the proportion of parents registering a conscientious objection to the vaccination of their child, from just 0.23 per cent in late 1999 to 1.77 per cent by the end of 2014.

> "In all, around a fifth of all young children who are not fully immunised are that way because of the conscientious objection of their parents"

In all, around a fifth of all young children who are not fully immunised are that way because of the conscientious objection of their parents.

The form being circulated by anti-vaccination groups, headed "Acknowledgement of involuntary consent to vaccination", is intended to circumvent the No Jab, No Pay laws and allow conscientious objectors to receive Government benefits without allowing the vaccination of their children.

But Mr Alati said the dubious nature of the document made it highly unlikely it would be effective in achieving its goal.

He said the very claim of 'involuntary consent' in the form's title was muddled.

"[Consent] may be grudging or doubtful, but if it is given by a person with capacity, apprised of relevant facts, it is consent," Mr Alati said. "If it is not voluntary, it is presumably not consent."

In the form, the doctor is asked to sign a statement that "consent provided by (name of parent) is not given 'voluntarily in the absence of undue pressure, coercion or manipulation', and hence that, according to Section 2.1.3 Valid Consent of the Australian Immunisation Handbook 10th edition, the consent is not legally valid. Given the absence of valid consent, I am/am not willing to proceed with the vaccination of (name of child)."

Mr Alati said the wording of the acknowledgment was "confusing, to say the least".

But he warned that although the form was likely to be legally meaningless, its wording was concerning.

He said the fact that it did not include a statement that the doctor had outlined the risks and benefits of vaccination may be used as evidence that the patient was not properly informed of the implications of not being immunised.

And he said the wording of the line "I am/am not willing to proceed with the vaccination of...", created the false impression that the choice of whether or not to proceed with the vaccination lay with the doctor, not the parent.

Mr Alati said where there was no medical reason for exemption, the doctor's job was to outline the relevant facts about immunisation and to provide vaccination where consent was given. Where it was withheld, "the doctor should not perform the procedure as it might constitute trespass to the person".

The AMA legal expert advised doctors presented with the form not to sign it.

"Given the unusual, confusing and misleading wording of the form and its dubious legal status, we do not recommend that any doctor sign it," he said. "Doctors should explain to the parent or carer that it is their choice whether to proceed with the vaccination, based on what they have been told, and note the situation on the patient's health record."

He said any doctor considering signing the form should "carefully weigh up the potential risks of doing so".

ADRIAN ROLLINS

Butt out smoking in pubs and clubs: AMA

Governments should ban smoking in pubs and clubs, ratchet up the excise on cigarettes, and require warnings at the start of films and television shows that depict smoking as part of a concerted effort to cut down on the deadly habit, according to the AMA.

As the tobacco industry considers its options after failing in its latest bid to overturn Australia's world-leading plain packaging laws, the AMA has called for governments across the nation to work together to help smokers kick the habit and prevent young people from ever taking it up.

The proportion of Australians who smoke is falling steadily. The latest National Health Survey by the Australian Bureau of Statistics found that just 14.5 per cent of adults lit up on a daily basis last financial year, down from 16.1 per cent three years earlier and 23.8 per cent 20 years ago.

But despite this, smoking remains a major killer. The ABS said tobacco was responsible for about 15,000 deaths a year, and a recent large-scale study found that two-thirds of smokers will die because of their habit.

In all, smoking contributes to more deaths and hospitalisations than drugs and alcohol combined, and accounts for 13 per cent of cancers, including 81 per cent of lung cancers.

The AMA said tobacco was unique among consumer products in causing disease and premature death when used exactly as intended, and declared it was committed to reducing the number of people who smoked.

In an updated Position Statement on the issue released in late 2015, the peak medical group detailed a series of measures it said governments and doctors should take to achieve this goal, including tightening up on advertising and promotion rules, increasing taxation, and bringing the regulation of electronic cigarettes in line with tobacco products.

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Butt out smoking in pubs and clubs: AMA

... from p11

The use of e-cigarettes, battery-powered devices that mimic smoking by emitting a vapour, has accelerated in recent years. They are often promoted as an aid to quitting smoking, and the use of bright packaging and flavourings has raised concerns that they may act as a gateway for young people to become smokers.

AMA President Professor Brian Owler said doctors were concerned that e-cigarettes were being marketed to appeal to young people, and should not be sold to anyone younger than 18 years.

> "While most workplaces were now smoke-free, the AMA said some workers in the hospitality industry continued to be exposed to passive smoking"

"The promotion of e-cigarettes to young people as recreational products has the potential to undermine tobacco control efforts and normalise the act of smoking," Professor Owler said.

Already, several states have acted to restrict the sale and use of e-cigarettes. In 2014, Queensland became the first State to subject e-cigarettes to the same laws as tobacco products, while a ruling by a Western Australian court in the same year effectively banned the sale of e-cigarettes, and South Australia has acted to prohibit the sale of e-cigarettes that resemble tobacco products.

Professor Owler said that although such measures were welcome, the Federal Government should work with all the states and territories to establish a uniform national approach to the regulation of e-cigarettes.

'The AMA believes that the marketing and advertising restrictions that apply to tobacco products should also apply to e-cigarettes," he said. "A nationally consistent approach is needed to stamp out any products or marketing that make smoking in any form appear attractive."

The AMA President disputed industry claims that e-cigarettes were effective as aids to help quit smoking.

He said the evidence for this was "mixed and low-level", they were not currently recognised as a cessation aid by the World Health Organisation, the Therapeutic Goods Administration, or the National Health and Medical Research Council.

"In fact, using an e-cigarette may significantly delay the decision to quit smoking," the AMA warned, adding that there was uncertainty about the long-term health implications of inhaling vapours produced by imported and unregulated solutions.

Professor Owler also called for repeated real increases in tobacco taxation, noting that for every 10 per cent price rise, there was a commensurate 4 per cent drop in consumption.

"We know that every time the price of cigarettes increases, some smokers quit the killer habit, and non-smokers are deterred from taking up smoking," he said.

In addition, the AMA has insisted that smoke-free areas be extended to all workplaces, including bars and clubs.

"People have a right to a clean, safe working environment," the peak medical group said.

While most workplaces were now smoke-free, the AMA said some workers in the hospitality industry continued to be exposed to passive smoking.

"It is unacceptable to discriminate against certain groups of workers when determining workplace safety," it said. "Workers in bars, pubs and gambling venues have just as much right to a safe, smoke-free workplace as any other workers."

In its Position Statement, the AMA also suggested that broadcasters be required to provide a warning for viewers at the start of any film or television program that includes depictions of smoking.

The *AMA Position Statement on Tobacco Smoking and E-cigarettes* can be viewed at: https://ama.com.au/position-statement/tobacco-smoking-and-e-cigarettes-2015

ADRIAN ROLLINS

Patients feel the pain as drug prices jump

The Federal Government's move to de-list Panadol Osteo from the Pharmaceutical Benefits Schedule have become embroiled in controversy amid claims of price gouging and broken agreements that could double out-of-pocket costs for patients.

Pharmacists warn concession card holders could end up paying more than $15 - twice as much they did under the PBS - for Panadol Osteo after the Government announced that the common painkiller would no longer be subsidised through the PBS.

The warning came as Health Minister Sussan Ley asked the consumer watchdog to investigate after GlaxoSmithKline announced it would jack up the price of its popular painkiller Panadol Osteo by 50 per cent from the start of the year.

Ms Ley said the two decisions were unrelated and there was no obvious explanation for Glaxo's price hike, prompting her to refer the matter to the Australian Competition and Consumer Commission.

"There are no obvious market changes that justify such a substantial increase," the Minister said. "Attempts by the makers of Panadol Osteo to link their proposed 50 per cent price increase to Government regulatory changes, without any detail to support their claims, can only be interpreted as an attempt to mislead consumers and pharmacists.

"With such a dominant share of the Australian market, this action by the makers of Panadol Osteo also raises questions about their intentions behind this 50 per cent price increase and, at the very least, requires examination."

