AUSTRALIAN
Medicine
The national news publication of the Australian Medical Association

ISSUE 27.11A - DECEMBER 1 2015

Jail break

Imprisonment no way to close health gap, p3

INSIDE

AMA

AUSTRALIAN
Medicine

Managing Editor: John Flannery
Editor: Adrian Rollins
Production Coordinator: Kirsty Waterford
Contributors: Sanja Novakovic
Odette Visser
Graphic Design: Streamline Creative, Canberra

Australian Medicine is the national news publication of the Australian Medical Association Limited. (ACN 008426793)

42 Macquarie St, Barton ACT 2600
Telephone: (02) 6270 5400
Facsimile: (02) 6270 5499
Web: www.ama.com.au
Email: ausmed@ama.com.au

AMA LEADERSHIP TEAM

President
Professor Brian Owler

Vice President
Dr Stephen Parnis

In this issue

Special report

National news

Health on the hill

Research

World News

Cover: AMA President Professor Brian Owler (R) and Reconcilliation Australia Co-Chair Professor Tom Calma launch the *2015 AMA Report Card on Indigenous Health* at Parliament House

Cut Indigenous imprisonment to help close health gap

AMA President Professor Brian Owler (R) with Rural Health Minister Senator Fiona Nash (C) and Reconcilliation Australian Co-Chair Professor Tom Calma (L) at the launch of the *2015 AMA Report Card on Indigneous Health* at Parliament House

Sky-high rates of Indigenous incarceration need to be dramatically reduced if the nation is to close the health gap blighting the lives of Aboriginal and Torres Strait Islander people, according to AMA President Professor Brian Owler.

Launching the *2015 AMA Report Card on Indigenous Health,* Professor Owler said being imprisoned had devastating lifelong effects on health, significantly contributing to chronic disease and reduced life expectancy.

"Our Report Card recognises that shorter life expectancy and poorer overall health for Indigenous Australians is most definitely linked to prison and incarceration," the AMA President said.

Aboriginal and Torres Strait Islander people are hugely over-represented in the nation's prisons - almost 30 per cent of all sentenced prisoners are Indigenous.

While some progress has been made in recent years in improving infant and maternal health, the AMA President said that imprisonment rates were rising, and the country was set to reach a "grim milestone" next July when, on current trends, the number of Indigenous people in custody will reach 10,000, including 1000 women.

Continued on p4 ...

Cut Indigenous imprisonment to help close health gap

... from p3

In its Report Card, launched by Rural Health Minister Fiona Nash, the AMA has urged Federal, State and Territory governments to set a national target for cutting rates of Indigenous imprisonment.

The call has come just days after disturbing details emerged of the death of a young Aboriginal woman who was being held in police custody for failing to pay $3622 of fines.

> "Indigenous adults are 13 times more likely to be jailed than other Australians, and among 10 to 17 year-olds the rate jumps to 17 times"

A West Australian coronial inquest has been told the 22-year-old woman, known as Miss Dhu for cultural reasons, was in a violent relationship and using drugs at the time of her arrest last year. While in the South Hedland Police Station, she complained of pain and difficulty breathing, and subsequently became unconcious.

It was later found she had several broken ribs following an attack by her partner, and died from a lethal combination of pneumonia and septicaemia.

Miss Dhu's death has fuelled calls for WA to overhaul laws regarding the imprisonment of fine defaulters.

But the AMA has said a much broader approach needs to be taken.

Indigenous adults are 13 times more likely to be jailed than other Australians, and among 10 to 17 year-olds the rate jumps to 17 times.

Professor Owler said it was possible to isolate the health issues that led to so many Aboriginal and Torres Strait Islander people landing in prison, included mental health conditions, alcohol and drug use, substance abuse disorders and cognitive disabilities.

He said the "imprisonment gap" was symptomatic of the health gap, and the high rates of imprisonment of Aboriginal and Torres Strait Islander people, and the resultant health problems, needed to be treated as a priority issue.

In particular, he said, the health issues identified as being the most significant drivers of Indigenous imprisonment "must be targeted as a part of an integrated effort to reduce Indigenous imprisonment rates".

Professor Owler said the evidence showed that Aboriginal and Torres Strait Islander people continued to be let down by both the health and justice systems, and firm and effective action was required.

"It is not credible to suggest that Australia, one of the world's wealthiest nations, cannot solve a health and justice crisis affecting 3 per cent of its citizens," he said.

