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Taken off course

Drop cost-cutting focus to bring MBS Review on track, p7

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In this issue

GPs hit by MBS Review misinformation

BY AMA PRESIDENT PROFESSOR BRIAN OWLER

GPs have been unfairly and wrongly portrayed recently as major contributors to waste in the health system. In fact, the integrity of all doctors was questioned.

The release of the MBS Review Discussion Paper, coupled with last month's controversial *Four Corners* program on waste in the health system, placed a lot of blame at the feet of hardworking and dedicated GPs. There was little evidence to back these claims.

Such is the nature of the MBS Review, and its politicisation, that we will be seeing a lot of misinformation, skewing of statistics, and blame and accusation before it is through.

The AMA mounted a strong defence of GPs, and we asked some serious questions about the direction the MBS Review was taking.

Let me make it clear that the AMA supports the Review. We have been there since day one.

But our support for the Review is based on some important considerations. The Review cannot and must not be primarily about saving costs for the Government. And it must deliver a modern Schedule, which must include the addition of new items that reflect modern medical practice.

The AMA reacted strongly to the release of the Discussion Paper because the commentary from the Government suggested our conditions were not being honoured.

We cannot support a Government and Department Review that does not include the ability to put new items on the Schedule outside the existing MSAC process, that pre-empts the outcome of the Review in terms of individual procedures, and which is clearly aimed at cost savings - with the bulk of the savings going to the budget bottom line, not back into health.

But this is what was being sold to the Australian community with the release of the Discussion Paper, and magnified by the unbalanced reporting on *Four Corners*.

The AMA strongly objects to attacks on the integrity of the medical profession.

We object to the characterisation that 30 per cent of medical procedures are unnecessary and harmful to patients, and performed for financial gain. This is an American claim of the American system, which has no evidence in the Australian context.

We also disagree with the claim that 150 procedures have been identified in an Australian study with evidence as being wasteful or harmful. The paper suggested that these procedures may be worthy of review in that they may be wasteful or harmful in some clinical contexts. Not a lot of evidence there.

People have to be careful how they use the terms 'evidence' and 'evidence-based' with this Review.

There are around 5700 items on the MBS, and three per cent have been through the evidence-based MSAC process, but that doesn't mean that there is no evidence behind all of the other things that doctors do.

This doesn't mean that we actually need to have evidence-based reviews of whether you need a general anaesthetic or whether you need a lifesaving operation.

For example, I don't need an evidence-based review to say that I should remove the tumour from a child that presents through the emergency department, because I know they're going to end up dead within the week if I don't do it.

So, there are some things that need to be evidence-base reviewed, but there are many on the schedule that don't. For people to be saying that 97 per cent of the Schedule does not have evidence is, I think, quite misleading.

It is for this and other reasons that the AMA will continue to comment on the Review and, where necessary, criticise the process and outcome.

We will continue to discuss our concerns with the Minister and others to advocate for a better outcome.

We will also engage with other organisations to understand their concerns about the Review as necessary.

We support the Review, but it has to be the right Review – for doctors, our patients, the health system, and the broader community.

Doctors as advocates for public health

BY **AMA VICE PRESIDENT DR STEPHEN PARNIS**

'Nanny state' is now a predictable putdown in response to public health initiatives from those with little understanding or sympathy for the issues involved.

> "Doctors see first-hand, every day, the tragic effects of irresponsible behaviour, the suffering of the individual and the innocent bystander - which is why we are unashamed champions for public health"

As my colleague Brian Owler recently put it, "Doctors see first-hand, every day, the tragic effects of irresponsible behaviour, the suffering of the individual and the innocent bystander - which is why we are unashamed champions for public health".

As an emergency physician, I'm often the first doctor to be confronted by these tragedies. I've treated a boxer who suffered a life threatening head injury as the result of a punch, and a number of children who have suffered head injuries while riding bicycles that could have been minimised or avoided altogether by wearing a helmet. I could fill a book with the litany of destruction caused by alcohol abuse, and I hope I never again have to diagnose whooping cough in an infant.

These individuals required my care because the public health measures in place fell short of the mark in some shape or form. It may relate to issues of enforcement, public understanding, practicality, cost, or even political ideology. But, as a result, the likelihood of avoidable harm taking place remains far higher than it should be.

In a society with as many freedoms as ours, Australians are able to make their own choices about lifestyle, as long as those choices are within the law. But these choices need to be informed, and they need to be respectful of the impact they have on others. After all, we live in a community, we benefit from each other, and we have the capacity to harm each other.

The Senate Standing Committee on Economics is pursuing an inquiry into personal choice and community impacts. The Inquiry is examining bicycle helmet laws, alcohol laws, marijuana and tobacco, and the classification of publications, films and computer games.

At best, this could be an opportunity to recognise our successes in public health and safety, and to look for improvements. However, I have no doubt that it is there to undermine many of the public health and safety measures upon which our community has long depended.

Our public health measures come from evidence and research, not a baseless ideology. There are valid, causal factors why the last case of polio in Australia occurred in 1972, why the road toll peaked in the early 1970s and is continuing to decline, and why smoking rates are at an all-time low. And yet, one of the Senators driving this inquiry saw fit to give a speech in Parliament recently entitled "Thank you for smoking". (No, it wasn't a joke.)

The AMA has lodged a submission with the Senate Committee. In it, we outlined the reasons for the importance of public health measures, and why there are times when these measures need to be implemented in ways that restrict personal choice to a degree.

Preventive health measures can work. In fact, they save lives, and I will cite a clear and enduring example. In the aftermath of the horrific Port Arthur massacre in 1996, the Howard Government introduced a series of laws curtailing gun ownership and use in Australia, despite passionate opposition. In the subsequent decade, gun-related homicides fell by 59 per cent, and gun-related suicides fell by 65 per cent. Our success has frequently been cited as a model to follow in the United States, where gun-related deaths, both accidental and deliberate, are commonplace.

In a civil society, governments have an essential role in the promotion of a safer, healthier community. Public health measures make this country safer and healthier, and do so for a fraction of the cost of acute treatment.

The AMA is committed to promoting Australia's health - it's a key part of our mission statement. We won't be deterred by those who would have us turn back the clock.

Health policy concerns persist despite Liberal leadership change

BY **AMA SECRETARY GENERAL ANNE TRIMMER**

> "Mr Wyatt is not only the first Indigenous person to be in the executive government, but he brings with him a strong background in health, having worked in the health system in Western Australia for some years"

The change in leader of the Federal Liberal Party has shifted the dynamics in Canberra, with high expectations that Prime Minister Malcolm Turnbull will live up to his promise of a 21st Century Government focused on innovation, science and technology.

The Health portfolio was relatively untouched in the reshuffle of ministries following the election of Mr Turnbull, with the senior Minister Sussan Ley remaining as Minister for Health and Minister for Sport.

The AMA has warmly welcomed the appointment of Ken Wyatt as Assistant Minister for Health. Mr Wyatt is not only the first Indigenous person to be in the executive government, but he brings with him a strong background in health, having worked in the health system in Western Australia for some years.

Senator Fiona Nash's portfolio is now dedicated to rural health. While workforce continues to be a significant issue in rural and regional areas, the appointment might well open the door to further lobbying for an additional medical school based in the Riverina.

The reviews initiated by Minister Ley remain a focus of the work within the AMA secretariat.

Members will have received an email from the President, Professor Brian Owler, during September highlighting his concerns with the direction of the MBS Review.

The head of the MBS Review Taskforce, Professor Bruce Robinson, outlined his approach in a presentation to a meeting of representatives of the Colleges and specialist societies convened by the AMA President in late August. This was followed by a series of media interviews which again highlighted the planned approach to the Review, which varied considerably from the approach which the Minister had presented in announcing the Review. The AMA is continuing to monitor closely the work of the Taskforce and the many working groups which are being established.

In late May, the AMA became aware of the provisions of the Australian Border Force Act 2015 which have the effect of exposing a medical practitioner, or other worker employed by or on behalf of the Department of Immigration and Border Protection, to the possibility of two years' imprisonment for disclosing information learned in the course of their work.

For doctors who are working with asylum seekers, this presents an unreasonable restriction on their capacity, or indeed obligation, to speak up where they see harm done to a patient.

The AMA has been working with other organisations, in particular the Law Council of Australia, to propose amendments to the legislation to exempt those speaking out on public interest grounds.

While commentators have suggested that it is unlikely that the Government would initiate a prosecution against a doctor for speaking out, the legislation on its own has the effect of preventing comment.

The legislation and other issues relevant to the health of asylum seekers was discussed at a recent roundtable convened by the President.

The AMA Federal Council has also established a small working group to revise the AMA's Position Statement on asylum seeker health. Recent events in Europe involving the mass movement of people fleeing war-torn regions has highlighted once more the vital role played by doctors in providing assistance.

Medicare review taken off course

The AMA has demanded the Federal Government recast its approach to the Medicare Benefits Schedule Review as medical researchers have distanced themselves from claims doctors are routinely ordering ineffective and potentially harmful tests and procedures that are costing the nation cost the nation hundreds of millions of dollars each year.

The AMA has reasserted its support for the Medicare Benefits Schedule Review (and the accompanying Primary Health Care Review) as long as it not only about removing outdated services and procedures, but replacing them with items that reflect modern practice.

AMA President Professor Brian Owler told *The Australian Financial Review* the medical profession backed efforts to update the MBS but "we're not going to have a Review that takes money away and puts it on the bottom line of the Budget, and the [Health] Minister [Sussan Ley] says that's where it's going. It takes services away from patients."

The blame game

There has been mounting disquiet over the Government's handling of the Review, including the depth of consultation with clinician representatives and claims that the vast majority of items were not backed by evidence, and around 30 per cent of all care was of little worth.

Fears about the direction the Government was taking were crystallised on 27 September when Ms Ley launched public consultations by arguing that only a tiny fraction of the 5769 items on the MBS had been assessed for effectiveness and safety, and "inefficient and unsafe Medicare services…cost the nation dearly".

Issuing the call for consumers to participate in the Review, Ms Ley said that, "30 per cent of expenditure is not necessary, wasteful, sometimes even harmful for patients".

Professor Owler said the claim was not only "factually incorrect", but was being used by the Government and the Review Taskforce Chair Professor Bruce Robinson to try and frame the discussion around the idea that there were massive savings to be made because doctors were milking the system.

The AMA President said the figure had been uncritically imported form the United States and there had been no evidence to support it in the Australian setting.

Instead, he said, the Government's real intention was to use the Review to make Budget savings.

"They need to be upfront about what this process is and that it's a budget preparation measure," he told the AFR. "We're having this conversation and it's 'No, no, this is not a cost saving exercise'. But, 'Yes, the cost savings are going to the bottom line of the budget'. They say 'Yes, we will reinvest', but it's going to be a very protracted, drawn out process to get any money back into MBS."

Follow the evidence

A day after the Government launched the consultation process, ABC television's *Four Corners* program aired claims that doctors were ordering tests and performing procedures that were of little or no benefit for patients and cost the nation hundreds of millions of dollars each year, including scans for lower back pain, spinal fusion surgery, knee arthroscopies and inserting stents in patients with stable angina.