Last year Ms Ley announced that she had accepted a recommendation from the Pharmaceutical Benefits Advisory Committee (PBAC) that a number of over-the-counter medicines, including Panadol Osteo, no longer be listed on the PBS.

The change was to correct an anomaly in which people without a prescription could buy Panadol Osteo off the shelf for less than $5, while a concession card holder purchasing it on prescription would pay $7.52.

But the Government has itself come under scrutiny over the change.

The Pharmacy Guild of Australia has warned that, as a result of the de-listing, Panadol Osteo will actually cost patients more, breaking the terms of the agreement the Guild struck with the Government over the delisting of a number of medicines.

The Guild said it agreed to the delisting of several over-the-counter drugs based on assurances from the Government that they would be available at prices comparable to those paid by Concession Card holders through the PBS.

"It is now clear that this is not the case with Panadol Osteo, which is a recommended first-line therapy for the pain management of osteoarthritis," the Guild said.

Under the PBS, concessional patients could buy two packs of 96 Panadol Osteo tablets for $7.52.

But the Guild said its analysis showed that the same patients would now pay between $11.90 and $15.00 for the same purchase, even before GlaxoSmithKline's price hike.

It said the decision by the drug maker to increase the manufacturer price of a 96-tablet pack from $4.28 to $6.31 would push the wholesale price up to $6.65.

"This means patients are likely to have to pay more than $15 to purchase two packs of 96 Panadol Osteo, compared with $7.50 for a concessional patient under the PBS," the Guild said.

In addition, because the purchases would no longer be made through the PBS, they would not count toward the Safety Net amount (general patients who spend more than $1475.50 on PBS medicines in a year get the rest at the rate of $6.20 per prescription. For concession patients the threshold is $372, after which medicines are free).

The Guild said it was concerned that "many people with chronic, debilitating osteoarthritis will have increased difficulty in affording their treatment" as a result of the changes.

It has asked the PBAC to undertake an analysis of the over-the-counter prices of delisted medicines, and to review its delisting recommendation of a number of medications, particularly Panadol Osteo.

ADRIAN ROLLINS

No place for bullies, harassers in medicine: AMA

Workplace bullies and perpetrators of sexual harassment should be hit with sanctions and penalties as part of efforts to clampdown on harassment and other unacceptable behaviour, according to the AMA.

Responding to evidence of widespread bullying and sexual harassment within medicine, the AMA has called for a cultural change in the medical workplace, led by the profession and underpinned by concrete actions by employers, educators, colleges, professional associations and unions, to encourage victims to make complaints and ensure there are repercussions for perpetrators.

The issue drew national attention after senior vascular surgeon Dr Gabrielle McMullin highlighted the problem by saying trainees who complained about sexual harassment risked ruining their career.

A subsequent report by the Royal Australasian College of Surgeons found almost 40 per cent of surgical fellows, trainees and international medical graduates said they were bullied at work, while almost one in five experienced harassment and 7 per cent reported being sexually harassed.

Among the incidents recounted in the report, one trainee said she was expected to provide sexual favours in return for being tutored by a senior colleague, while another was told she would only be considered for a job if she had her “tubes tied”.

AMA President Professor Brian Owler said the profession had been “deeply shocked and challenged” by the seriousness and breadth of the problem.

Professor Owler said such behaviour could have both immediate and lifelong effects on individuals.

“The impact of sexual harassment is profound,” he said. “It affects physical and mental health,...undermines performance and professionalism in the workplace [and] can influence career choice and career progression.

The AMA has released two Position Statements – one on sexual harassment, the other on workplace bullying and harassment – in which it declares there must be a “zero tolerance” approach to such behaviour.

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No place for bullies, harassers in medicine: AMA

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But stamping it out is likely to be a long and difficult task.

In its *Position Statement on Workplace Bullying and Harassment*, the AMA warned that the hierarchical nature of medicine, the power imbalance inherent in medical training, gender and cultural stereotypes and the competitive nature of practice and training, "has engendered a culture of bullying and harassment that has, over time, become pervasive and institutionalised in some areas of medicine".

While sexual harassment occurred in many occupations, the AMA said characteristics of the medical workforce increased the risk of it occurring, particularly the male-dominated nature of some specialities.

> "... it could not just be left up to the profession, and there had to be collaboration with employers and educators to promote respectful and safe working and training environments" - Professor Owler

"Gender inequity has a proven causal relationship with the incidence [of] sexual harassment of female employees," the AMA's *Sexual Harassment in the Medical Workplace Position Statement* said. "This is particularly relevant for medicine, where significant gender imbalances emerge in the majority of specialties."

Professor Owler said the medical profession – including colleges and professional bodies - needed to take the lead.

But he said it could not just be left up to the profession, and there had to be collaboration with employers and educators to promote respectful and safe working and training environments.

"Tackling the problem of bullying and harassment requires changing the culture within organisations," the AMA Position Statement said, warning that hospitals and professional associations may inadvertently foster a culture of bullying and harassment by failing to discourage it.

"Bullying and harassment thrives in a workplace culture where it progresses unchallenged and is ignored," it said, and emphasised the need for clear and robust complaints processes.

"Incidences of bullying and harassment are often not reported because of fear or reprisal, lack of confidence in the reporting process, fear of impact on career, and [a culture of minimising the problem]."

The AMA has detailed a set of "practical and positive" measures to tackle the problem. These include:

- making it clear there is a zero tolerance approach to bullying and harassment;
- providing flexible work arrangements and training opportunities to ensure all are able to fully participate in the workforce;
- educating staff and students about bullying and harassment;
- providing robust complaints processes, including assurances that people can make complaints free of shame, stigma or repercussions;
- encouraging and supporting bystanders to speak up and act on instances of bullying and harassment;
- apply appropriate sanctions, consistently applied, on those who bully or harass; and
- penalise workplaces that do not have policies in place, and which fail to properly investigate and address complaints.

The AMA Position Statement on Sexual Harassment in the Medical Workplace is available at https://ama.com.au/position-statement/sexual-harassment-medical-workplace

The updated AMA Position Statement on Workplace Bullying and Harassment is at https://ama.com.au/position-statement/workplace-bullying-and-harassment

ADRIAN ROLLINS

IMGs deserve a much better deal: AMA

The AMA has called for a major improvement in conditions for overseas-trained doctors amid concerns that many are being forced to work in some of the country's most challenging environments with little support, hindering their professional development and potentially putting patients at risk.

Calling for an end to the 10-year moratorium on Medicare provider numbers for doctors coming from overseas to work in Australia, the AMA said current arrangements meant international medical graduates (IMGs) were being sent to work in difficult clinical settings with often limited support and supervision, undermining their professional development and exposing patients to potential harm.

The nation has relied heavily on overseas-trained doctors to help plug gaps in the medical workforce, particularly in country areas that have struggled to attract locally trained medical practitioners. While they comprise about a quarter of all doctors working in Australia, they make up more than 40 per cent of those working in rural and remote regions.

One of the principal policies used to achieve this has been the Health Department's requirement that IMGs work in areas of workforce shortage for their first 10 years in the country. In addition, IMGs who might not otherwise be eligible for registration can be recruited to work in locations designated by State and Territory governments as an Area of Need.

But the AMA has raised concerns that many overseas-trained doctors are being recruited without being adequately prepared or supported for the work they are expected to undertake.

AMA Vice President Dr Stephen Parnis said IMGs were a vital part of the nation's medical workforce, and deserved a better deal.

"Without their valuable contributions, many Australians – especially in rural and remote communities – would find it much harder to get access to medical care," he said.

Dr Parnis said current arrangements meant IMGs were often being recruited to work in some of the most professionally challenging clinical environments in the country, frequently without being adequately prepared.

"It is not their fault. It can be difficult for them to get access to the resources, supervision and mentoring they need to perform effectively," he said, hampering their professional development.

In addition to these professional challenges, the AMA Vice President said IMGs and their families often also faced significant problems in getting the personal care and support they needed.

"In their private lives, many IMGs get only limited support for their own or their family's medical and educational requirements," Dr Parnis said, pointing out that they do not get access to Medicare-funded services or equal access to public education.