Reconciliation Australia Co-Chair Professor Tom Calma said the AMA's "very substantial" Report Card was the latest in a long list of reports identifying the need for action, and urged governments to "get on with it".

Professor Calma said there had been "some really good outcomes" from recent initiatives to improve prisoner health, particularly moves in many states to ban smoking in jails.

But he said more needed to be done to tackle recidivism, citing figures showing 50 per cent of Indigenous prisoners reoffended.

The Indigenous leader said that this was not surprising because often people getting out of prison returned to the same situation that got them into trouble in the first place, and urged action to tackle the causes of offending in the place, such as alcohol and drug abuse.

Among its recommendations, the AMA has called for funds freed up from reduced rates of Indigenous incarceration to be reinvested in diversion programs; for governments to support the expansion of chronic health and prevention programs by Aboriginal Community Controlled Health Organisations; for such organisations to work in partnership with prison health authorities to improve health and reduce imprisonment rates; and to directly employ Indigenous health workers in prison health services.

ADRIAN ROLLINS

Gatekeeper role of GPs under scrutiny in MBS review

The crucial gatekeeper role played by GPs is coming under scrutiny as the Federal Government explores a possible overhaul of the operation of Medicare as part of its review of the MBS.

While around 35 Clinical Committees will be set up to conduct an item-by-item review of the MBS, a memorandum by Review Taskforce Chair Professor Bruce Robinson shows "high-level" issues affecting the overall functioning of the Medicare system are also under active consideration.

The Review Chair was at pains to insist that there was no set savings target for the MBS Review, but added there was "a need to look at the full breadth of the $19.1 billion MBS spend, not just general practitioner services".

His comments came as it was revealed the final results of the MBS Review would not be submitted to the Government until December 2016, almost certainly putting them beyond the next Federal election, which is due by late next year.

Much of the attention so far has been on the Review's appraisal of more than 5700 items on the MBS, but the fact that it also encompasses an examination of the over-arching rules governing the operation of Medicare is less well known.

But the far-reaching possibilities this entails started to become clearer at a series of stakeholder forums organised by the Taskforce, including fundamental changes in professional roles and responsibilities, models of remuneration, and the use of the MBS to "actively guide" clinical decision-making.

In his report on consultations, Professor Robinson said some had complained that the gatekeeper role played by GPs was limiting the effectiveness of team-based care, such as by requiring all referrals to be made through the GP.

The Taskforce Chair said that though some participants reaffirmed the importance of GPs as gatekeepers, there were suggestions that specialists be able to make direct referrals in selected cases, such as a physiotherapist requesting a knee x-ray.

Suggestions of any dilution in the central role played by GPs in coordinating care fly in the face of the latest advice from health experts here and abroad, who have argued that, far from diminishing the position of the family doctor, governments should enhance it.

In its latest review of the Australian health system, the Organisation for Economic Cooperation and Development argued strongly against any further fragmentation of the health system, and urged that primary health care be strengthened.

And University of Sydney researchers last month reported that GPs were holding health costs down by coordinating the care provided by hospitals, specialists, allied health professionals and community and aged care services.

"If general practice wasn't at the core of our health care system, it is likely the overall cost of health care would be far higher," the researchers said.

The MBS Review process has also included discussion about a shift away from the fee-for-service remuneration model to pay for performance – an issue being explored in detail by the Primary Health Care Advisory Group being led by former AMA President Dr Steve Hambleton.

"While many participants felt the MBS could improve quality of care by paying for performance, concerns were voiced that clinicians may be averse to taking on high-risk patients who are unlikely to achieve target outcomes," Professor Robinson reported. "Furthermore, some rebates may need to reflect the additional risk that providers would be taking on – potentially a complex analysis."

In addition to exploring so-called 'macro' issues, Professor Robinson provided more detail on how the review of individual Medicare items would proceed.

He said each of the Clinical Committees would conduct an initial "triage" of usage patterns, evidence and descriptors to identify items in need of more detailed investigation.

It would then conduct a rapid evidence review and make recommendations to the Taskforce based on its appraisal.

Given the scale of the task, Professor Robinson said the Committees, which would be peer-nominated and clinically-led, would be likely to appoint subsidiary working groups.

Already, six pilot Clinical Committees have been established, including in obstetrics.

Continued on p6 ...