Ms Ley seized on the program, which she said had exposed "real – not perceived – waste in health spending", and demonstrated the need for the MBS Review.

The Minister said medical specialists and health researchers appearing on the program had "put their professional reputations on the line to provide important insight into billions of dollars being spent on unnecessary, outdated, inefficient and even potentially harmful procedures".

Follow evidence, not myths, in Medicare review

... from p7

But two researchers whose work was drawn on in the *Four Corners* program to help substantiate claims that doctors used inappropriate and unnecessary tests and procedures said their data had been misinterpreted and taken out of context.

Writing in *Medical Observer,* Associate Professor Helena Britt and Associate Professor Graeme Miller said that although their research showed GPs ordered imaging in about 25 per cent of new cases of low back pain, "conversely, we could equally state that 75 per cent of new cases were not sent for imaging".

The researchers said that while they did conclude that the rate of imaging for back problems at the initial encounter was inconsistent with guidelines, this was only the case if there were no 'red flag' issues present, such as significant trauma, fever, weight loss, inflammatory conditions or advanced age.

"Unfortunately," they said, "we cannot identify whether or not patients referred for imaging for back symptoms had any of these red flags, but the guidelines suggest that zero imaging for all cases would not represent best quality care."

Ms Ley rejected claims the Government had launched an attack on the medical profession, and asserted that 97 per cent of MBS items had never been assessed for their clinical effectiveness or safety.

But Professor Owler said the Minister's claim was "quite misleading".

While just 3 per cent of items had been assessed through the Medical Services Advisory Committee process, the AMA President said, "but that doesn't mean that there's not evidence behind all of the other things that we do".

He questioned the need for evidence-based reviews for performing life-saving operations: "I don't need an evidence-based review to say that I should remove the tumour from a child that presents through the emergency department because I know they're going to end up dead within the week if I don't do it."

"There are some things that, yes, we need to evidence-based review, but there are many on the schedule that don't, and saying that 97 per cent doesn't have evidence is quite misleading."

MBS reviews nothing new

He said the medical profession had to be "vigilant" about the narrative being used to shape debate about the Review.

Professor Owler said the AMA not only supported the MBS reviews, but had been engaged with successive governments in undertaking them since 1990. He said in the last five years alone, the AMA had participated in reviews covering 26 areas of the MBS.

"Can we save money? Yes, and the AMA's more than happy to engage in that process, but let's actually go through and do the reviews and come up with the evidence before we actually pre-empt what the outcome is and what procedures might have conditions or be removed from the Schedule," he said.

"The risks to patient care from an emasculated MBS are too great to allow this Review to go off the rails."

ADRIAN ROLLINS

MBS timeline

22 April, 2015

Health Minister Sussan Ley announces the formation of:

- Medicare Benefits Schedule Review Taskforce, to be led by Professor Bruce Robinson;
- Primary Health Care Advisory Group, to be led by former AMA President Dr Steve Hambleton

10 July

The terms of reference for the Reviews are released

15 August

AMA hosts roundtable of 60 representatives of specialist colleges and institutes to discuss MBS Review

27 September

MBS Review Taskforce releases Consultation Paper, invites submissions from the public and the medical profession

9 November

Consultation process ends

Before end of 2015

Ley says she will have "more to report about how I think the system can be improved...towards the end of the year"

What they said ...

Professor Brian Owler

"The AMA supports the MBS reviews...but I do take exception to the way that the narrative has been shaped so that there are these huge areas of savings to be had, that people are doing inappropriate practice"
- AMA President Professor Brian Owler, Radio National, 1 October.

"It's clearly a cost-cutting exercise. If we want a new, modern MBS, engage constructively with the [medical] profession; don't accuse us of doing things that are harmful for patients.

"Come up with something that's going to actually reflect modern medical practice, and reinvest some of the savings into new items"
– Professor Owler, Sky News, 27 September.

Sussan Ley

"We want to rewrite the Medicare Benefits Schedule because it's outdated. It's cluttered up with items that no longer actually happen in the surgeries and operating theatres around Australia.

"What we have in the MBS is a large volume of items that have not been renewed or refreshed since the early 80s.

"Thirty per cent of expenditure is not necessary, wasteful, sometimes even harmful, for patients.

"Where we realise efficiencies...we will reinvest them back into procedures that are new and innovative. We will also reinvest back into the Government's bottom line"
– Health Minister Sussan Ley.

Professor Bruce Robinson, MBS Review Taskforce Chair

"It has been estimated that 30 per cent or more of health expenditure is wasted on services, tests and procedures that provide no or negligible clinical benefit and, in some cases, might be unsafe and could actually cause harm to patients"
– Professor Bruce Robinson.

Dr Stephen Parnis

"We need a Schedule that does reflect modern practice. But the Government seems to have gone off the rails. What they're trying to do at the moment...is cut away from the Medicare Benefits Schedule without updating or adding new items numbers, [which] is of profound concern to us"
– AMA Vice President Dr Stephen Parnis, Sunrise, Channel 7, 28 September.

Catherine King

"The Minister has made it clear that 'redefining' or 'reviewing' Medicare is simply code for more cuts to health"
– Shadow Health Minister Catherine King, 28 September.

Richard Di Natale

"This is where health reform should have begun, instead of trying to shift costs onto patients and the states through Medicare co-payments and cuts to hospital funding. It is crucial that the Government commits to reinvest any savings back into the health system"
– Greens leader, Senator Richard Di Natale, 28 September.

Professor Stephen Duckett

"Public subsidy for treatments should be based on assessment of value, so it is right that the Review checks whether the Schedule has kept pace with changed knowledge and practice. [But] it is rare that a particular treatment has no benefit for any patient. Simply de-listing – tasking the test or treatment off the Schedule – is not the right approach"
– Professor Stephen Duckett, Health Program Director, Grattan Institute, 28 September

MBS Review Q&A

The claim	The AMA says
Thirty per cent of health spending is wasted on services, tests and procedures that provide little or no clinical benefit and, in some cases, are unsafe and could cause harm.	This is a claim that has been made about the United States health system, and which has been uncritically applied to Australia without any corroborating evidence.
A 2012 study found more than 150 MBS items were of low value or are harmful	The study actually reported that services that were ineffective or unsafe for all patients were "probably quite rare". Instead, the effectiveness of a service varies according to the characteristics of the patient.
Medical practitioners are performing unsafe and unnecessary procedures for financial gain, like ordering scans for patients with lower back pain, and performing spinal fusions.	This is an unacceptable slur on the integrity of the medical profession and undermines the confidence patients have in their doctors. The Medicare data does not say that GPs are referring patients with lower back pain for scans on their first visit, and there is very strong evidence for spinal fusion.
MBS items have never been assessed or amended since the 1980s	The AMA has been involved in regular reviews since 1990 and in the last five years alone has been involved in reviews of 26 areas of the MBS.
The Review is not about cost-cutting.	Health Minister Sussan Ley has admitted that some of the 'efficiencies' realised by the Review will be "reinvest[ed] back into the Government's bottom line".
The Review will enable the listing of new items on the MBS.	Processes to add new items to the MBS are explicitly precluded from the Review. The Government reaffirms the use of the existing lengthy and expensive Medicare Services Advisory Committee process.
"Only patients know if they actually benefit from what happens and get better, or whether they are unwell and incapacitated for a long time for no real improvement" – Sussan Ley	While patients are very capable of reporting on outcomes, such an approach does not take into account procedures and treatments intended to stop people getting sick, such as colonoscopies for patients with a history of colon cancer, or tests to detect and treat diabetic retinopathy.

AMA backs codeine call as deaths rise

The AMA has backed calls for codeine be withdrawn from chemist shop shelves amid evidence of a rise in the number of overdose deaths involving the painkiller.

A Therapeutic Goods Administration expert committee has recommended that from 1 June next year medicines containing codeine, which currently include Panadeine, Codral Cough and Cold Tablets and Mersyndol, be re-classified as Schedule 4 drugs, meaning they could no longer be sold over-the-counter and would instead be only available by prescription.

In arriving at its decision, the TGA's Advisory Committee on Medicines Scheduling found that codeine was no better than a placebo in treating coughs, was increasingly being abused and was potentially deadly in cases of overdose.

"Codeine shares the properties of other opioid analgesics and is potentially capable of producing dependence and, in overdose, respiratory depression and reduced level of consciousness," the Committee said. "[And it is] emerging as an increasingly commonly used drug of abuse internationally and in Australia."

Its concerns have been underlined by research published by the *Medical Journal of Australia* showing that the rate of codeine-related deaths in Australia virtually doubled between 2000 and 2009, from 3.5 per million to 8.7 per million.

Of the 1437 codeine-related deaths examined for the study, almost half were due to accidental overdose, while 34.7 per cent were as a result of intentional self-harm.

Pharmacists and consumer groups have criticised the Committee's recommendation, arguing that most people use codeine responsibly and derive benefit from the painkiller, and forcing patients to obtain a prescription would just mean more money for doctors, a bigger Medicare bill for taxpayers and longer waits to see the family doctor.

But AMA Vice President Dr Stephen Parnis backed the call to withdraw codeine from over-the-counter sales and rejected suggestions it was a cash grab by doctors.

"This about the patient's interests, not the people treating them," he said, arguing the move was likely to result in more people seeking medical advice about codeine dependence.

"If that means more expenditure, so be it, but the loss of a young life from the misuse of an addictive medication like codeine is astronomical to the community in social as well as economic terms," Dr Parnis said.

Health Minister Sussan Ley was cautious in her response to the TGA Committee's recommendation, telling ABC Radio it was "a difficult issue".

The Minister said the needs of patients who use the drug carefully and find it beneficial had to be balanced against concern for those who do abuse the medicine.

Ms Ley said the issue highlighted the importance of pain management in health care, and suggested that "probably we need more of them around the country, and we need people to be connected to them further. Because to live with chronic pain is very difficult and problematic, and specialised help is required".

The study published in the *MJA* found that, in the large majority of cases (84 per cent), death was attributed to multiple drug toxicity, reflecting the fact that often people take codeine in combination with other medications, including paracetamol and ibuprofen.

The researchers from the National Drug and Alcohol Research Centre cited several risks associated with long-term codeine use, including escalating doses, dependence, gastrointestinal disease and renal failure when taken in combination with ibuprofen over long periods, and hepatoxicity when combined with paracetamol for extended periods.

While those who intentionally overdosed on codeine were more likely to have a history of mental health problems, those who accidentally overdosed were more likely to suffer chronic pain or have a background of substance abuse problems.

Underlining the dangers of prolonged codeine use, the researchers said patterns of fatal accidental overdose might be evidence of the use of codeine to 'top-up' prescribed painkillers, an escalation in the doses of codeine taken as tolerance increases and drug dependence.

In recommending the listing of codeine as a Schedule 4 drug, the TGA's Advisory Committee said appropriately qualified medical practitioners should assess the risk before decision on using codeine is made.

And it said recently-released drugs that combined ibuprofen and paracetamol appeared to be more effective than codeine-containing analgesics and could fill the gap left by pulling codeine products off the shelves.

These drugs gave consumers access to "a more effective analgesic without requiring a prescription, and without the risks of marked variability in pharmacokinetics or abuse potential that are associated with codeine".

A decision on the Committee's recommendation is expected by the end of November.