He said there needed to be an end to such inequity.

"We have asked a lot of IMGs to come into Australia, and we've asked them to work in places where the demands are often the greatest, and the supports the least," Dr Parnis told *Medical Observer*. "That is not only grossly unjust, it's a recipe for burnout and for standards to be put at risk."

In its *Position Statement on International Medical Graduates,* released in December 2015, the AMA urged a significant change in approach to recruiting and supporting IMGs.

The qualifications of overseas-trained doctors should be rigorously verified, and they should be able to demonstrate a good grasp of English, the AMA said.

But in return, it has insisted that "appropriate regard" is paid to overseas qualifications, and any assessments IMGs are required to undertake are nationally consistent, transparent, evidence-based and robust.

Addressing concerns that IMGs undertaking assessments often encountered lengthy delays and high costs, the AMA said they must be conducted "in a timely fashion", should not impose unjustified costs, and should be accompanied by fair and accessible appeals processes based on principles of natural justice.

Regarding the recruitment of IMGs, the AMA said employers seeking an Area of Need declaration in order to hire people must demonstrate that they have undertaken labour market testing, have arranged for adequate resources and supervision to support IMGs, and ensure that the needs of IMGs are properly recognised and accounted for.

"While Australia has policies in place to encourage IMGs to work here, more needs to be done to ensure that their work is appropriately recognised, and that they can quickly become part of their local communities," the AMA Position Statement said.

The AMA Position Statement on International Medical Graduates can be viewed at: https://ama.com.au/position-statement/international-medical-graduates-2015

ADRIAN ROLLINS

Set time limit on refugee detention

Federal Parliament has been urged to set a time limit on the detention of asylum seekers and remove all children from behind bars as part of steps to reduce human suffering.

The AMA has called for laws to enshrine an absolute upper limit to detention amid mounting concerns about the enormous physical and emotional toll prolonged and indeterminate internment is having on those seeking refuge, particularly children.

In an update of its *Position Statement on the Health Care of Asylum Seekers*, the AMA said prolonged and open-ended detention not only violated basic human rights, but badly affected health.

"The longer a person is in detention, the higher their risk of mental illness," the AMA said. "Detention in immigration detention centres should be used only as a last resort, and for the shortest practicable time."

According to the Department of Immigration and Border Protection, 436 people have been held in immigration detention for more than 730 days – almost a quarter of all detainees.

The average time people have been held in detention has climbed sharply in the last two years, from around two months in mid-2013 to around 15 months as at last November.

AMA President Professor Brian Owler said the detention of children was particularly concerning.

Official figures show that by 30 November last year, 104 children were being held in immigration detention centres on the mainland, and further 70 were being detained on Nauru, while a further 331 were living under detention in the community and almost 4000 were on bridging visas.

Professor Owler acknowledged that under the Coalition Government the number of children being held in detention had fallen substantially, down from 2000 in mid-2013, but he said the practice should be eliminated altogether.

"Detention has severe adverse effects on the health of all asylum seekers, but the harms in children are more serious," he said. "Some of the children have spent half their lives in detention, which is inhumane and totally unacceptable.

"These children are suffering extreme physical and mental health issues, including severe anxiety and depression. Many of these conditions will stay with them throughout their lives."

The AMA said unaccompanied children should never be held in detention facilities, and those who were accompanied should only be detained for the shortest possible time, and certainly "no more than one month".

The peak medical group has repeated its call for the establishment of an independent statutory body of clinical experts empowered to investigate and advise on the health and welfare of asylum seekers and refugees. Under the proposal, the body would report directly to Parliament.

Professor Owler said such an arrangement would ensure honesty and transparency in how Australia protects the health and wellbeing of vulnerable people held under its care.

In addition, he said, there should be changes to the Australian Border Force Act to ensure doctors who blew the whistle on the treatment of asylum seekers would not be liable for prosecution.

The Act includes clauses that threaten up to two years imprisonment for those found to have made unauthorised disclosures about conditions in detention centres, causing consternation that medical practitioners could be jailed for speaking up for their patients.

Professor Owler said doctors had an ethical and moral obligation to act in the best interests of their patients, including speaking out about concerns for their welfare.

"The biggest concern of the ABF Act, with the secrecy provisions, is the possibility of doctors and whistle-blowers possibly facing two years in jail for leaking information in regards to offshore detention facilities," he said. "Doctors have an ethical obligation to treat asylum seekers and refugees in need."

The AMA said detention centres must provide humane living conditions, and medical services should be run by organisations capable of providing timely access to the appropriate range of health services.

It said medical professionals or nurses should used to conduct health screening and administer medications, and should be consulted in the transfer of detainees to ensure continuity of care.

While not specifically calling for the end of temporary visas, the AMA said they created undue stress and anxiety, and undermined the ability of refugees and asylum seekers to successfully integrate into the community.

ADRIAN ROLLINS

The flabby country

Children are continuing to pack on the pounds even though the pace of weight gain among adults appears to be slowing, underlining concerns that a combination of poor diet and inactivity is putting millions at heightened risk of heart disease, diabetes and other serious lifestyle-related health problems.

There has been a small but notable slowing in weight gain among adults – particularly women – since the global financial crisis struck in 2007-08. The proportion considered overweight or obese increased by just 0.6 of a percentage point to 63.4 per cent in the last three years after jumping more than 6.5 percentage points in the previous 15 years.

But Australian Bureau of Statistics figures show that children are putting on weight much more rapidly. The proportion who are overweight or obese leapt 1.7 percentage points in the last three years.

Overall, the country continues to have a severe weight problem.

Last financial year, more than 63 per cent of adults were overweight or obese, including more than 70 per cent of men, while more than a quarter of all children (27.4 per cent) are carrying too much weight.

The results mean Australia retains the unenviable status of having some of the highest rates of overweight and obesity in the world. By comparison, the World Health Organisation calculates that 39 per cent of adults worldwide are overweight, and 13 per cent obese.

The nation's waistline has continued to bulge against a background of poor eating and exercise habits.

The ABS found that although half of all adults, and 70 per cent of children, eat two or more serves of fruit a day, Australians are not getting enough vegetables in their diet – just 7 per cent of adults and 5.4 per cent of children meet dietary guidelines for the consumption of vegetables.

Just as concerning, a large proportion of Australians are not getting enough exercise. While 55 per cent of adults reported doing at least two-and-a-half hours of moderate physical activity or 75 minutes of vigorous exercise each week, 30 per cent did not manage to do even this much, and almost 15 per cent said they did none.

AMA Vice President Dr Stephen Parnis said the findings showed much more needed to be done on health prevention.

"The message from this survey is clear – Australians have to get moving," Dr Parnis said.

He said while it was heartening that rates of smoking and risky drinking were declining, the incidence of preventable disease highlighted the need to do more.

The ABS, which surveyed 19,000 people for its report, found that just 14.5 per cent of adults smoke on a daily basis – down from 16 per cent in 2011-12 – while the proportion who drink excessively has slipped to 17.4 per cent, a 2 percentage point decline over the same period.

Dr Parnis said the results showed the effectiveness of Australia's tobacco control measures, including its plain packaging laws, but warned that alcohol continued to "wreak havoc" on families and communities.

"We cannot be complacent about alcohol because one in four men and one in 10 women are still exceeding the lifetime risk guidelines [for consumption]," he said.

The effects of excessive drinking, poor diet and relative inactivity are showing up in persistent rates of lifestyle-related illnesses identified in the ABS report, *National Health Survey: 2014-15*.

It found that rates of diabetes and heart disease (both affecting about 1.2 million people) are continuing to grow, while 2.6 million have hypertension and 1.6 million suffer from high cholesterol.

Dr Parnis said that, amidst the flurry of reviews of Medicare, primary care and private health insurance, the ABS report showed the "urgent need" for greater attention on preventive health measures.

"Investing in prevention pays big dividends. It keeps people healthy and away from costly hospital care," he said. "We need to do more to make Australians more aware of their diets, their exercise regime, and the serious health risks of smoking and excessive or irresponsible alcohol consumption."