Gatekeeper role of GPs under scrutiny in MBS review

... from p5

The Taskforce Chair said items suggested for review fell into one of six categories: they were obsolete, misused, applied inappropriately, under-utilised, placed undue restrictions on providers or did not reflect modern practice.

He said participants stressed the importance of Taskforce plans to share the evidence used to support recommendations about items, to improve clinical practice and inform the future direction of research.

The Review Taskforce is due to provide an interim report to the Government by the end of the year.

Professor Robinson's Memorandum of the MBS Review Taskforce November 2015 Stakeholder Forums can be viewed at: https://ama.com.au/sites/default/files/Summary%20Memorandum%20MBS%20Review%20Stakeholder%20Forums%20November%202015%20%282%29.pdf

ADRIAN ROLLINS

MBS Review – tell us what you think

The Federal Government's MBS Review could have far-reaching implications for clinical practice.

To facilitate conversations about the clinical aspects of the Review and identify the common clinical opinions, the AMA has created an online discussion forum in doctorportal for medical practitioners.

To start or contribute to a discussion, click here: http://www.doctorportal.com.au/discussions/

Information on how to register for doctorportal is available at www.doctorportal.com.au/user-register/

Govt survey a smokescreen to undermine equal access: AMA

Charging smokers and the obese higher health insurance premiums is the first step toward a US-style system in which the poorest and sickest are shunted into over-stretched public health services while insurers book big profits, AMA President Professor Brian Owler has warned.

Professor Owler has launched a full-blooded attack on the Federal Government over a survey it has launched which asks consumers whether they think insurers should be given the discretion to charge different premiums according to smoking habits, obesity and other health risks.

The AMA President said the Government's move played into the hands of health funds keen to offload customers with serious and chronic illnesses onto the public system in order to boost their profits, and would do nothing to cut down on smoking or otherwise improve health.

"We all know that non-smokers are going to say 'Yes, I want to pay less for my premiums," the AMA President said. "This is not the way to tackle smoking."

He said the bigger policy question was whether people were prepared to let health funds pick and choose who they insured, taking into account that procedures like genetic screening for potentially fatal diseases would soon be a reality.

"If you're positive for a genetic test, are you going to be denied cover? These are the sorts of questions that we need to be asking," Professor Owler said.

Health Minister Sussan Ley seized on figures showing health insurance policies covering 500,000 people were dumped or downgraded in 2014-15 to argue insurers need to provide much better value.

Continued on 8 ...

Govt survey a smokescreen to undermine equal access: AMA

... from p7

Ms Ley said the Government was committed to "recalibrating" the private health system to make it value for money following a succession of premium increases that have outstripped inflation and the proliferation of junk policies that offer nothing more than a public hospital bed.

> "Consumers are angry, confused, and I'm concerned that simply shopping around is no longer enough to get the best value for money" – Ley

"Consumers are angry, confused, and I'm concerned that simply shopping around is no longer enough to get the best value for money," she said, inviting them to take part in an online survey being run by the Health Department.

Premium increases outstrip costs

The private health insurance market is dominated by five big funds and the industry recorded an after-tax profit of $1.1 billion in 2014-15. Premium revenue surged by 7.3 per cent, leading the regulator to note that "the increasing cost of health services and growing utilisation rates have been more than offset by higher premiums".

But the Minister has been forced on to the defensive amid criticism that her approach puts the interests of insurers ahead of patients, particularly the sickest and most vulnerable.

Shadow Health Minister Catherine King said suggestions in the survey that insurers be allowed to charge different premiums according to age and gender as well as lifestyle habits like smoking showed that women and the elderly were in the Government's sights.

Ms King said it was alarming that the survey highlighted the higher benefits paid out to patients 75 years or older, while asking about gender was a "clear sign" that women of child bearing age would be required to pay higher premiums.

Community rating under attack

Professor Owler said the private funds wanted to undermine community rating, the principle under which insurers must offer the same price of health cover to all, regardless of their health risk, in order to boost their bottom line.

This was the intention behind the push to have smokers charged a higher premium, he said, warning the idea would eventually be extended to policyholders with other health risks.

"Where does it stop, because we know that genetic testing is coming down the track. You know that obesity and all sorts of other issues are going to be brought into play in the future, and...the insurers are only going to want to insure those people that are fit and healthy and don't need anything done to them," Professor Owler said. "That is all about maintaining their bottom line and...improving their margins."