ADRIAN ROLLINS

Doctors face annual examination to prove they are up to the job

Doctors would undergo annual appraisals involving assessments of their on-going professional education and acceptance of feedback from peers, supervisors and patients as part a regular process to reaffirm their fitness to practise medicine, under proposals being considered by the Medical Board of Australia.

A study of so-called revalidation regimes around the world commissioned by the Board has found that they enhance patient safety and confidence in the medical profession, and has suggested three alternative approaches based on international evidence and experience.

The least onerous would require doctors to provide an annual account of continuing medical education activities they had undertaken, signed off by a manager or professional body. It would be taken as a demonstration that their medical knowledge was up-to-date, and every fifth year would result in a recommendation for revalidation.

But the researchers said a major drawback of this 'lite' approach was that it said little about a practitioner's fitness to practice, because it did not include feedback from peers and patients.

While a mid-way option would be to supplement directed learning activities with participation in feedback sessions involving a specified number of colleagues and patients, the report authors instead recommended a dual process (Model C) that included both evidence of participation in self-directed and mandatory learning activities, as well as taking part in facilitated feedback sessions involving colleagues, patients and other relevant participants, and a review of patient complaints.

"Model C offers the best model of revalidation informed by the current evidence base, and is most likely to assure both safe and, over time, better practice, to the betterment of patients," the report by the Collaboration for the Advancement of Medical Education Research and Advancement (CAMERA) said. "Model C ensures doctors are both up-to-date and fit to practise, representing a dual approach to revalidation."

Under this regime, doctors would be required to attend a core of continuing medical education events, supplemented by continuing professional development activities of their own choosing. The researchers put particular emphasis on the benefits of blended learning opportunities, where traditional teaching methods are combined with online and other methods of instruction, which they said would "help to incorporate the vast majority of learning preferences...and close the current gap between evidence and practice".

In addition, "all physicians would engage in annual appraisals providing valuable reflective practice opportunities. And a review of patient complaints would provide an additional layer of reflective practice and ensure that the patient voice was both heard and acknowledged".

While the CAMERA report clearly advocates the adoption of Model C, the Board is yet to specify its preference.

Instead, it has appointed University of Wollongong Medical School Clinical Professor Liz Farmer to head an expert group to advise on revalidation and suggest ways to evaluate the effectiveness and feasibility of the CAMERA models.

The work of the expert advisory group will be complemented by a separate Consultative Committee, chaired by the Medical Board Chair Dr Joanna Flynn and including representatives from the AMA, specialist colleges, medical schools and consumers, to provide feedback on issues regarding the introduction of revalidation.

In addition, the Board is commissioning research into professional and community expectations about what practitioners need to do to prove their competence and fitness to practise.

The expert advisory group has been given 12 months to recommend one or more revalidation models, and how it could be piloted.

"Regulation is about keeping the public safe and managing risk to patients," Dr Flynn said, "and part of this involves making sure that medical practitioners keep their skills and knowledge up-to-date."

"The Board is seeking expert advice, as well as feedback from the profession and the community, about the most practical and effective way to do this that is tailored to the Australian health care environment."

The AMA is among groups that have expressed concern about the additional regulatory burden revalidation would impose on already-stretched practitioners, and who would ultimately carry the cost of the process.

But Dr Flynn told the AMA National Conference in 2013 that some form of revalidation regime was unavoidable if the medical profession wanted to continue to enjoy community confidence.

Though only a small proportion of doctors are the subject of patient complaint, Dr Flynn said more was needed to maintain the public's trust, and the CPD program alone was not sufficient.

For more on the revalidation debate, see also *Revalidation: do doctors need it?* (https://ama.com.au/ausmed/revalidation-do-doctors-need-it).

ADRIAN ROLLINS

Support for GPs on domestic violence frontline

Family doctors will receive specialised training in broaching the issue of domestic violence and providing support to women and children as part of a $100 million Federal Government initiative to tackle the issue.

In his first major policy announcement as Liberal leader, Prime Minister Malcolm Turnbull has detailed a package of measures aimed at providing a safety net for women and children at high risk of violent attacks.

“The tragic and avoidable deaths of women and children at the hands of current or former partners or family members highlight the need for urgent action,” Mr Turnbull said. “We must elevate this issue to our national consciousness, and make it clear that domestic, family or sexual violence is unacceptable in any circumstances.”

Earlier this year, the AMA and the Law Council of Australia launched a toolkit to help medical practitioners raise the issue of domestic violence with their patients and provide support.

Mr Turnbull’s announcement came just days before a Victorian Coroner released his findings into the murder of Luke Batty, son of Australian of the Year Rosie Batty.

While determining that Luke’s father Greg Anderson “alone was responsible for Luke’s death”, Coroner Ian Gray nonetheless found serious shortcomings in the justice system that failed to protect the 11-year-old.

At the time of the murder, Mr Anderson was the subject of four outstanding arrest warrants and two intervention orders.

Ms Batty said the release of the Coroner’s findings were a “monumental day”.

“Luke’s findings helped me realise, and through the journey before the inquest, Greg was never made accountable, not once,” Ms Batty said.

The domestic violence campaigner also praised Mr Turnbull for his approach to the issue.

“We now have federal government in a leadership role,” she said. “It’s a huge turning point, because we have a Prime Minister who actually understands that this is a gender issue. And when he spoke and said that disrespect does not always end in violence, but violence always starts with disrespect, I felt for the first time that, as a woman, we’re starting to gain the support that we need to understand that this issue requires men to lead the change.”

As well as increasing support for frontline services such as GPs, social workers and legal aid, the package provides for the trial and use of devices such as GPS trackers, ‘safe phones’, closed circuit television systems and bug detectors to improve women’s safety.

Among the measures, $14 million will be used to expand the existing domestic violence-alert training program, aimed at improving the ability of hospital emergency department staff, police and others to detect signs of domestic violence, as well as to expand specialised training to GPs.

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

ADRIAN ROLLINS

Government policies driving health divide

More than a fifth of patients in some areas have avoided seeing a doctor or filling a prescription even though they need care, with many saying they are put off by the cost.

Although a majority of Australians report little difficulty in seeing their GP, the latest snapshot of patient experience from the National Health Performance Authority shows that in parts of rural New South Wales, Queensland, Western Australia and Tasmania, many people are avoiding or delaying treatment because of cost, running the risk of developing more serious and expensive-to-treat health problems.

Just as worrying, in some areas up to one in 10 say they cannot afford to fill their prescriptions, raising concerns around the management of serious chronic diseases such as diabetes and the treatment of infections.

The results underline the city-country divide in access to affordable care. While Australia-wide it was common for between 15 and 25 per cent of patients to complain of how long they have to wait to get an appointment with their GP, only around 2 to 4 per cent of those in major metropolitan areas said they could not afford to see their doctor, while in rural and regional Australia the rate was two to four times as high.

Chair of the AMA Council of General Practice Dr Brian Morton said strong competition between medical practices in urban areas drove high rates of bulk billing and helped contain patient out-of-pocket charges.

But the relative scarcity of doctors in country areas, and the need for adequate remuneration to recruit and retain them, encouraged lower rates of bulk billing and higher patient charges.

Dr Morton said this was not the fault of individual practitioners, and was instead the result of Federal Government policies including to screw down the value of Medicare rebates and hold back investment in training and support for rural GPs.

Dr Morton said of even greater concern when it came to preventive care was the relatively high instance of patients delaying or forgoing medicine because of expense.

He said patients, particularly those with a number of co-morbidities that had to be managed simultaneously, often faced a hefty monthly pharmacist bill.

For instance, he said, a patient with high blood pressure might be on three different medications which would cost more than $100 a month. If two or more people in a household have on-going courses of drugs, the costs can quickly mount up.

The consequences of foregoing treatment can be severe, Dr Morton said. Patients identified as at risk of heart disease who decide not to take prescribed statins can suffer a build-up of plaque in their blood vessels that can lead to blocked arteries, blood clots and other serious circulatory problems.

Protecting affordable access to care was at the centre of the AMA's campaign late last year and early this year against the Abbott Government's plans for a GP co-payment.

The AMA warned that charging a co-payment would deter many of the sickest and most vulnerable in the community from seeking care, creating the likelihood that their health would deteriorate and need more significant and expensive treatment later on.

And the latest official figures on national health spending suggest the pressure on patients to contribute to the cost of there is increasing.

The Australian Institute of Health and Welfare reported in September that the Commonwealth's share of total health spending has plunged from almost 44 per cent to 41.2 per cent in just five years.

At the same time, individuals and families are shouldering more of the burden. In the past decade, the contribution of patients to the cost of health care has grown by an average of 6.2 per cent a year in real terms.

ADRIAN ROLLINS

Patients face potentially lethal delays as hospitals struggle

Emergency physicians have warned the public hospital system is at "breaking point", with thousands of patients being forced to wait hours for a hospital bed, clogging emergency departments and preventing ambulances from unloading.

A survey by the Australasian College of Emergency Medicine of all the nation's 121 accredited emergency departments has found that 70 per cent of emergency department patients are being delayed more than eight hours as they wait for beds in other parts of the hospital to become available, adding to evidence of enormous strain in the system.

The survey's author, Associate Professor Drew Richardson, said the result highlighted the extent of the "access block" problem, when a dearth of free beds in the main body of a hospital prevents patients moving out of emergency. The knock-on effect is to clog the emergency department, which in turn means ambulances cannot unload patients.

"These figures...show that too many patients are waiting too long to receive the proper care," A/Professor Richardson said. "They reflect a hospital system that is critically overburdened and that is putting patients into the firing line."

More than half the hospitals in the survey reported that at least one patient had to wait for more than 12 hours for a bed, an outcome A/Professor Richardson said was "completely unacceptable", and should be ringing alarm bells for health authorities across the country.

Evidence indicates that the longer patients are forced to wait in emergency, the worse their health outcome is likely to be. A Canberra Hospital study found that older patients forced to wait more than four hours for a ward bed were 51 per cent more likely to die than those who suffered shorter delays.

The survey's results underline AMA warnings of an impending crisis in the public hospital system as a result of the Federal Government's decision to rip $57 billion from its funding over the next 10 years.

The Federal Government has walked away from the National Health Reform Agreement with the states, cut incentive payments, dump activity-based funding and reduce indexation of its public hospital funding to inflation plus population growth.

AMA President Professor Brian Owler has warned the cuts will have a profound effect on the hospital system, warning that "public hospitals and their staff will be placed under enormous stress and pressure, and patients will be forced to wait longer for their treatment and care".

"Rather than funding the necessary hospital capacity, the

Commonwealth has withdrawn from its commitment to sustainable public hospital funding and its responsibility to meet an equal share of growth in public hospital costs," Professor Owler said earlier this year. "Funding is clearly inadequate to achieve the capacity needed to meet the demands being placed on public hospitals."

The AMA's annual Public Hospital Report Card, released in April, showed that although there had been marginal improvement in public hospital performance against Government benchmarks, no State or Territory met the target to see 80 per cent of emergency department Category 3 urgent patients within clinically recommended triage times.

Professor Owler said access block was a particularly concerning issue.

He said that emergency departments were able to meet performance targets for patients who did not require admission to hospital.