ADRIAN ROLLINS

Government rethinks pre-Christmas kick in the guts

Patients have been saved from being left with huge unexpected out-of-pocket expenses after the AMA intervened to secure a delay in major changes to Medicare benefits for abdominal surgery.

The AMA acted after the Health Department, in a letter sent to AMA President Professor Brian Owler on 17 December, gave just 14 days' notice of significant amendments to Medicare items for lipectomy services, which involve the removal of large flaps of skin left hanging from the gut following rapid weight loss.

Increasingly, lipectomies have been performed on people who have lost significant weight following lap band surgery or other medical interventions.

A review of Medicare Benefits Schedule items for lipectomy services conducted in 2013 found a large increase in the number of claims made in the previous decade. Most of the procedures were carried out on women between 35 and 54 years of age.

In its letter to Professor Owler, the Department said that the review had found little strong evidence regarding the effectiveness, safety and quality of lipectomies.

"But [the review] concluded that patients with a major abdominal apron following massive weight loss due to bariatric surgery or other weight loss measures were the most likely patient population for clinically relevant lipectomy, with personal hygiene and ulceration as the main clinical issues," the Department said.

In April, the Medical Services Advisory Committee, which oversees the listing of services on the MBS, supported changes to Medicare items for lipectomies recommended by an expert working group.

But the Government did not act on this advice until deciding to implement the changes as part of its Mid Year Economic and Fiscal Outlook deliberations, and it announced they were to come into effect from 1 January 2016.

In her letter to Professor Owler, Health Department Assistant Secretary Natasha Ryan admitted that the rapid implementation of the changes meant there was little time to give doctors and patients notice. But she argued the nature of the changes meant they were likely to cause "only minimal inconvenience".

But the AMA told the Department patients already booked in for a lipectomy, particularly those undergoing the procedure in

January, were likely to be left badly out-of-pocket as a result of the extremely tight timeframe.

"There may be cases where patients are booked for services in January, who will now not be eligible for Medicare rebates and, therefore, private health insurance rebates," the AMA warned. "Without proper notice to the relevant medical practitioners, the Department may be exposing some individuals to having to pay the full costs of treatment, [including both] the medical and hospital costs".

The AMA said the period of notice given by the Department was "unacceptable", and urged for a delay.

It said there was no material reason why the changes had to be implemented so quickly, and the decision showed "a lack of insight by the Department in how the health system works and how changes need to be planned for".

Following strong representations from the AMA, the Department has announced that the changes will be deferred until 1 April 2016.

ADRIAN ROLLINS

Two-year limit put on cure

A push to give sufferers of a rare but debilitating disease lifelong subsidised access to a $500,000 a year treatment has been rebuffed by the Federal Government's top pharmaceutical experts.

Patients with acute haemolytic uraemic syndrome (aHUS) will now have subsidised access to the drug Soliris – which has been shown to be effective in treating many people with the condition – for two years following a decision by Health Minister Sussan Ley.

> "Soliris has been shown to be an effective, if very expensive, treatment for aHUS, a rare condition which can cause blood clots to form in small blood vessels throughout the body"

But hopes for longer subsidised treatment have been dashed after the Pharmaceutical Benefits Advisory Committee dismissed claims by the manufacturer, Alexion Pharmaceuticals, that it should be lifelong. PBAC Chair Professor Andrew Wilson said there was "no evidence" to support the claim.

Soliris has been shown to be an effective, if very expensive, treatment for aHUS, a rare condition which can cause blood clots to form in small blood vessels throughout the body, potentially leading to stroke, heart attack, kidney failure and death.

Around 35 people are diagnosed with the disease every year, including children, and Soliris has been hailed as a breakthrough treatment that can not only control symptoms and the severity of attacks, but can restore critical organ function and lead to remission in some patients.

But its listing has been surrounded by controversy.

A stand-off developed between the PBAC and Alexion in 2014 when the expert committee recommended that subsidised be restricted to 12 months - subject to ongoing monitoring and an immediate resumption of treatment at any sign of a relapse.

The Committee said that although Soliris demonstrated significant clinical benefits in the short term, there was little evidence to support its sustained use in patients who had experienced remission.

"In reaching this conclusion the PBAC noted, among other matters, that the vast majority of the benefit observed in patients receiving occurs in the first six months of treatment," the Committee said in a statement.

But Alexion voiced strong objections.

"It's dangerous, clinically inappropriate, and goes against dose administration guidelines," the Managing Director of Alexion's Australian subsidiary, David Kwasha, told PharmaDispatch. "We all agree that this needs to be resolved quickly, we have this one issue, but we just can't agree to the experiment being proposed by the PBAC."

The company eventually acceded to the conditions imposed by the PBAC, and the Government allocated $63 million over four years to provide subsidised access for about 70 patients across the country.

But the company has continued to advocate the need for ongoing treatment ever since, and may claim a victory of sorts in the PBAC's decision to extend the term of subsidised treatment to two years.

In an admission that the PBAC got its initial decision wrong, Professor Wilson said that, "based on updated information, we now believe it would be appropriate to wait up to 24 months before assessing a patient's clinical response to this drug to determine if they should stay on it or not".

Nonetheless, patients should be tested every six months during this time "to ensure they are responding to the treatment".

Ms Ley said the Government's decision to list Soliris for 24 months reflected its commitment to reverse the political interference in drug listings that occurred under the Labor Government.

The Health Minister said the Government accepted the advice of the PBAC without fear or favour, and said current arrangements ensured listing decisions were made without undue influence or pressure.

ADRIAN ROLLINS

Did they really say that?

What people were saying about health this fortnight

MBS Review

"I've said to doctors right from the beginning, I see this as roughly investing half for sustaining Medicare, and half for new items. But the intention of this process is not a savings exercise" – Health Minister **Sussan Ley** explains what the MBS review is really about.

Bulk billing incentive cuts

"The vast majority of patients do not have to pay any out-of-pockets for their pathology and radiology, so we really believe this is a co-payment by stealth because the only way we can cope with cuts of this magnitude is by introducing a co-payment" – Sonic Healthcare Chief Executive Colin Goldschmidt comments on how the Federal Government's decision to axe bulk billing incentives for pathology services will affect patients.

"RT fyi NO cut 2 $ value of Medicare Rebate YOU receive 4 pap smear/test or your access to it as falsely claimed 2day. MYEFO changes about inefficient payment 2 pathology corporations, complaining bout impact on shareholders. Medicare not corporate bankroll" – **Sussan Ley** tweets after a change.org petition against bulk billing incentive cuts for pap smear pathology services garners more than 150,000 signatures.

"Labor is deeply concerned by reports these cuts could force women to pay more for crucial preventive health checks like pap smears that are essential for detecting life threatening conditions like cervical cancer" – Shadow Health Minister **Catherine King** joins the chorus condemning cuts that mean women could be charged for pap smear pathology services.

"The average Australian is sick of this Liberal Government fiddling with bulk billing rates for vital medical checks like women's Pap smears. Over my dead body will I allow the Liberals to try and sneak through more changes and cuts to our Medicare system" – Independent Senator **Jacqui Lambie** leaves no room for doubt about what she thinks of the Government's latest health policy initiative.

Hospital-acquired complications

"We will certainly consider the implications of this expanded scope in our ongoing consultation with our hospital partners" – Medibank Private Chief Medical Officer **Dr Linda Swan** puts private hospitals on notice that it will use a list of 40 complications identified by the Australian Commission on Safety and Quality in Health Care when it negotiates new contracts with Healthscope and Ramsay this year.

"It…needs to be understood that even when all appropriate guidelines are followed, complications can still occur – that is, they are in some cases effectively unavoidable" – Calvary National Chief Executive **Mark Doran** pushes back against Medibank's plans, arguing that "applying financial sanctions without a clinical review process…will do little to actually improve patient outcomes."