His concerns were given added weight when Mark Fitzgibbon, Chief Executive of insurer NIB, told Fairfax Media that although higher premiums for smokers would be the first move, insurers might eventually monitor the habits of policyholders to reward healthy behaviour like exercise (and, by implication, to punish unhealthy activity).

But Ms Ley said it was not the Government's intention to impair access to health care, and its starting point was that Medicare and public hospital system remain universally accessible.

"It's important we're able to ask consumers what they expect from their private health insurance, and there's plenty of room to do that without moving towards US or UK models that exclude sick people, or make it only available to rich people, which we don't support," she said.

But the Minister flagged changes to industry regulation, remarking that a succession of the above-inflation premium increases suggested there was "something wrong" with its regulatory foundations.

Professor Owler said this was worrying.

"I find it very concerning when the Health Minister makes statements like she's concerned that the health insurers are wrapped up in regulation or being restricted by regulation," he said. "Those regulations are there to protect the public health system, and they're there for a good reason."

ADRIAN ROLLINS

'Flashpoint' warning as Medibank pushes cost agenda

The nation's largest health insurer will no longer cover the costs of many patients who become sick or injured in hospital as a result of what it deems to be avoidable medical complications or errors under the terms of a deal struck with major private hospital operator Healthscope.

> "While the details of the arrangement have not been publicly disclosed, it is believed to include clauses regarding liability for costs arising from hospital acquired complications and avoidable readmissions"

In an important development for Medibank Private as it tries to squeeze down on payouts, the insurer and Healthscope have reached agreement on a two-year contract that includes provisions regarding the safety and quality of care.

While the details of the arrangement have not been publicly disclosed, it is believed to include clauses regarding liability for costs arising from hospital acquired complications and avoidable readmissions.

The deal follows an attempt by Medibank earlier this year to pressure Calvary Health Group into accepting responsibility for 165 complications the insurer described as preventable, including deep vein thrombosis and maternal death arising from amniotic fluid embolism.

The demand initially led to a breakdown in negotiations, but eventually Medibank and Calvary reached agreement – though the terms are confidential.

A senior hospital executive has warned the issue could become a "flashpoint" for the sector.

"To use quality and safety to some extent as a Trojan horse, and taking the role of arbiter of quality and safety for the contributor is interesting," Calvary Chief Executive Mark Doran told a UBS Australasia conference in Sydney in November. "It means you're in conflict with the medical profession, who see themselves as the arbiter of quality and safety for their patient. If you don't engage with them, you risk them pulling back."

Medibank's deal with Healthscope is significant for the insurer because the company operates 46 private hospitals across the country and provides around 165,000 episodes of care to Medibank members each year.

Healthscope Chief Executive Officer Robert Cooke insisted his company was "working in partnership" with Medibank in reducing waste and inefficiency.

"Healthscope has a longstanding commitment to improving our patients' experience in hospital, including robust safety and quality programs," Mr Cooke said. "Medibank's focus on reducing hospital acquired complications and avoidable readmissions is complementary to the quality data we have been publishing since 2012."

Outgoing Medibank Managing Director George Savvides said the Healthscope deal was one of a number of "performance-based contracts" it was seeking to strike with hospital providers, and set an example of how insurers and providers could work together to "maintain excellence...while also reducing rising health costs".

But AMA President Professor Brian Owler said "close attention" needed to be paid to what Medibank was trying to do.

Professor Owler said that because hospital expenses and prosthetics together made up about 85 per cent of private health fund costs, it "stands to reason" these would be a focus for Medibank.

Continued on 10 ...

'Flashpoint' warning as Medibank pushes quality agenda

... from p9

The major health funds have commissioned a report on prosthetic costs amid complaints they are paying $800 million a year more on devices compared with the public sector.

But Professor Owler warned that the insurer should not pursue cost-cutting under the guise of patient safety and quality assurance.

"What we don't want is punitive measures that punish patients and interfere in what would otherwise be routine clinical cases in order to save money," the AMA President said.

While some serious mistakes, such as operating on the wrong limb or transfusing the wrong blood type, should never occur, Professor Owler said complications were an unfortunate and inevitable part of clinical practice, particularly when doing high-risk procedures on patients with multiple co-morbidities.

"Of course, every effort should be made to minimise these complications, but we are never going to be able to eliminate them," he said.

Professor Owler said if Medibank's true goal was to increase patient safety and improve quality, imposing financial penalties was the wrong way to go about it.