"But when they have to be admitted, that is where performance suffers. That is an issue of the capacity of our public hospital system," he said.

Professor Owler warned the system would be hit by "a perfect storm" when lower indexation funding arrangements kick in in 2017-18.

"This will lock in a totally inadequate base from which to index future funding for public hospitals," he said. "State and Territory governments, many of which are already under enormous economic pressures, will be left with much greater responsibility for funding public hospital services. Performance against benchmarks will worsen and patients will suffer. Waiting lists will blow out."

ADRIAN ROLLINS

'Slash and burn' insurers endanger health system

AMA President Professor Brian Owler has accused the major health funds of destabilising the health system through an aggressive push to cut costs, shirk responsibility and downgrade the value of insurance cover.

While the nation's biggest health insurer, Medibank Private, has struck a peace deal with Calvary Health after the two were at loggerheads over the terms of a service contract, Professor Owler warned the dispute was only part of a broader shift underway that could critically undermine the balance between the public and private sectors that underpins the health system.

The AMA President told the Ramsay Health Managers Conference on the Gold Coast last month that the dispute, which revolved around an attempt by Medibank to force Calvary to accept responsibility for 165 medical events it described as highly preventable, was "a pivotal moment" for the health system.

"This was an attempt by Medibank Private to impose financial sanctions on a provider for events which, although they have some degree of preventability, are an unfortunate, yet integral, part of clinical practice," Professor Owler said. "It was an attempt to impose cost-cutting measures through a commercial contract thinly disguised by the cloak of quality."

The details of Medibank's deal with Calvary have not been revealed publicly, provoking unease about what concessions the private hospital group may have made.

Professor Owler warned that acceding to Medibank's demands could destabilise the health system by creating a situation in which private hospitals refuse to admit patients with complex needs or considered to be at high risk.

"This has the potential to overload our public hospital system. It would upset that important balance between the public and private systems," he said. "There would also be the potential for those patients who required re-admission to be sent to public hospital emergency departments, rather than being re-admitted to the same hospital."

Medibank Private has rejected Professor Owler's concerns, downplaying the significance of its dispute with Calvary.

The insurer's Executive General Manager of Provider Networks and Integrated Care, Dr Andrew Wilson, told *The Australian Financial Review* the changes it had sought were "modest and are about helping to reduce three categories of mistakes that can occur related to a small number of surgical complications, falls in and around hospital wards and hospital acquired pressure sores".

Dr Wilson the insurer's actions were based on a thorough review of Australian and international evidence, "refined in discussions with a number of our healthcare partners, including some of Australia's most respected hospitals".

"From an original list of over 4,500 events in hospitals that lead to unintentional patient harm, and after considering the available evidence, we have focused on a small number of events where there is good evidence that action can be taken to prevent them or reduce their frequency."

But Professor Owler said the events itemised by Medibank were not mistakes but clinical complications, and was misusing information prepared by the Australian Commission on Quality and Safety in Health Care.

He said that if the insurer was truly concerned about improving the quality of care, it would support the work of the Commission, back improved clinical governance in private hospitals and invest in registries for medical devices.

"If funders, whether it be governments or health funds, are serious about quality, then they need to invest," the AMA President said. "They need to provide the resources, and they need to allow those in the system to drive change that delivers better outcomes. I can guarantee that, if they do this, then doctors, nurses, and managers within the health system will step up. They are only too eager to do it. They just the need the support."

Professor Owler added that insurers were debasing the health system by failing to honour policies and providing cover that was inadequate or, in some cases, "junk".

"We are seeing a systematic downgrading of policies, and in a way that is not transparent to policy holders," he said.

"These tactics to exclude treatments from policies are not about improving the value of the private health insurance product. They are blatantly about avoiding paying benefits for the treatments that people need, and expect to be covered for. "

He said the "slash and burn' approach being taken by some insurers should not be tolerated.

"A key to a sustainable private sector is adequate rates of private health insurance. For that to occur, we need to ensure that private health insurance premiums are affordable - and represent value."

ADRIAN ROLLINS

Combat sport ban call as deadly toll mounts

The risk run by athletes who suffer regular head injuries while playing sport has been underlined by a study that found a self-selected sample of former professional gridiron players in the US suffered a rare but devastating degenerative brain disease as a result of repeated collisions.

> "My response is that where I sit, this is a very real disease. We have had no problem identifying it in hundreds of players"

As Australian legislators come under increased pressure to ban boxing and other combat sports following the death of a second professional boxer this year, researchers at the US Department of Veteran Affairs and Boston University conducted autopsies on 91 former NFL players and found chronic traumatic encephalopathy (CTE) was present in 87 of them – a 95 per cent prevalence rate.

Researcher Dr Ann McKee, chief of neurophysiology at the VA's Boston Healthcare System, told *The Independent* that, aside from the prevalence of CTE among the sample of pro-gridiron players, what was particularly striking was that 40 per cent of those who suffered the disease played in positions where bone crunching collisions were less common – suggesting that repeated smaller blows to the head were more dangerous than big hits.

Even more worrying, the US research suggests CTE is not confined to professional gridiron players. The researchers found CTE in the brain tissue in 131 out of 165 individuals who, before their deaths, played football either professionally, semi-professionally, in college or in high school.

The result is startling because CTE is rare in the general population, and it reinforces concerns that athletes who suffer regular head trauma playing their sport are at higher risk of developing the condition.

Dr McKee told *The Independent* the results showed the extent of the problem, and the risk players of all abilities were running.

"People think that we're blowing this out of proportion, that this is a very rare disease and that we're sensationalising it," she said. "My response is that where I sit, this is a very real disease. We have had no problem identifying it in hundreds of players."

Already, the NFL has settled a $US1 billion class action with almost 5000 former players over the issue, and in Australia claims that a number of former Australian Rules and rugby

Combat sport ban call as deadly toll mounts

... from p17

players have developed CTE-like symptoms after suffering multiple head collisions on the playing field has heightened concerns about the long-term risks of head blows in sport.

There is as yet no evidence of a link between concussion and CTE, but there are calls for this to become a focus of research.

The potentially fatal consequences of brain injury suffered in sport were tragically underlined last month when professional boxer David Browne Junior died after competing in a title fight.

Browne was knocked unconscious near the end of a 12-round contest and was rushed to hospital in a critical condition. He was placed in an induced coma and eventually his family made the gut-wrenching decision to take him off life support.

His was the second death of a professional boxer this year, after 23-year-old Braydon Smith collapsed soon after losing a WBC Asian Boxing Council fight in March.

The deaths, and the results of the US research, add weight to calls by the AMA for boxing to be banned from the Olympic and Commonwealth Games, and for a prohibition on all combat sports for people younger than 18 years.

In a Position Statement released last month, the AMA voiced its opposition to all combat sports, arguing that they should be banned.

In the interim, the Association has urged tighter rules and regulations governing combat sports, including that they be undertaken under medical supervision and that doctors be empowered to halt contests.

In addition, the AMA has said gloves should be made larger, the time between weigh-in and bout be extended to 72 hours, make mouthguards mandatory, change scoring methods to reduce the emphasis on head blows and introduce graded time-out periods following significant blows to the head.

AMA Vice President Dr Stephen Parnis said critical injuries were inevitable in boxing.

"One punch can kill - whether you are outside a pub on a Friday night or in a boxing ring - and this is the thing that causes young lives to be ended so traumatically," he said. "People need to be careful and they need to think twice about participating in this sport."

Dr Parnis said the death of Mr Browne Junior had left him "feeling very empty".

"It's a terrible tragedy for a young man with a young family, but the fact that is was entirely avoidable just leaves a real sense of bitterness," he said. "I know they don't intend for this to happen but ... the way that boxing is designed there will be these times inevitably where someone will get bleeding or irreversible damage to the brain and they will either lose their life or end up with brain damage. That is why the AMA thinks that we cannot continue with it [boxing]."

The AMA *Position Statement on Combat Sport (2015)* is at https://ama.com.au/position-statement/combat-sport-2015

ADRIAN ROLLINS

Review of AMA policy on euthanasia and physician assisted suicide

BY DR MICHAEL GANNON, CHAIR OF THE AMA ETHICS AND MEDICO-LEGAL COMMITTEE

As part of its five year position statement review cycle, the AMA's policy on euthanasia and physician assisted suicide is now due for review. This will be coordinated by the Federal AMA's Ethics and Medico-Legal Committee (EMLC).

The current policy is contained in the AMA's *Position Statement on the Role of the Medical Practitioner in End of Life Care 2007. Amended 2014*, provided in full at the end of this article (it is also available on the AMA's website at https://ama.com.au/position-statement/role-medical-practitioner-end-life-care-2007-amended-2014).

The current policy states that medical practitioners should not be involved in interventions that have as their primary intention the ending of a patient's life. This position is qualified by clearly stating that the following actions (or inactions) do not constitute euthanasia or physician assisted suicide so long as they are undertaken in accordance with good medical practice:

- not initiating life-prolonging measures;
- not continuing life-prolonging measures;
- not offering futile care;
- the administration of treatment or other action intended to relieve symptoms which may have a secondary consequence of hastening death (commonly known as the doctrine of double effect).

At this early stage of the review, we invite AMA members to provide your views on the current policy via email to ethics@ama.com.au by COB Friday, 11 December 2015. This initial method of engagement allows members to express their views in an open-ended manner, without the limitations associated with directed survey questions.

This initial engagement is restricted to AMA members only. While all comments will be kept confidential, we ask that you include your name in the response so that we can verify that you are an AMA member.

Member comments will be considered in a de-identified way by the EMLC and Federal Council and will be used to inform the next stage of the review process.

We will keep all members informed of the progress of the review and further opportunities for member engagement.

The *Position Statement on the Role of the Medical Practitioner in End of Life Care 2007. Amended 2014* reads as follows:

1. *The AMA believes that while medical practitioners have an ethical obligation to preserve life, death should be allowed to occur with dignity and comfort when death is inevitable and when treatment that might prolong life will not offer a reasonable hope of benefit or will impose an unacceptable burden on the patient.*
2. *Medical practitioners are not obliged to give, nor patients to accept, futile or burdensome treatments or those treatments that will not offer a reasonable hope of benefit or enhance quality of life.*
3. *All patients have a right to receive relief from pain and suffering, even where that may shorten their life.*
4. *While for most patients in the terminal stage of an illness, pain and other causes of suffering can be alleviated, there are some instances when satisfactory relief of suffering cannot be achieved.*
5. *The AMA recognises that there are divergent views regarding euthanasia and physician- assisted suicide. The AMA believes that medical practitioners should not be involved in interventions that have as their primary intention the ending of a person's life. This does not include the discontinuation of futile treatment.*
6. *Patient requests for euthanasia or physician-assisted suicide should be fully explored by the medical practitioner in order to determine the basis for such a request. Such requests may be associated with conditions such as a depressive or other mental disorder, dementia, reduced decision-making capacity, and/or poorly controlled clinical symptoms such as pain. Understanding and addressing the reasons for such a request will allow the medical practitioner to adjust the patient's clinical management accordingly or seek specialist assistance.*
7. *If a medical practitioner acts in accordance with good medical practice, the following forms of management at the end of life do not constitute euthanasia or physician assisted suicide:*
   - *not initiating life-prolonging measures;*
   - *not continuing life-prolonging measures;*
   - *the administration of treatment or other action intended to relieve symptoms which may have a secondary consequence of hastening death.*
8. *Medical practitioners are advised to act within the law to help their patients achieve a dignified and comfortable death.*

A better way to bond

A cut in the return-of-service obligation on new Bonded Medical Places participants should be extended to all existing BMP practitioners, the AMA has said.