Alcohol-fuelled violence

"It is shameful that while young people are killed in these unprovoked attacks, children continue to be exposed to harmful alcohol advertising as families tune their televisions to live sporting events over the holidays" - Co-Chair of the National Alliance for Action on Alcohol and Chair of the Royal Australasian College of Surgeons Trauma Committee **Dr John Crozier** calls for action following the death of Cole Miller, 18, as the result of a late-night one-punch attack in Brisbane's Fortitude Valley.

Government policy, not consumer behaviour, is driving rising Medicare costs

BY PROFESSOR STEPHEN DUCKETT, DIRECTOR, HEALTH PROGRAM, GRATTAN INSTITUTE

This article first appeared in The Conversation on 2 December, 2015, and can be viewed at: https://theconversation.com/government-policy-not-consumer-behaviour-is-driving-rising-medicare-costs-51604

Announcing the ill-fated 2014 budget initiative to introduce a consumer co-payment for general practice visits, the-then Health Minister, Peter Dutton, lamented that annual Commonwealth health costs had increased from $8 billion to $19 billion over a decade.

He described the increase as "unsustainable", and used it to justify the Budget's bitter pill.

The implication of his announcement was that consumers were driving the increase in costs, and that action to change consumer behaviour was necessary to rein them in.

The growth numbers were presented as part of the government's then mantra of a "debt and deficit disaster", and massaged to create maximum shock and awe. The minister's numbers did not adjust either for population growth or inflation.

Nonetheless, a more legitimate set of growth numbers would still show Medicare Benefits Schedule (MBS) payments growing at an annual rate of 2.3 per cent in real per -head terms, faster than growth in Government expenditure overall (1.8 per cent).

But this still leaves open the question of whether consumer behaviour is driving rising costs, or whether there may be other causes.

A report released in late November by the Parliamentary Budget Office shows that Government policy has driven a significant proportion of the growth in MBS costs. In fact, of the $325 real increase in MBS spending per head since 1993-94, all but $74 has been the result of explicit government decisions.

MBS spending per head is the product of the rebate for each MBS item and the per head use of those items. Both elements of this calculation have been tinkered with as part of policy change over the last two decades.

A significant proportion of the growth in Medicare costs has been driven by Government policies such as items for new services and larger rebates.

Governments have increased rebates for some items faster than inflation. This has been done, for example, to encourage an increased rate of bulk billing.

> "... implementation of policies to expand magnetic resonance imaging and reform diagnostic imaging items more generally has been poor"

New item numbers have also been added as part of major policy reviews. (Each MBS service involves one or more item numbers and an associated description. For example, an ordinary consultation with a general practitioner is item number 24.) The single largest cost impact ($51 per head) came from changes to diagnostic imaging items, including new items for magnetic resonance imaging (MRI).

But implementation of policies to expand magnetic resonance imaging and reform diagnostic imaging items more generally has been poor. It is questionable whether consumers are getting value for money from this investment. Also, some diagnostic imaging tests appear to be overused.

Policies designed to increase bulk billing accounted for an extra $70 per head: increasing the GP rebate from 85 per cent of the schedule fee to 100 per cent accounted for $42 per head; targeted increases in the rebate to increase bulk billing rates accounted for the rest.

When did Medicare spending soar?

In the decade to 2003-044, Medicare spending grew by $53 per head. Just over half of that was attributable to the addition of new diagnostic imaging items to the schedule. In the next decade, spending grew at five times that rate – by $272 per head.

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Government policy, not consumer behaviour, is driving rising Medicare costs

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Most of the growth was due to decisions taken when Tony Abbott was Health Minister, between 2003 and 2007. In fact, almost half (47 per cent) of the growth in Medicare spending over the last two decades is the result of policy decisions taken when he was running the health portfolio.

The changes were introduced over the years for a mix of policy and political reasons.

The decline in bulk billing was associated with public dissatisfaction with Medicare and was clearly having political impacts. This led to new bulk billing incentives and increases to the rebates for general practitioner fees.

The increasing prevalence of chronic diseases, such as diabetes and heart disease, led to new assessment and care planning items.

A decline in the proportion of GPs providing after-hours care led to new items to redress that as well.

General practitioners got more rebate income (in real terms) for seeing the same number of patients, so it was actually changes initiated by Government that led to the increase in spending.

What does this mean for Medicare reform?

Two main lessons can be drawn from the Parliamentary Budget Office report.

First, the Government must be clear about what is driving growth in expenditure. The co-payment proposal sank like a lead balloon partly because it was seen as inefficient and unfair, but also because the public didn't have any ownership of the "problem" the changes sought to address. The way the problem was initially presented was wrong, causing confusion between Medicare services (which include diagnostic tests) and GP visits. The vast majority of the population, who have few visits, refused to accept that per-head use was going up.

Second, the report shows how much governments have relied on tinkering with the Medicare Benefits Schedule to drive system change in the last decade. "Here a new item, there a new item, everywhere a new item", became the Canberra policy song sheet.

Health Minister Sussan Ley wiped the slate clean when she was appointed in December, setting up a raft of reviews to look at everything from primary care to disinvestment.

Importantly, reviews must consider whether the Medicare Schedule is still "fit for purpose" in the context of the increase in chronic disease and the impact this is having on clinical practice.

It must be hoped new policies developed in response will be both more sophisticated and less profligate than we have seen over recent decades.

INFORMATION FOR MEMBERS

Essential GP tools at the click of a button

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

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

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

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

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

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

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

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

Health on the hill

POLITICAL NEWS FROM THE NATION'S CAPITAL

'Why has this Government got it in for sick people?'

AMA President Professor Brian Owler has accused the Federal Government of 'having it in' for the ill over its plan to scrap bulk billing incentives for pathology services and downgrade them for diagnostic imaging.

As Health Minister Sussan Ley admitted some patients "may be worse off" as a result of the changes announced in the Mid Year Economic and Fiscal Outlook, Professor Owler warned they would increase expenses for patients and amounted to a "co-payment by stealth".

"I really don't understand why this Government has it in for sick people," he told Channel Nine.

The AMA President said the Government's decision to save around $300 million by axing bulk billing incentives for pathology services would force many providers, who haven't had their Medicare rebate indexed for 17 years, to introduce a charge for patients.

"That is why it is a co-payment by stealth," Professor Owler told ABC radio. "It's about forcing providers to actually pass on those costs to their patients.

"So, while Tony Abbott might have said that the co-payments plans was dead, buried and cremated, it seems to have made a miraculous recovery and it's reaching out from beyond the grave – or, at least, components of it are."

Treasurer Scott Morrison has denied the claim, and Health Minister Sussan Ley said competition in the pathology industry would ensure increased costs were absorbed by providers rather than being passed on to patients.

In an interview on ABC Radio she initially claimed there were 5000 providers operating in a "highly corporatised and highly competitive" environment.

She later clarified her comments, admitting that there were 5000 collection centres rather than individual operators, and most were owned by "two very large corporate entities and they're doing very nicely."

Ms Ley said the charging practices of providers was a commercial decision and "we can't dictate what they charge patients".

But Professor Owler said it was "completely ridiculous" for the Government to pretend its cuts would not result in charges for patients.

"You can't take out what is essentially over $300 million from pathology and not expect that there's going to be some sort of effect on patients," he said. "Without that money being supplied to those providers, of course they're going to have to charge the patients and so you're going to see more patients with more out of pocket expenditure.

"And that is the plan of this Government - to pass more expense on to the pockets of the patients, and that is going to affect the sick and the most vulnerable in our community."

In addition to axing and downgrading bulk billing for pathology and diagnostic imaging services, the Government expects a further $595 million will be saved by "streamlining" health workforce funding, including dumping several programs including the Clinical Training Fund (which was originally intended to fund up to 12,000 clinical training places across a range of disciplines), the Rural Health Continuing Education Program, the Aged Care Education and Training Initiative and the Aged Care Vocational Education and Training professional development program.

The Federal Government is also tapping the aged care sector for significant savings. It plans to cut more than $480 million by improving the compliance of aged care providers and making revisions to the Aged Care Funding Instrument Complex Health Care Domain.

The Government also expects to realise $146 million in savings from improving the efficiency of health programs, and

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plans to extract $78 million from the Independent Hospital Pricing Authority and $104 million from the National Health Performance Authority.

A further $31 million will be withdrawn from public hospital funding over the next four years.

Professor Owler said the health sector needed more detail and explanation from the Government regarding the MYEFO cuts.

"All up, MYEFO has delivered another significant hit to the health budget with services and programs cut, and more costs being shifted on to patients," he said.

The health savings have been announced as part of measures to help improve the Budget, which has been rocked by a plunge in revenues caused by soft economic activity and falling commodity prices.

Since May, the Budget deficit has swelled by more than $2 billion to $37.4 billion, and is expected to be $26 billion bigger than anticipated over the next four years. Mr Morrison has targeted social services and health to deliver the bulk of spending cuts needed to put the Budget on the path to a surplus, which has been pushed back to 2020-21.

But the tenuous nature of this goal has been underlined by the fact that several of the savings measures the Government is relying on to help achieve its surplus have little prospect of being implemented.

In particular, proposed changes to the Medicare Safety Net, worth $267 million, were withdrawn by Ms Ley after failing to garner sufficient support in the Senate, but are still included in the Budget.

While the Government targeted health for major cuts, it did announce some initiatives welcomed by the AMA, including $131 million to expand the Rural Health Multidisciplinary Training Program and establish grants for private health care providers to support undergraduate medical places, and a further $93.8 million to develop an integrated prevocational medical training pathway in rural and regional areas – a measure the AMA has long been advocating for.

The Government has also introduced new MBS items for sexual health and addiction medicine services.

ADRIAN ROLLINS

Ley tries to stymie critics with hep C link

Health Minister Sussan Ley has attempted to stifle opposition to controversial pathology and diagnostic imaging bulk billing incentive cuts by linking the changes to plans to eradicate hepatitis C within a generation.

The Health Minister said a $1 billion initiative to publicly subsidise access to breakthrough hepatitis C drugs had been "fully accounted for" in the mid-year Budget update unveiled on 15 December, but had not been announced at the time to enable confidential price negotiations with the drug companies to be finalised.

Ms Ley confirmed to the *Adelaide Advertiser* that axing and winding back bulk billing incentive payments for pathology and diagnostic imaging tests – collectively expected to save $650 million over four years – would help fund the subsidy for hepatitis C drugs.

"This demonstrates that the Government is prepared to make the tough decisions to prioritise where we should put our health dollar in Australia," the Minister said.

By linking the two measures, Ms Ley will make it harder for political opponents of the bulk billing incentive cuts to block the measures in the Senate, where many previous health measures have foundered – most recently proposed changes to the Medicare safety net.

Shadow Health Minister Catherine King told the *Adelaide Advertiser* that, while she welcomed the decision to list hepatitis C treatments on the PBS, it was "an absurd proposition" to make patients with cancer, diabetes and other serious health conditions pay for the treatment of other seriously ill people.

AMA President Professor Owler has criticised the bulk billing cuts, warning that they amounted to a "co-payment by stealth" because they would force pathology companies to begin charging patients a fee.

One of the nation's largest providers, Sonic Healthcare, has already warned that patients could be charged $20 for a blood test.

Professor Owler said such a co-payment would hit chronically ill patients in need of frequent pathology tests particularly hard, and would discourage many from having diagnostic tests, increasing the risk of more serious health problems later in life.

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But Ms Ley has vowed to confront providers over any plans to introduce a co-payment, claiming such a move was "not appropriate".

She has argued that competitive pressures in the pathology industry meant that companies should absorb the cut, rather than passing it on to patients.

But the pathology market is dominated by two major providers, and the fact that they are contemplating introducing a co-payment suggests the Government's analysis of the dynamics of the market is flawed.

But the Minister appears confident that she has the upper hand in the politics of the debate, particularly given her move to link the bulk billing incentive cuts to the hepatitis C announcement.

"I have every expectation that Labor will pass these savings, as they make perfect sense – and, particularly, in the context of an announcement like [the hepatitis C initiative]," she told the *Australian Financial Review*.

Under the measure, the Government will list four new frontline drugs for the treatment and cure of hepatitis C, including sofosbuvir with ledipasvir (Harvoni), sofosbuvir (Sovaldi), daclatasvir (Daklinza), and ribavirin (Ibavyr), on the Pharmaceutical Benefits Scheme from March next year.

The move is expected to benefit around 233,000 people currently infected with the blood-borne virus that attacks the liver causing serious illness, including cirrhosis and cancer. Around 10,000 people are diagnosed with the disease each year, and it responsible for about 700 deaths annually.

The Government's decision came eight months after the Pharmaceutical Benefits Advisory Committee recommended that sofosbuvir be listed on the PBS because of "high clinical need".

This overturned advice from the PBAC a year earlier, in which it recommended against listing the drug because it was likely to have "a high financial impact on the health budget".

In recommending the drug's listing, the PBAC warned it was likely to cost taxpayers $3 billion over five years to put 62,000 chronic hepatitis C patients through a course of treatment – three times the Government's current budgeting.

Though sofosbuvir has been hailed as a "game-changing" medicine that can cure hepatitis C in as little as 12 weeks, its prohibitive price – a course of treatment can cost more than $110,000 – has meant that until now it has been out of the financial reach of most sufferers.

Listing on the PBS means a prescription will cost as little as $37.70 for general patients and $6.10 for concession card holders.

Ms Ley said the combination therapies listed on the PBS had a 90 per cent success rate, and caused fewer side effects than current treatments. She said in most cases patients will only need to take the drug as a pill.

The fact that the Government has budgeted just $1 billion for the measure suggests either that it has managed to negotiate a significant discount with the drug companies, or will eventually need to allocate more money to the effort.

ADRIAN ROLLINS

Tribunal snuffs out latest bid against plain packaging

The tobacco industry is pushing ahead with efforts to overturn Australia's world-leading plain packaging laws despite failing in its latest attempt to kill them off.

Less than a month after France became to the latest country to introduce plain packaging legislation, a bid by tobacco giant Philip Morris to have plain packaging ruled invalid under the terms of Australia's bilateral investment treaty with Hong Kong has been rejected by the Permanent Court of Arbitration sitting in Singapore.

The Tribunal unanimously accepted the Federal Government's argument that it did not have jurisdiction to hear a claim by Philip Morris Asia that the legislation breached trademark protection laws.

The ruling is the latest setback for tobacco companies fighting a rearguard action against plain packaging measures, which are being adopted by a growing number of countries.

The French parliament backed the introduction of plain packaging from May 2016, joining Britain, Ireland and

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Australia, which in 2012 became the first country in the world to enact the measure.

Under the laws, tobacco products must be sold in plain packets carrying graphic health warnings.

The measure has been vehemently opposed by the tobacco industry, which has claimed it infringes on copyright and will drive an increase in trade in illicit tobacco products.

Philip Morris International Senior Vice President Marc Firestone described the tribunal's ruling as "regrettable", and said the company was reviewing the decision.

The arbitration ruling means the tobacco industry is running out of legal options to challenge plain packaging.

Soon after the legislation was passed in late 2011, British American Tobacco launched action in the High Court, but its bid was rejected.

Several tobacco-producing countries have also launched action against the legislation under the auspices of the World Trade Organisation, and this bid remains outstanding.

Several courts in Europe are also assessing the legality of plain packaging under national and international law.

In its latest *Position Statement on Tobacco Smoking and E-cigarettes*, the AMA said tobacco companies had used packaging to convey messages around social status, values and character, and there were signs that forcing producers to use plain packaging was having an effect rates of smoking.

A group of studies published in the *British Medical Journal* found that plain packaging reduced brand appeal and image, and indicated that the proportion of smokers who wanted to quit jumped 7 percentage points following the introduction of plain packaging.

The AMA said that although the measure has not been in place long enough to establish strong evidence of effectiveness, "preliminary research is very promising".

In addition, it said there was no evidence that plain packaging had led to an increase in the consumption of illicit tobacco.