Following up on the Federal Government's decision to trim the return-of-service (ROS) obligation to one year, AMA Vice President Dr Stephen Parnis has written to Health Minister Sussan Ley urging her to offer the change to doctors currently operating under the scheme.

Dr Parnis said experience from the Rural Clinical School model showed that the recruitment and retention of doctors in rural areas was improved by limiting the ROS obligation to one year, and if this evidence had influenced the Government's decision, then it made sense for the change to be extended to include all BMP scheme participants, not just new entrants.

"If a shorter ROS means that more people are prepared experience rural clinical practice, and evidence shows this may translate to a longer term commitment, then it would make good policy sense for all BMP participants to be given the choice to take up this option," Dr Parnis wrote. "Retaining a longer ROS for current BMP participants is likely to prove counter-productive as they will simply continue to withdraw from the scheme or buy out their obligations."

The AMA has consistently opposed the Bonded Medical Places scheme as an ineffective solution to the challenge of recruiting and retaining practitioners in rural areas. Its concern has been borne out by Health Department figures showing only 37 practitioners have completed their ROS obligation, while 307 have withdrawn from the program or breached their agreement.

Instead of imposing an obligation, the AMA has proposed programs focussed on recruiting doctors who have lived in the country or providing training in rural areas.

"The AMA is very conscious of the need to encourage more doctors to work in underserviced areas, particularly rural and remote Australia," Dr Parnis wrote. "We know that a having a rural background or training in a rural area are among the factors that are most likely to encourage doctors to take up a career in these locations."

He told the Minister that in the past it had been standard practice to include existing participants in any changes to the BMP scheme, and it made sense, both in terms of equity and "sound policy" to act accordingly on this occasion.

"I urge you to take the same approach to the implementation latest changes to BMP scheme ROS arrangements. The scheme has clear problems and, in this regard, reforms designed to improve its operation and chances of success should be adopted to the broadest extent possible," Dr Parnis said.

ADRIAN ROLLINS

Online PBS Authority system pushed back to 2016

The long-awaited shift to an automated online approvals system for PBS Authority medicines has been pushed back to early next year.

There had been hopes the new arrangement, which is expected to save doctors and patients thousands of hours currently spent waiting for calls to the PBS Authority hotline to be answered, would be in place by the end of this year.

But, although work on the online system is underway, it is not expected to be ready until at least early 2016.

It is a frustrating delay for practitioners, who for years have chafed under the burden of the current cumbersome arrangement, which requires doctors to call a Department of Human Services clerk to obtain authorisation to prescribe almost 50 different types of medicine.

In 2012, almost one in five doctors reported spending more than 10 minutes a day on the phone seeking prescription authority, and 3 per cent said they spent more than 30 minutes a day on the phone to the hotline. At the time, it was estimated that the system wasted the equivalent of 25,000 GP consultations every month.

While the number of drugs requiring authority has been trimmed down, and the Department has streamlined the approval process for many medications, the system remains an administrative burden that the Productivity Commission has recommended should be scrapped.

The AMA has been lobbying for many years for the hotline to be abolished and replaced with an automated online process and, as part of this, has in recent months arranged for Department officials to visit doctors in their workplace to see how software systems are being used to prescribe PBS medicines.

The Department has also used the results of an AMA survey conducted

ADRIAN ROLLINS

Jolie-gene not up for grabs

Attempts by commercial operators to patent human genes have been dealt a blow after Australia's highest court overturned a patent awarded to a US-based company claiming rights to two cancer genes.

In a decision with important international implications, the High Court has supported an appeal by two-time cancer survivor Yvonne D'Arcy after biotech company Myriad Genetics won Federal Court recognition of a patent for its discovery of the BRCA genes, which are linked to an increased risk of breast and ovarian cancer.

The company argued that by identifying and isolating the BRCA1 and BRCA2 gene - often referred to as the Jolie-genes after actress Angelina Jolie, who in 2013 revealed she had a mastectomy after it was found she had the variant – it had a patentable invention.

It used its discovery to assert a monopoly over tests for the BRCA1 and BRCA2 gene, holding the cost of diagnosis up.

The Federal Court had supported Myriad's claim, judging that the discovery of the gene fell within the definition of manufacture.

But the High Court found differently.

In a unanimous decision, the judges said that, "While the invention claimed might be, in a formal sense, a product of human action, it was the existence of the information stored in the relevant sequences that was an essential element of the invention as claimed".

The High Court ruling follows a similar defeat for Myriad in a case in the US Supreme Court two years ago.

The decision marks the end of lengthy legal battle for Ms D'Arcy and her legal team, which had argued that genetic material is a product of nature and cannot be patented.

Ms D'Arcy said the High Court's decision would make cancer t4esting more affordable.

"For all those people who do have the genetic footprint for breast cancer, or any cancer basically, it's a win for them because now they're forewarned," she told the ABC. "The testing will be a lot cheaper and it will be more available ... rather than using only Myriad's agents at a price that nobody really can afford. I'm just hoping that other countries will see sense and follow us and the Americans."

While the case is likely to lead to cheaper BRCA cancer tests for many, the High Court's ruling has raised concerns that it could stifle genetic research by denying commercial enterprises rights to discoveries they make.

ADRIAN ROLLINS

Small changes a proven lifesaver

Almost 40,000 cancer cases could be avoided each year if Australians cut down on drinking smoking and sun baking, and improved their eating habits.

A study on the incidence and prevention of cancer has found that smoking, drinking, poor diet, excess weight and exposure to the UV radiation cause about 90 per cent of all preventable cancers.

The research, conducted for Cancer Council Australia by the QIMR Berghofer Medical Research Institute, estimated that 37,000 cancer cases could be prevented every year if people adopted healthier lifestyle habits, including eating a healthier diet.

"It's time to bust the myth that everything gives you cancer and do more to reduce the risks that we know cause cancer," Cancer Council Chief Executive Professor Sanchia Aranda said.

She said not eating enough fruit and vegetables and eating too much red meat contributed to about 7000 new cancer cases a year, while obesity was the cause of about 3900 cases.

ADRIAN ROLLINS

Forcing half-baked e-health record on GPs a recipe for failure

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

The Health Department has released a discussion paper on proposed changes to the eHealth Incentive under the Practice Incentive Program (PIP).

Despite advice to the contrary from the AMA and other key GP stakeholders, the Department is determined to revise the eHealth Incentive requirements to include a measure demonstrating 'active and meaningful use'. They plan to implement the changes on 1 February 2016.

Member feedback confirms that this will discourage GP involvement with the My Health Record (MyHR) rather than promote its active and meaningful use.

One proposal outlined in the paper is for PIP practices to be required to upload a target number of Shared Health Summaries (SHS) to demonstrate active and meaningful use. The proposal for a practice payment ignores the work involved for individual GPs and, alone, will not motivate individual GP engagement with the MyHR. A Service Incentive Payment (SIP) and MBS item that recognises this would be more appropriate and effective.

The Department is pushing these policies in an attempt to implement Recommendation 36 of the *Review of the Personally Controlled Electronic Health Record – December 2013* (PCEHR Review). The problem is that they are attempting to implement meaningful use metrics before the most important recommendation has been implemented – making the health record an opt-out arrangement.

The target date for moving to an 'opt-out' model was originally meant to be 1 January 2015, and a trial was to have been undertaken in early 2014. This is now behind schedule - trials are only now about to commence, and the outcomes are unlikely to be known before late 2016.

There are also a number of other recommendations from the PCHER Review that relate to the clinical utility of the MyHR. These must be implemented before revising the eHealth Incentive requirements.

The eHealth Incentive has been successful in encouraging PIP registered general practices to become MyHR ready – 85 per cent of PIP practices now claim it. However, imposing new eligibility criteria ahead of recommended improvements to clinical functionality and ease of use poses a real risk that GPs will just wash their hands of the incentive, and the record itself. As one of my colleagues recently said, "If GPs thought it was a goer, we would have jumped on it to help care for our patients."

GPs have been slow to engage with the record because, in its current form, there is no value proposition. Less than 10 per cent of the population have signed up for a record, and the reliability of the information in the record cannot be trusted because of the capacity of patients to remove information from view.

There are also complicated legislative requirements backed by severe penalties for breaches, as well as concerns around privacy and security. Combined with the lack of system integration, low take up by hospitals and poor participation by other specialists and other health providers, it is not hard to see why the MyHR and its predecessor has been a failure.

We understand that the Government wants to gets some runs on the board with the MyHR and there is no doubt that, done properly, the MyHR has the potential to improve patient care. However, if clinician advice is ignored and unrealistic timeframes continue to be pursued, then it is hard to see us doing anything but repeating the mistakes of the past.

The AMA's submission on the PIP eHealth Incentive is available from the General Practice page on the AMA website. In short, it recommends:

- delaying the implementation of a revised eHealth Incentive from 1 February 2016 until such time as the MyHR is easy to use, clinically relevant, reliable and interoperable;
- implementing a SIP and MBS item to support active and meaningful use;
- giving further consideration to redesigning the incentive to support ongoing eHealth capacity and use; and
- retaining quarterly payments rather than moving to an annual payment.

Good for the economy while good for your health

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

Prominent among the proposals for the future from Mr Turnbull as he assumes the prime ministership are ones that relate to economic growth. He seeks a more agile economy, one in which innovation is promoted and prized and where the negative forces of debt and deficit are dealt with by increasing productivity and growth. These aspirations are supported by stronger recognition in the new Cabinet of science and innovation.

Recently I have had cause to reflect on the place of health care in one piece of the Australian economy. Specifically, I was considering how much health care for the million citizens in western Sydney actually contributes to the economy. The answer is a lot. So, rather than portraying health care as a terrible drain on the national economy and incessantly saying we should cut our costs, we might express it differently.

We're an investment, not a cost!

Our health care is based strongly on science and innovation. The revolution that has occurred in diagnostic and therapeutics due to new technology is profound. Procedures that once took days now take minutes. New drugs work wonders. CT and MRI have completely replaced the ghastly contrast-medium angiograms and pneumoencephalograms. The productivity of surgeons and other proceduralists has multiplied many times over.

So, if you are looking to grow an 'industry' through science and innovation, you could do no better than to look at health. It leads the way. Great efficiencies and immense amounts of suffering due to dreadful procedures have been banished by science and innovation.

In western Sydney, the health services provide care to nearly a million people. Public hospital and associated community services operate with a recurrent budget of nearly $1.4 billion per annum. That's a lot of money pumped into the local economy. General practice likewise generates local expenditure in the millions.

Whether all this money is wisely or optimally spent is a separate and (I agree) an important question. But overlaying this concern is the fact that health care is a big contributor to the Australian economy.