ADRIAN ROLLINS

Profit-hungry insurers put health system at risk

Aggressive cost-cutting by health insurers is leaving patients stranded without adequate cover and putting the private health system at risk, the AMA has warned.

The peak medical group has told the Federal Government's Private Health Insurance Review that industry practices including downgrading existing policies, habitually rejecting claims, lumbering patients with bigger out-of-pocket costs, pressuring policyholders into reducing their cover and selling people cover they don't need, were badly compromising the value of private health cover and could eventually upset the delicate balance between the public and private health systems.

"On their own, these activities reduce the value of the private health insurance product," the AMA said in its submission to the Review. "Collectively, they are having a destabilising effect on privately insured in-hospital patient care and treatment."

Health Minister Sussan Ley launched the Review amid growing outrage about the remorseless rise of private health insurance premiums, which far outstrip inflation.

Ms Ley said people were increasingly calling into question the value for money in private health insurance, and late last year sought consumer views on changes including allowing insurers to charge different premiums according to age, gender and smoking status - effectively ending the system of community rating.

But whereas the Health Minister has put the focus on industry regulation as much of the cause of the problem, AMA President Professor Brian Owler said it was being driven largely by the hunger for profit.

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Professor Owler said there were several emerging trends in private health insurance that were alarming, most notably a steady downgrading in the quality of cover on offer.

He said that in the last six years the proportion of people with policies that had exclusions had jumped from 10 to 35 per cent, often with serious consequences.

The AMA President said it had become virtually a daily occurrence for patients booked in for common treatments to discover upon arrival that they were not covered by their insurance.

He said all too often insurers made changes to a policy after it had been bought without informing policyholders, leaving many unexpectedly stranded.

"People are shocked to make this discovery only when they need a particular treatment, and doctors are seeing this happen on a daily basis," Professor Owler said.

The AMA is also concerned by growth in policies that only cover admission as a private patient in a public hospital, or which contain significant exclusions, such as for cardiac treatment or joint replacement.

"A high rate of 'insured' people with exclusion policies is effectively creating a risk rating system, as insurers reduce their exposure by offering products that are less likely to require them to pay benefits," it said, adding that many were inadvertently buying "junk" policies that are designed solely to avoid incurring the Medicare surcharge and provide no practical health cover.

"People think they have purchased a product that will allow them [a] choice of doctor and to jump the public waiting list, but this is unlikely in reality," the AMA said.

Another development in the peak medical group's sights is the decision of some insurers not to cover the costs of patients readmitted to private hospital because of complications arising from their treatment.

The AMA said the new approach, pioneered by Medibank Private, the nation's largest insurer, has serious implications for patient care, and interfere with established safety and quality arrangements.

It warned this could lead private hospitals to refuse to admit patients at high risk of complications, directly compromising the ability of doctors to care for their patients and likely forcing more patients with chronic and complex conditions into the public system.

This risk would be compounded by the possibility, aired by Ms Ley in her consumer survey, that insurers could charge different premiums according perceived health risk.

The AMA warned that such a change would fatally undermine the central tenet of community rating, which requires that all holders of a particular policy pay the same premium – a requirement that helps ensure private cover is available to all.

Professor Owler said that, taken together, these developments in private health insurance did not bode well for the nation's health system.

"The nature of the current policy offerings, coupled with the behaviour of some insurers to minimise the benefits they pay, is undermining the quality of the product," he warned. "If consumers withdraw from private health insurance because it is a low value product, or quality products are unaffordable, or risk-rating means some people are uninsurable, there will be additional pressure on the public hospital sector, which is already struggling to meet demand."

Professor Owler said the Private Health Insurance Review needed to take account of how developments in private health insurance would affect the balance between the public and private health systems.

But he said the Government appeared to have little interest in this, and was instead "more focused on removing itself from financial and regulatory responsibility for the private health sector".

The Government has flagged interest in dumping the private health insurance rebate and substituting it with a Medicare-style rebate system for hospital treatment that could be used in both the private and public sectors.

ADRIAN ROLLINS

Research

ADHD drugs may cause more bad than good

Researchers have urged caution when prescribing methylphenidate-based drugs to treat Attention Deficit Hyperactivity Disorder (ADHD).

Despite large amounts of research documenting the drug's usefulness in treating ADHD, evidence that it causes increased sleeplessness and loss of appetite has caused Danish researchers to reconsider its effectiveness.

ADHD is a commonly diagnosed childhood disorder that can continue through adolescence into adulthood. Symptoms include difficulty focusing attention and remaining on task, excessively impulsive behaviour, and extreme hyperactivity. Methylphenidate-based drugs have been used to treat ADHD for more than 50 years.

The researchers reviewed data from 185 randomised control trials involving more than 12,000 children. The studies were conducted in the US, Canada, and Europe and included males and females from ages three to 18 years. The studies all compared methylphenidate-based drugs with either a placebo or no intervention.

The researchers found that methylphenidate led to modest improvements in ADHD symptoms, general behaviour, and quality of life. But an analysis of adverse effects showed children were more likely to experience sleep problems and loss of appetite while on the drug.

The researchers raised concerns over the validity of the data that they examined, saying it was possible participants were aware of which treatment the children were receiving, and the reporting of the results was not complete in many of the trials.

Nonetheless, the researchers urged clinicians to weigh up the benefits and risks more carefully before prescribing methylphenidate-based drugs to treat ADHD.

Lead researcher Professor Ole Jakob Storebo from the Psychiatric Research Unit in Region Zealand, Denmark, said the review highlights the need for long-term, large, and better-quality randomised trials to determine the average effect of the drug more reliably.

The researchers said that clinicians and families should not rush to discontinue using methylphenidate, and if a child or young person has experienced benefits without experiencing adverse effects, then there may be good clinical grounds to continue using it.

Patients and their parents should discuss any decision to stop treatment with their health professional before doing so.

The researched appeared in the *British Medical Journal*.

KIRSTY WATERFORD

Omega-3 supplements may not help with depression

The effectiveness of taking omega-3 fatty acid supplements to treat major depressive disorders has been cast into doubt by British researchers.

Omega-3 fatty acids are widely thought to be essential for good health and are found naturally in fatty fish and some nuts and seeds.

Clinical trials have indicated that omega-3 can be effective as an adjunctive treatment for people with treatment-resistant depression. More recent evidence indicates that it may also be a useful monotherapy for childhood depression and for depressed mood in patients who engage in recurrent self-harm.

But University of Bournemouth researchers have found the common supplement may offer only a small enhancement to mood. They collated data from 26 randomised trials involving more than 1400 participants, and examined the defect of taking an omega-3 fatty acid supplement in capsule form compared with a placebo.

The researchers found that while patients given omega-3 fatty acids reported lower symptom scores than patients on the placebo, the effect was small, and there were limitations that undermined their confidence in the results. The researchers said more data was needed to understand the effects and risks of taking omega-3 fatty acids to enhance mood.

Lead author Associate Professor Katherine Appleton said that currently there was not enough high-quality evidence to determine the effectiveness of omega-3 fatty acid as a treatment for major depressive disorder.

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"It's important that people who suffer from depression are aware of the facts around omega-3, so that they can make informed choices about their treatment, "Associate Professor Appleton said.

"We found a small-to-modest positive effect of omega-3 fatty acids compared to placebo, but the size of this effect is unlikely to be meaningful to people with depression, and we considered the evidence to be of low or very low quality."

The research was published by the Cochrane Library.

KIRSTY WATERFORD

Infectious bacteria found in sticky situation

Sticky fingers are unavoidable when indulging in sugar coated sweets, but scientists have discovered that some infectious disease causing-bacteria use this sticky situation to their advantage.

Pathogenic bacteria has been found to initiate infection in a rather unique way – it uses its surface sugars to attach bacteria directly to sugars on the surface of human cells.

Researchers have found that four different types of bacteria pathogens: Campylobacter jejuni, Salmonella typhimurium, Shigella flexneri and Haemophilius influenzae, use this method to spread infection.

University of Adelaide researchers found that the Shingella flexneri bacteria, which causes millions of episodes of dysentery each year, use sugars of their surface lipopolysaccharide molecules to stick to human gut cells.

There is no Shingella vaccine currently available despite decades of research worldwide, and the bacteria can be resistant to antibiotics. The researchers hope their new understanding of how the bacteria spreads will advance progress towards a vaccine and other ways to block the sugars.

Lead researcher Associate Professor Renato Morona said that "as a result of the discovery we now have a better understanding of how bacteria initiate infections and how many current vaccines work".

"It's been known for a long time that sugars on the surface of bacteria can be involved in bacteria sticking to cells, to promote infections," Associate Professor Morona told Adelaide Advertiser.

"What hasn't been realised is that these sugars are often sticking to is sugars on the surface of cells."

Associate Professor Morona said that while bacteria were known to use sugars to attach proteins, any sugar-to-sugar interaction was considered either impossible, weak, or irrelevant.

"The discovery is fundamental knowledge that is broadly applicable to many other bacteria and microbes, and could have other translational outcomes such as probes for studying human cells, and development of better infant milk formula," Associate Professor Morona said.

The research was supported by the National Health and Medical Research Council. The team has received a four-year grant to explore the potential of their discovery.

The University of Adelaide in collaboration with Griffith University published the research in the *Proceedings of the National Academy of Sciences journal.*

KIRSTY WATERFORD

Brit doctors strike over dangerous work changes

Key points

- NHS doctors to strike
- Talks deadlocked over unsafe hours, weekend pay cut

Junior doctors working in British public hospitals are set to go on strike in landmark industrial action following the failure to resolve a dispute over safe working hours and pay rates.

The British Medical Association has announced that a 24-hour strike planned for 12 January will go ahead because it remains at loggerheads with the Government and the National Health Service (NHS) over planned changes it warns will increase doctor fatigue, compromise patient safety and undermine staff retention and recruitment.

During the strike, which has the backing of hundreds of other NHS staff including nurses, health care assistants and porters, junior doctors will provide emergency care only. Similar strike action is planned for 26 January, and junior doctors are threatening full withdrawal of their labour on 10 February if the dispute is not resolved by then.

The action centres on a push by Health Secretary Jeremy Hunt to roster more doctors on the weekend and water down safeguards against excessive hours without offering any extra compensation.

The Minister's plans were overwhelmingly rejected by junior doctors in November, when 98 per cent voted to strike. The BMA called off a strike planned for late last year and instead organised mediated talks with the Government and NHS.

But, in a statement issued last week, BMA Council Chair Dr Mark Porter accused the Government of failing to take doctor concerns seriously.

"Throughout this process, the BMA has been clear that it wants to reach agreement on a contract that is good for patients, junior doctors and the NHS," Dr Porter said. "This is why, despite overwhelming support for industrial action, the BMA instead sought conciliation talks with the Government; talks which were initially rejected and delayed by Jeremy Hunt.

"After weeks of further negotiations, it is clear that the Government is still not taking junior doctors' concerns seriously.

"We sincerely regret the disruption that industrial action will cause, but junior doctors have been left with no option. "It is because the Government's proposals would be bad for patient care as well as junior doctors in the long-term that we are taking this stand."

The doctors and the Government appear to be close to reaching an agreement on changes to salary arrangements, including basing pay progression on undertaking greater responsibilities and the principle of pay for all work done.

But the two sides are deadlocked on rostering changes.

To fulfil Mr Hunt's vision for a "seven-day NHS", the Government wants junior doctors to work to a round-the-clock, seven-day week roster without any additional compensation.

The BMA said junior doctors were willing to work with the Government on ways to realise the Minister's goal, but "only in a sustainable way that does not make a career in medical practice in the UK less attractive".

"This is a significant area of disagreement," the Association said. "The BMA fundamentally rejects the idea that Saturday is a normal working day and should be paid as a weekday."

Doctors are particularly concerned that the Government is trying to push through rostering changes without sufficient safeguards.

The BMA said patient and doctor safety must be the primary focus, and raised fears that the arrangements sought by Mr Hunt and employers could result in "extremely detrimental rotas for non-resident on-call shifts", including forcing doctors to work the day after being on-call, without an adequate break.

It said there needed to be limits set on working hours "to ensure that patients are not treated by tired, overworked doctors". This should include caps on hours worked per shift, the number and type of shifts worked in each rolling seven-day period, and provision for adequate breaks.

The BMA said that in addition to ensuring patient and doctor safety, such safeguards would improve the ability of the NHS to attract and retain staff.

"Ensuring that junior doctors are paid fairly for work they do in unsocial hours will go some way to addressing recruitment problems in specialties that work most intensely across 24 hours," it said. "This is crucial in order to safeguard the future workforce of the NHS."

Mr Hunt has condemned the proposed strike, saying it "helps no-one".

He claimed that the only outstanding area of disagreement was cuts to weekend pay, implying the industrial action was unnecessary.

ADRIAN ROLLINS

Health gets a guernsey in Paris

The right to health has been explicitly recognised in the agreement negotiated at the United Nations Paris climate change talks, boosting hopes of an increasing focus on the health effects of global warming.

In its preamble, the Paris Agreement directed that, when taking action on climate change, signatories should "respect, promote and consider their respective obligations on...the right to health".

Director of the World Health Organisation's Department of Public Health, Environmental and Social Determinants of Health, Dr Maria Neira, hailed the declaration as a "breakthrough" in recognising the health effects of climate change.

"This agreement is a critical step forward for the health of people everywhere," Dr Neira said. "The fact that health is explicitly recognised in the text reflects the growing recognition of the inextricable linkage between health and climate."

Dr Neira said that health considerations were essential to effective plans to adapt to climate change and mitigate its effects, and "better health will be an outcome of effective policies".

Under the Paris deal, countries have expressed an "ambition" to limit global warming to less than 2 degrees Celsius, the point at which science suggests climate change becomes untenably dangerous.

While avoiding setting an explicit target, the signatory countries, including Australia, committed to "pursuing efforts to limit the temperature increase to 1.5 degrees Celsius".

Attempts to orchestrate concerted global climate change action have in the past been frustrated by arguments over who should bear the greatest responsibility for causing climate change and, as a consequence, who carries the greatest obligation to ameliorate its effects.

Developing countries have argued that industrialised nations have become rich on fossil fuel-based economic activity and should bear the greater share of the burden in adopting to its consequences.

But developed countries have countered that any progress they make in curbing greenhouse gas emissions should not be simply offset by an increase in emissions from emerging economies.

The Paris agreement has sought to break the impasse by detailing a framework of "differentiated responsibilities" for climate action. Developed countries are expected to take the lead in reducing greenhouse gas emissions, but developing nations are also expected to contribute.

To help drive the global response, it is expected that by 2020, countries will contribute $US100 billion a year to a global fund to finance emission reduction and climate change adaptation measures.

Though the agreement does not include any enforcement mechanism, countries are required to provide an update on their climate change action every five years, and each successive update has to be at least as strong as the current one, leading to what the framers of the document hope will be a "ratcheting up" of measures over time.

The promising outcome to the Paris meeting followed a call by the AMA and other peak medical groups worldwide for more concerted action to prepare for and mitigate the health effects of climate change.

In an updated *Position Statement on Climate Change and Human Health* released last year, the AMA highlighted multiple health threats including increasingly frequent and severe storms, droughts, floods and bushfires, pressure on food and water supplies, rising vector-borne diseases and climate-related illnesses and the mass displacement of people.

AMA President Professor Brian Owler said significant health and social effects of climate change were already evident, and would only become more severe over time.

"Nations must start now to plan and prepare," Professor Owler said. "If we do not get policies in place now, we will be doing the next generation a great disservice. It would be intergenerational theft of the worst kind – we would be robbing our kids of their future."

The AMA's *Position Statement on Climate Change and Human Health* can be viewed at: https://ama.com.au/position-statement/ama-position-statement-climate-change-and-human-health-2004-revised-2015

ADRIAN ROLLINS

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