What is the goal of the economy, we may ask? Surely it is to support the Australian community and enable us to compete in the world to maintain our prosperity and assist, as we see fit, to bring less-developed nations up to speed. Given that the segment of the global economy in which we compete is highly innovative and science-based, then we need to place emphasis on those attributes here Down Under.

As our future prosperity is unlikely to depend as heavily as it has in recent decades on ripping stuff out of the ground and selling it to China, inventing nothing, doing no innovation, making no scientific progress and then buying in all the creature comforts that we need from the US and Japan (and increasingly form China), we need to achieve self-sufficiency in innovation. That requires investment – in science, technology and education.

While it is hard to see these opportunities through the clouds of day-to-day slog in our hospitals and surgeries, investment in medical technological innovation, the education of smart scientists to develop even more and better equipment and drugs, the support of health research of all sorts - these things make an economy grow. These are the ways in which we develop economic agility and the nimbleness necessary to be able to adapt to change.

Health as a superior good

There is another important fact that tends to get in the way of clear perception of where health fits in the economy, and that is the complex notion that health is a superior good, something that we spend on almost without limit, constrained only by the extent of our discretionary income.

That is what makes trying to keep health costs under control so difficult. As affluence increases, ordinary goods such as food do not attract all that much additional expenditure. But health? We feel we can never get enough of it, and we are prepared as individuals and as a nation to keep on paying!

We have emerged from a period of economic discussion in Australia dominated by what many experts see to be an exaggerated concern for a relatively small deficit. The real economic challenge is the changing base of our revenue, away from minerals and coal toward service industries such as finance, education and health care. We need to be agile; we need to look for ways to increase our productivity through innovation and invention.

Health can help achieve those economic goals for the nation. Rather neatly, this can occur as a secondary outcome of our continued concentration on providing the best possible care for all Australians.

MBS Review a quick and nasty cost-cutting exercise

BY DR DAVID RIVETT, CHAIR, AMA RURAL MEDICAL COMMITTEE

Firstly, congratulations to the new Rural Health Minister Senator Fiona Nash, and to the Turnbull Government for recognising the long-neglected imperative to improve rural health care by creating such a ministry.

The Nationals Senator has long been a champion of health care in rural and regional Australia, and is most deserving of such elevation.

All rural medicos will, I am sure, join me in both wishing her well, and hoping she can achieve a long overdue about turn in health fortunes for the bush.

Secondly, congratulations to the National Broadband Network on successfully launching the Skymuster satellite to bring high speed broadband access to the bush in seven months' time. This bush-focussed initiative will enable a huge variety of care provision to many in rural and remote Australia, provided it does not come with insurmountable financial barriers to participation. I trust the NBN will recognize that the bush is not awash with funds, and will heavily subsidise access.

So champers out and raise a glass. But there is a cloud on the horizon and it sure isn't a rain-bearing one.

The current MBS Review, of which the AMA is not a part, is a cheap, quick, and nasty cost-cutting exercise. Patient needs be damned, this is about improving the Federal Budget bottom line.

The AMA has always supported reviewing and updating the MBS, and has participated in multiple MBS reviews.

But any such reviews must be of high quality and ongoing as medical care changes and evolves.

Think back on the millions of dollars poured into a genuine review of the MBS by the AMA, namely the Relative Value Study (RVS). When it became apparent to the Government of the day that the RVS would show the need for the investment of substantial dollars in providing fair MBS rebates for patients, they pulled the plug. Not surprisingly, they are the same mob we have in the driver's seat today.

Reviews must not have publically announced, predetermined outcomes, and their focus must be on the best interests of patients, not on cost-cutting.

Sadly, the Review currently underway - if one can grace it with such a title - is a two-bob watch. It is a Mickey Mouse inquiry programmed to fail, with the Health Minister publically salivating at the prospect of reduced costs rather than improved patient outcomes.

The de facto involvement of the AMA through the participation of high profile AMA members leaves us open to blame for adverse outcomes.

But the reality is that the AMA has been excluded from this Review, and will in no way be to blame for its outcomes.

UK Govt's war on the working week sets a nasty precedent

BY DR DANIKA THIEMT, CHAIR, DOCTORS IN TRAINING COMMITTEE

Last month, I wrote about Australia being the lucky country. We have beautiful beaches, sunny weather and, at least in comparison with the DiTs working in the Britain's National Health Service, great working conditions.

While the AMA and the Council of Doctors in Training have and continue to work hard for the conditions we enjoy, our English colleagues have had to go on strike following long and unsuccessful negotiations with the UK Government.

> "Without penalty pay, there is no difference between 9pm on a Saturday night and 9am on a Tuesday"

The British Government is seeking to impose new working conditions on their doctors in training that are complex and have far-reaching implications. Significant changes in working hours and award rates would result in a notable reduction in total salary for DiTs who currently start their internship on the equivalent of $A50,000.

Under the contract, normal working hours will be considered to stretch from 7am until 10pm, and to include Saturday in addition to the traditional week. This means that the 'working week' will leap from the 60 hours between 7am and 7pm on weekdays (a big enough shock to many Australian DiTs), to a huge 90-hour week. By redefining what the normal working week looks like, the contract would result in the loss of compensation for working antisocial hours.

Further, there is a push to remove logical pay progression, as well as a cut in pay for on-call work. This will lead to a decrease in the penalty payments that many junior doctors depend on.

Without penalty pay, there is no difference between 9pm on a Saturday night and 9am on a Tuesday, and there are concerns the new arrangements would result in DiTs working to excess.

It also sets a dangerous precedent about what is seen as 'normal'.

Other changes include the removal of GP trainee subsidies (which aim to increase GP trainee salary to closer to that of their hospital colleagues), and the axing of pay protection for trainees who go on maternity leave, train part time or re-train in a new specialty.

The BMA Doctors in Training are asking for five guarantees before they re-enter negotiations with the Department of Health:

- proper recognition of unsocial hours as premium time;
- no disadvantage for those working antisocial hours compared with the current system;
- no disadvantage for those working less than full-time and taking parental leave;
- pay for all work done; and
- proper hours safeguards protecting patients and their doctors.

If any politician, clinician, patient or otherwise thinks these are unreasonable demands then we have a problem. If this is all that our NHS counterparts are after, then we should certainly be worried.

It makes it easy to feel lucky to be an Australian DiT, doesn't it? But let's look at this more closely.

If we really think about it, the people affected by this new contract are us (albeit with funny accents and 'bleepers' instead of pagers).

They are doctors who are working as hard as they can to care of their patients and develop their medical careers. They are the doctors who staff the hospitals overnight, on the weekends and on public holidays, and they are doctors who may one day work alongside us.

This should matter to Australian DiTs because we have seen a trend of cost cutting in health.

And really, that is what the changes outlined above are really about - not patient safety, and not efficiency.

We have seen the Federal Government remove millions of dollars in health funding, targeting our general practitioners, our primary health care and, most recently, the MBS.

How long do we have to wait before we are told that we are too expensive, too inefficient, or too entitled?

Ultimately, we should be sitting up and taking notice because, one day soon, this could be us.

More than one way to lead change

BY ASIEL ADAN SANCHEZ, UNIVERSITY OF MELBOURNE MEDICAL STUDENT, NLDS DELEGATE AND AMSA LGBTIQ HEALTH OFFICER.

We all have a picture of leadership. Too often are those images that of a confident CEO, a tall man, a white man, a suit, success and money. Leadership, to some people, can become a tangled mess of privilege, calling the shots and misplaced success. For others, it's an opportunity to give voices to the marginalised, empower the most vulnerable and share opportunities.

Last month, Canberra hosted AMSA's National Leadership Development Seminar. The four-day event saw health professionals, community advocates, doctors and politicians come together to share their wisdom and experience. The theme, "Power of a Voice", sought to empower individuals to effect change through their individual experiences.

There were, of course, practical workshops on basic leadership skills which you would never really be exposed to in your medical training: public relations, networking, event management, social campaigns, project start-ups and the like. These, however, never became goals in themselves, but rather the basic tools which could be used to effect change.

The emphasis was on the diversity of experience. Talks focused on the big social injustices facing medical students today, from the health of minority groups to the internship crisis, bullying, harassment and the mental health of future doctors. Delegates brought their own unique perspectives to the discussion, giving a real sense of the work medical students are doing nationwide. It was a humbling experience, and it served as an inspiration to learn from one another to do better.

In wider terms, the idea behind the Power of a Voice opens up an exciting space for aspiring leaders.

The medically-minded tend to thrive on structure, hierarchy and rigid systems - not only for our patients, but for ourselves. We love nothing more than a clearly structured guideline. With this mindset, it is easy for leaders to care more for the systems they work in rather than the people within them. Overlooking instances of prejudice and discrimination embedded in the organisations they work in becomes only too easy.

At the Seminar, delegates were encouraged to re-think notions of leadership.

It is suggested we are moving from a corporate, productivity-driven management style to one which puts people and their experiences at the centre.

For the most part, medical students are not interested in becoming management consultants; they are interested in making a positive difference in the world.

Leadership is not an end in itself, but rather a tool to make the world a better place – a perspective that characterises the approach medical students are taking to top advocacy issues.

Over the past few years we have seen a much needed change in the conversation around mental health, both in the public sphere and within the world of health professionals.

AMSA has led the way with its Mental Health Campaign to raise awareness and combat stigma within the medical student population.

The latest Humans of Medicine project profiles medical students who have experienced mental illness. This has opened up a platform for individuals to share their stories, struggles and coping strategies, which can be an incredibly powerful experience for them.

At a more local level, this initiative is encouraging individuals to take new strategies to their medical schools and advocate for local solutions. Delegates attending the Seminar had an opportunity to meet with MPs and raise issues of importance to medical students. Mental health was one of the most popular, ensuring a united voice for those who at times cannot speak for themselves.

There's no one person behind these efforts, no one great ego driving it all.

It is a reminder that leadership is never about being at the top; that individual experiences can form the basis for powerful advocacy; and that leaders in organisations must have the insight to listen to marginalised and minority voices.

True leadership is about empowering others to bring about change.

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

Do all doctors need to meet the same CPD requirements for General Registration?

BY **DR ROBYN LANGHAM**

There are many reasons, apart from retirement, why a medical practitioner may choose to reduce their scope of practice or limit the time they work at various points through the course of their career.

A doctor with a young family might want to reduce their contact hours, while a medical advisor employed by government or a private provider may seek to 'keep their hand in' by practising half a day a fortnight. Even practitioners who have retired might want to continue to undertake activities covered by the definition of practice, such as writing prescriptions and referrals for themselves and their family.

This is a complex issue that AMA policy committees debated long and hard during 2010 and 2011 when medical practitioner registration categories and continuing professional development (CPD) requirements were being reviewed by the Medical Board of Australia.

At the time, the Federal Council concluded the AMA could not continue to advocate for a registration category for retired medical practitioners solely on the basis that they would be writing prescriptions and referrals for themselves and their family outside of a formal doctor-patient relationship.

It was agreed that anyone involved in direct patient care, or acting in a capacity that would impact on safe patient care, and who wants to identify themselves as a medical practitioner, should hold full registration and meet full CPD requirements.

As well, it was noted that medical practitioners in primarily non-clinical practice roles generally have a direct impact on practising doctors and, as such, should also meet the same CPD requirements as practitioners engaged in direct clinical practice.

The Medical Practice Committee examined this issue again earlier this year following ongoing requests from senior members, and have advised Federal Council to maintain the AMA's earlier position, proposing policy to formalise the position.

Subsequently, Federal Council has formally resolved that:

- the AMA supports the registration categories in the Health Practitioner Regulation National Law for medical practitioners, noting that the General Registration category affords medical practitioners flexibility to limit their scopes of practice and/or their amount of practice from time to time during their professional life, and in transition to retirement; and
- the AMA considers that for the General Registration category, 50 hours per year of self-directed continuing professional development is appropriate to ensure contemporary practice, and affords medical practitioners the flexibility to tailor their own CPD program to their scope of practice.

Time to launch NATSIHP

BY AMA PRESIDENT ASSOCIATE PROFESSOR BRIAN OWLER

New Prime Minister Malcolm Turnbull has made it clear he wants to reshape the focus and direction of the Coalition Government. He talks of a modern Government with modern approaches. Let's hope this enthusiasm translates to Indigenous health.

While former PM Tony Abbott made a virtue of his commitment to Indigenous issues – including his pledge to spend a week each year living and working in an Indigenous community – genuine new policy rollout was slow under his leadership.

A prime example of this is the National Aboriginal and Torres Strait Islander Health Plan (NATSIHP).

In July 2013, the former Labor Government launched a new NATSIHP, which set out a 10-year framework for the direction of Government policy to improve the appalling health status of Aboriginal and Torres Strait Islander people. The plan had bipartisan support.

The development of the NATSIHP was a clear example of the Government working in partnership with Aboriginal and Torres Strait Islander people to achieve improved health outcomes for the Aboriginal and Torres Strait Islander community.

But, in the two years since the launch of the NATSIHP, we are yet to see the new Government put its commitment into action.

The Government has developed an Implementation Plan for the NATSIHP, but has not yet launched it.

The Implementation Plan provides the basic architecture for turning the NATSIHP into concrete action. More work on defining service models, workforce requirements, and funding strategies is needed.

Guided by the Implementation Plan, the NATSIHP is capable of driving real progress towards the best possible health outcomes for Aboriginal and Torres Strait Islander people, and could realise health gains in a relatively short period of time.

To achieve these improvements, a key strategy is for the Government to identify areas of poor health and inadequate services for Aboriginal and Torres Strait Islander people, and direct investment accordingly.

This must include increased support for Aboriginal and Torres Strait Islander community controlled health services to enable them to fulfil their pivotal role in improving health outcomes for Aboriginal and Torres Strait Islander people.

The NATSIHP recognises that culture is central to the health and wellbeing of Aboriginal and Torres Strait Islander people, and this must be reflected in practical ways throughout the actions of the NATSIHP Implementation Plan.

The NATSIHP broke new ground with the identification of racism as a key driver of ill-health. The implementation of the NATSIHP must provide a clear focus on strategies to address racism, and strengthen the cultural safety of Australia's healthcare system.

This includes identifying and eradicating systemic racism within the health system and improving access to, and outcomes across, primary, secondary, and tertiary health care.

While we need to continue to strengthen health care, we also need to enhance our focus on building pathways into the health profession for Aboriginal and Torres Strait Islander people, as well as supporting the existing Indigenous health workforce.

Aboriginal and Torres Strait Islander people are significantly underrepresented across all health professions, particularly medicine, nursing and allied health. This must change.

Aboriginal and Torres Strait Islander health professionals are an important resource to improve Aboriginal and Torres Strait Islander health, as they are able to use their unique cultural and clinical expertise to contribute to greater health outcomes for Indigenous people.

Specific actions to address Indigenous health workforce shortages must be reflected in the actions of the NATSIHP Implementation Plan.

NATSIHP implementation is long overdue. It must occur without further delay.

The initial Implementation Plan was to be developed within 12 months of the NATSIHP's release. That time is long gone.

At a Senate Estimates hearing in June, Government officials indicated that the Implementation Plan for the NATSIHP was still being developed, and that it would be released soon. That was three months ago, and still no action.

PM Turnbull strengthened and reordered his Health portfolio team upon taking over the leadership, with now Rural Health Minister Senator Fiona Nash retaining responsibility for Indigenous health. I will be discussing the inactivity on NATSIHP with her at the earliest opportunity.

The AMA's Indigenous Health Taskforce is keen to see the Government make NATSIHP a reality – and a success story.

Signs workforce planning getting back on track

BY AMA VICE PRESIDENT DR STEPHEN PARNIS

It's been a chequered time for medical workforce planning in recent years.

Health Workforce Australia (HWA) was a Commonwealth statutory authority established in 2009 to deliver a national and co-ordinated approach to health workforce planning, and had started to make substantial progress toward improving medical workforce planning and coordination. It had delivered two national medical workforce reports and formed the National Medical Training Advisory Network (NMTAN) to enable a nationally coordinated medical training system.

> "Regrettably, before it could realise its full potential, the Government axed HWA in the 2014-15 Budget, and its functions were moved to the Health Department"

Regrettably, before it could realise its full potential, the Government axed HWA in the 2014-15 Budget, and its functions were moved to the Health Department. This was a short-sighted decision, and it is taking time to rebuild the workforce planning capacity that was lost.

NMTAN is now the Commonwealth's main medical workforce training advisory body, and is focusing on planning and coordination.

It includes representatives from the main stakeholder groups in medical education, training and employment. Dr Danika Thiemt, Chair of the AMA Council of Doctors in Training, sits with me as the AMA representatives on the network.

Our most recent meeting was late last month, and the discussions there make us hopeful that NMTAN is finally in a position where it can significantly lift its output, contribution and value to medical workforce planning.

In its final report, *Australia's Future Health Workforce*, HWA confirmed that Australia has enough medical school places.

Instead, it recommended the focus turn to improving the capacity and distribution of the medical workforce – and encouraging future medical graduates to train in the specialties and locations where they will be needed to meet future community demands for health care.

The AMA supports this approach, but it will require robust modelling.

NMTAN is currently updating HWA modelling on the psychiatry, anaesthetic and general practice workforces. We understand that the psychiatry workforce report will be released soon. This will be an important milestone given what has gone before.

Nonetheless, it will be important to lift the number of specialties modelled significantly now that we have the basic approach in place, so that we will have timely data on imbalances across the full spectrum of specialties.

The AMA Medical Workforce Committee recently considered what NMTAN's modelling priorities should be for 2016.

Based on its first-hand knowledge of the specialities at risk of workforce shortage and oversupply, the committee identified the following specialty areas as priorities: emergency medicine; intensive care medicine; general medicine; obstetrics and gynaecology; paediatrics; pathology and general surgery.

NMTAN is also developing some factsheets on supply and demand in each of the specialities - some of which now available from the Department of Health's website (http://www.health.gov.au/internet/main/publishing.nsf/Content/nmtan_subcommittee_factsheet). I encourage you to take a look.

These have the potential to give future medical graduates some of the career information they will need to choose a specialty with some assurance that there will be positions for them when they finish their training.

Australia needs to get its medical workforce planning back on track.

Let's hope that NMTAN and the Department of Health are up to the task.

High standards essential to sustaining patient trust

BY DR MICHAEL GANNON

There is no professional relationship where trust is more intrinsic than the doctor-patient relationship.

Patients trust us when they are at their most vulnerable – when they are sick, hurt, confused, scared, when they are born, when they are dying. They trust us to care not only for them, but for their loved ones, to treat their bodies and their minds, to be honest, to be respectful, to protect their confidentiality, to put their health needs first.

> "If people do not trust doctors, they may seek care elsewhere, or not seek care at all – outcomes which may prove detrimental not only to their own health, but the wellbeing of the wider public"

If people do not trust doctors, they may seek care elsewhere, or not seek care at all – outcomes which may prove detrimental not only to their own health, but the wellbeing of the wider public.

The success of the doctor-patient relationship, as well as the wider profession-society relationship, depends on trust, which can be maintained through a strong adherence to medical professionalism.

Medical professionalism refers to the values and skills that the profession and society expects of individual doctors and the medical profession, encapsulating both the doctor-patient relationship and the wider 'social contract' between the profession and society.

Individual doctors are expected to uphold the core values of the medical profession such as respect, trust, compassion, altruism, integrity, advocacy and leadership, collegiality (among others).

The medical profession is expected to adhere to the social contract with society. The profession is granted a high level of autonomy and clinical independence because society values the profession's highly specialised knowledge and skills in serving the public interest.

In return for this relative autonomy and independence, the medical profession is expected to use its unique expertise to set and maintain high standards of ethics, practice, competency and conduct through an open and accountable process of profession-led regulation.

More than anything, medical professionalism encapsulates the profession's commitment to prioritise patient interests above all else.

But our ability to appropriately care and advocate for our patients is increasingly challenged by today's often chaotic and demanding health care system.

We work in an environment of mounting costs; increasing bureaucracy, managerialism and regulation; changes to the structure and funding of the workforce; rising consumerism; and shifting perceptions of the medical profession.

While such issues may prove frustrating, demoralising, or even overwhelming at times, they should never undermine or compromise our commitment to our patients and the values of medical professionalism.

Through leadership, unity, solidarity and collegiality, the medical profession should adhere to and promote the values of medical professionalism to its own members, from medical students through to retiring doctors, from doctors who work in clinical practice to those who work in research, academia and administration. These qualities are fundamental to quality medical care.

*The AMA's *Position Statement on Medical Professionalism 2010* has been revised as part of the five year position statement review cycle. The Position Statement defines medical professionalism, sets out the core values of the profession and acknowledges the challenges that the modern, dynamic health care environment poses to putting patients' interests first. It can be viewed at: https://ama.com.au/position-statement/medical-professionalism-2010

Nuclear weapons: towards international disarmament

BY DR MARGARET BEAVIS, PRESIDENT, MEDICAL ASSOCIATION FOR PREVENTION OF WAR, AUSTRALIA

As a profession, we recognise that disease prevention is as important as treatment. Nuclear weapons continue to represent an enormous health threat, and the AMA is working with other international medical associations to address this issue.

So why are nuclear weapons a major health issue?

Firstly, any use would cause direct damage with huge numbers of civilian lives lost. As an example, India and Pakistan have a contested, volatile border. They have been to war three times since independence, and have mobilised for war twice more. Estimates show that a limited exchange of nuclear weapons between these two countries would cause 44 million casualties, including 21 million deaths, in major cities in India and Pakistan. Moreover, both countries and their neighbours, including Nepal, Bangladesh, Sri Lanka, Tibet and China, would suffer radioactive contamination.

Secondly, the indirect effects would be even more disastrous. Global climate disruption from smoke and soot would result in a decade long "nuclear winter", with reduced growing seasons and rainfall. Detailed modelling shows reduced yields of maize, soybean and wheat crops, resulting in global famine, with the most food insecure nations such as Kenya, Ethiopia, and Somalia the worst affected. The lives of up to 2 billion people would be at risk.

With more than 15,000 nuclear weapons in existence, it is only a matter of time before we have a nuclear disaster. On a number of occasions nuclear attack has been ominously close.

Far from disarming, the United States, Russia, China and France are currently undertaking extensive arsenal renewal - the US alone is planning to spend US$ 355 billion in the next decade. Such massive expenditure steals funding from health, education and other crucial social services.

The good news is that a new approach, the International Campaign for Abolition of Nuclear Weapons (ICAN) has developed and is working. ICAN was started here in Australia in 2007 by the Medical Association for Prevention of War (MAPW). ICAN has since spread to 97 countries and has more than 400 partner organisations.

The focus internationally has shifted to the catastrophic humanitarian impacts. Three international intergovernmental conferences have been held in the last two years, with 158 governments attending the most recent in December last year. This year, 117 nations have signed the Humanitarian Pledge, which commits to the creation of a legal ban.

With biological and chemical weapons, landmines and cluster munitions, a legal ban came first, and was followed by moves to phase them out. A ban is a necessary starting point for nuclear disarmament to happen. While the dismantlement of all nuclear arsenals might be a long process, a clear international rejection of these weapons is going to be an essential component of future disarmament efforts.

A resolution calling for "a ban and elimination" of nuclear weapons is going to the World Medical Association meeting in Moscow this month. In March, the AMA Federal Council gave unanimous support for the WMA resolution condemning the use of nuclear weapons, and this approach has been echoed by medical associations around the world.

If you would like to find out more, or want to support the campaign, please join ICAN or the Medical Association for Prevention of War, and help us with education and advocacy.

We are at a very important stage in building momentum towards a ban. Advocacy by medical associations around the world sends a very powerful message. The AMA can be justly proud for taking action on this important global health issue.

War: A Global health problem, a one day conference for health professionals organised by the Medical Association for Prevention of War, will be held in Melbourne on Saturday, 31 October. Speakers include: Julian Burnside SC on asylum seekers, Phoebe Wynn Pope (Red Cross international humanitarian law expert) and Professor John Langmore (expert in peace negotiations). For more details, please visit https://www.facebook.com/events/1488895628096768/. To RSVP, email eo@mapw.org.au or call 0431 475 465.

Health on the hill

POLITICAL NEWS FROM THE NATION'S CAPITAL

'Stepped-care' part of Govt's mental health blueprint

Health Minister Sussan Ley has backed a "stepped-care" approach to mental health services despite ruling out calls to divert $1 billion funds from hospitals to boost primary and community-based programs.

Ms Ley used Mental Health Week to reassure beleaguered practitioners and service providers the Federal Government's long-awaited reform plans for the nation's fragmented 'system' would be unveiled by the end of the year.

Though the details of the Government's reform package are still being worked on, the Minister adopted the language of the National Mental Health Commission's report in saying it would involve a stepped-care approach.

"It's got to be a stepped-care system. And what that means is you have a level of care appropriate to your needs at the time, so that you don't leave hospital and then find your way back in because that stepped-down care wasn't available for you," the Minister told ABC Radio.

But it is unclear what resources might be given to GPs and other community-based services to support such a shift in service focus, with Ms Ley appearing firm in her decision earlier this year to rule out a Commission recommendation to channel $1 billion from hospital-based services to primary care.

"We know that there aren't enough acute hospital facilities, but that's not the point. The point is that we don't want people in there if we could have cared for them earlier and in the community," she said.

The National Mental Health Commission review, released in April, identified "fundamental structural shortcomings" in the nation's health system.

The Commission argued that changing to a "stepped care approach", with a major focus on prevention and early intervention, would reduce the severity and duration of mental health issues, ultimately slowing demand for expensive acute hospital care and lowering the incidence of long-term disability.

In June, the Government appointed a group to advise on how to implement the Commission's recommendations into action, and it reported earlier this month.

Ms Ley said the Government would "move away from [a disjointed and fragmented] system to one where people can get the level of help that they need, in the location they need, at the time they need."

Ms Ley said a key aim was to improve coordination between services to ensure continuous care.

"We needed to re-think our approach...and change the focus from a service-centred approach to one where services are organised around the needs of the person," the Minister said.

"It needs to, for example, recognise that where somebody may go into hospital after a suicide attempt, when they leave hospital they're not left on their own, they do have somewhere to go, and they do have some follow-up," she said. "I've heard countless stories and examples where people are falling through the cracks."

ADRIAN ROLLINS

Aged care handed back to health

Responsibility for aged care has been returned to the Health portfolio and Minister for Rural Health Senator Fiona Nash has been given oversight of indigenous health among changes made to the allocation of roles by Prime Minister Malcolm Turnbull.

In a move welcomed by the AMA, the Federal Government announced on 30 September that Health Minister Sussan Ley would retain her hold on the Sport portfolio and would take on the additional role as Minister for Aged Care.

Mr Turnbull said that giving Ms Ley responsibility for aged care would ensure that ageing was "front and centre with the health portfolio as our population continues to live longer and healthier lives".

As part of the change, aged care functions will be transferred from Department of Social Services to the Health Department.

AMA President Professor Brian Owler said aged care had languished in recent times because taking it out of Health had reduced the political focus.

"It is vital that the health needs of older Australians are considered as a key component of the broader health policy debate, and it is fitting that aged care is back with the Health Minister," Professor Owler said. "Caring for older Australians, whether they live in residential aged care or independently in their own homes, is an integral part of medical practice."

One of the major issues to be tackled in the area is the dislocation of care for people in nursing homes, as well as adequate support for GP-led primary health teams in providing co-ordinated care to enable the elderly to live at home.

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"Most older Australians have longstanding relationships with their GP, who is best placed to determine which services will work best for their patient," Professor Owler said. "Early medical assessment is critical to ensuring that older Australians receive the appropriate support to maintain their level of independence before their social and health situation deteriorates.

He said including the clinical opinion of a patient's usual treating doctor in the assessment of their care needs and formulating a care package should be normal practice, not, as is currently the case, an optional extra.

"We also need to see improved processes to allow doctors to manage the provision of straightforward care, such as wound care, for older people still living in their own home," the AMA President said. "The aged care sector must be able to provide the level and quality of medical, nursing, and allied health services required to meet the needs of our ageing population."

Professor Owler said the AMA would seek to discuss these issues and other aged care policy priorities "at the earliest opportunity."

In addition to rural and Indigenous health responsibilities, Senator Nash has retained her oversight of drug and alcohol policy and organ donation.

Assistant Health Minister Ken Wyatt will provide support for Ms Ley in aged care.

ADRIAN ROLLINS

The end of $250,000 degrees – at least for now

The Federal Government has deferred controversial plans to deregulate university fees, providing relief for aspiring medical students fearful the change would have pushed the cost a medical degree above $250,000.

Education Minister Simon Birmingham has confirmed that the higher education reform package designed by his predecessor Christopher Pyne has been taken off the table pending further consultation with the sector.

In a radical proposal unveiled in the 2014 Budget, Mr Pyne detailed plans to cut university funding and deregulate course costs, sparking fears it would push the cost of a medical degree well in excess of a quarter of a million dollars.

But legislation for the change has stalled in Parliament because of strong opposition in the Senate, and Mr Birmingham told a higher education conference on 1 October it had been shelved until after the next election.

"With only three months left in 2015, it is necessary to give both universities and students certainty about what the higher education funding arrangements for 2016 will be," Senator Birmingham said. "Therefore, I am announcing that higher education funding arrangements for 2016 will not be changed from currently legislated arrangements while the Government consults further on reforms for the future. Any future reforms, should they be legislated, would not commence until 2017 at the earliest."

The Minister's decision was welcomed by AMA President Professor Brian Owler, who said the prospect of $250,000 degrees would have had damaging effects on the practice of medicine.

"This would have discouraged students from low socio-economic backgrounds from entering medicine, it would have

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pushed future graduates towards higher paying specialties, and it would have deterred graduates from working in underserviced areas, including rural Australia," Professor Owler said.

Former Prime Minister Tony Abbott said he was disappointed by the decision to defer the legislation, and told radio 3AW he was "frankly...a little disappointed that more of the people who keep saying we need reform, we need cuts in government spending, did not get behind the 2014 budget".

But Professor Owler urged the Government go one step further and give assurances that there will be no future blow-out in university fees.

"The Government needs to give students some certainty that education will not be priced out of their reach should the fee deregulation proposals re-emerge after the next election," he said, adding that the AMA was keen to work with the Government to develop reforms that boost funding for undergraduate medical education without putting the cost of a medical degree beyond the means of most students.

"The new Minister for Education and Training, Simon Birmingham, has declared he wants to consult broadly about future reforms, and the AMA wants medical workforce and training issues near the top of his agenda," the AMA President said.

The *Higher Education Base Funding Review: Final Report* identified medicine as a discipline that was under funded, both in terms of the resourcing required, and in comparison with the funding provided internationally for medical schools, and Professor Owler said these concerns should inform discussions about changes in the sector.

"Any future reform package must maintain our world renowned system of medical education," he said.

ADRIAN ROLLINS

Tobacco cuts a deadly swathe through China

While tobacco companies and their deadly products are under siege in Australia and many other developed countries, the death toll from cigarettes in emerging markets is soaring as they make huge inroads into markets like China and Indonesia.

A study in the peer-reviewed journal Cancer has highlighted the heavy human cost that has resulted, reporting that smoking now causes almost a quarter of all cancers in Chinese men.

The authors of the study said that since the 1980s there had been an explosion in the number of men in China who smoke, to the point that the vast Asian country now produces and consumes around 40 per cent of all the world's cigarettes.

Already, smoking is estimated to cause 435,000 new cancers each year in China (83 per cent of them in men), and researchers warn this will be only the tip of the iceberg as the effects of increased smoking rates now feed through in coming decades.

"The tobacco-related cancer risks among men are expected to increase substantially during the next few decades as a delayed effect of the recent rise in cigarette use, unless there is widespreasd cessation among adult smokers," the research team, led by Professor Zhengming Chen of Oxford University and Professor Liming Li of the Chinese Academy of Medical Sciences, said.

The team analysed the results of a survey of more than 510,000 Chinese men and women conducted between 2004 and 2008, and a follow-up survey conducted after seven years found around 18,000 new cancers among those interviewed.

Underlining the dangers of tobacco, the survey found 68 per cent of men smoked, and they were at 44 per cent greater risk of developing cancer than non-smokers, particularly cancer of the lung, liver, stomach and oesophagus. The increased risk accounted for 23 per cent of all cancers found in people aged between 40 and 79 years.

But, in a result that should spur efforts to get people to quit the habit, the study found the excess risk of cancer had virtually disappeared 15 years after a smoker stubbed out their last cigarette.

Professor Zhengming said getting smokers to dump cigarettes would be the most potent and cost-effective strategies to avoid cancer and premature death "over the next few decades".

The results came as Assistant Health Minister Fiona Nash dismissed complaints by tobacco companies about an increase in the excise charged on their products in Australia, and reaffirmed the nation's commitment to defend the country's world-leading plain packaging laws against legal challenge in international forums including the World Trade Organisation.

Senator Nash said the heavy tobacco excise had helped reduce the proportion of Australians who smoke daily to an all-time low of 12.8 per cent.

Cigarette manufacturers have complained that plain packaging, the hefty excise and other Government measures are fuelling an illegal trade in tobacco, but the Minister said such "scaremongering...[was] no reason to roll back sensible health policies".

ADRIAN ROLLINS

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