He said there was already a multilayered system in place to improve quality of care, including clinical groups, peer reviews, continuous professional education and training and accreditation standards.

"Financial penalties should not be the major lever to try and improve the quality of care," Professor Owler said. "Doctors and nurses are already very motivated to improve the outcomes of care for their patients."

ADRIAN ROLLINS

Health funds spend millions on unproven treatments

There is no evidence that any of the natural therapies typically covered by private health insurance deliver clinical benefit, increasing the focus on the value for money provided by health funds.

An exhaustive review of 17 natural therapies conducted by the Office of the National Health and Medical Research Council found that while a small number may provide some short-term pain relief, most lack any scientific evidence to back their health claims.

"Overall, there was not reliable, high-quality evidence available to allow assessment of the clinical effectiveness of any of the natural therapies for any health conditions," the review, chaired by the Chief Medical Officer Professor Chris Baggoley, said.

> "The funds argue that natural therapy cover encourages younger, healthier people to take out private health insurance, helping offset the financial drain from older and sicker members"

The report, which has been with the Government for months, looked at therapies including massage, yoga, pilates, shiatsu, homeopathy, kinesiology, reflexology, naturopathy, aromatherapy, herbalism, iridology, Bowen therapy and Alexander technique – many of which are covered by insurers under their extras cover.

Medibank Private, for instance, will provide up to $200 a year toward consultations for reflexology, kinesiology, Chinese and Western herbalism, exercise physiology, shiatsu, aromatherapy, homeopathy, Bowen therapy, Alexander technique and Feldenkrais for singles with extras cover.

The Baggoley review found there was "moderate quality evidence" that massage therapy could provide immediate-term relief for people with chronic lower back pain, but said there was only very low-quality evidence that tai chi benefited health. For therapies like kinesiology, homeopathy, reflexology and rolfing, it found scientific evidence was either lacking, insufficient or uncertain.

The funds argue that natural therapy cover encourages younger, healthier people to take out private health insurance, helping offset the financial drain from older and sicker members.

But critics argue it is a misuse of resources which should only be directed to therapies of proven clinical effectiveness.

The Baggoley review was commissioned by the former Labor Government, which wanted to stop paying the Private Health Insurance Rebate for therapies not backed by scientific evidence. It estimated the cut would save $32 million a year.

The report has been released in the midst of a Government review of private health insurance.

Health Minister Sussan Ley has launched a round of consultations, including a consumer survey, and has aired a range of ideas including allowing insurers to charge higher premiums for smokers or the obese, and to reduce industry regulation.

The Minister said cover for natural therapies would be considered as part of the review, but has so far stopped short of declaring the rebate for such claims would be axed.

She told *The Australian* that, in theory, she supported the rebate only going toward treatments backed by evidence, but said Labor's decision to launch the Baggoley review had been "purely about desperate budget cuts...not evidence".

Ms Ley claimed that around 500,000 dumped or downgraded their health cover in the past 12 months in a clear demonstration that something was wrong.

But AMA President Professor Brian Owler said that although there was clearly a problem, the Minister was misreading what was going on.

Professor Owler said most people were not choosing to downgrade their cover. Instead, insurers were shifting often-unsuspecting consumers onto policies with bigger excesses and more gaps and exclusions, leaving them liable for unexpected charges.

The AMA President warned that insurers, driven more by the search for profit rather than the health of their customers, were taking the health system down a path toward US-style managed care, which would see the poorest and sickest increasingly shunted into the already-stretched public health system.

Public concern about the quality of health insurance has been fuelled by relentless above-inflation premium increases and reducing coverage.

It has been reported that the funds, which are subsidised by the $6 billion a year Private Health Insurance Rebate, are seeking an average 7 per cent premium increase next year.

ADRIAN ROLLINS

FBT tax cap: we are not entertained

Patients could face a blow-out in waiting times for elective surgery if the Federal Government pushes ahead with controversial plans to cap tax concessions on entertainment benefits for hospital employees, the AMA has warned.

The nation's peak medical group had told Treasury its proposal to impose a $5000 cap on salary sacrificed meal and entertainment expenses that are eligible for fringe benefit tax exemptions would harm the ability of public hospitals and other not-for-profit health groups to attract and retain skilled medical staff, undermining the services they are able to provide.

In its May Budget, the Federal Government claimed the tax concession – currently worth around $17,000 a year - was being exploited and abused, and estimated its crackdown on the perk would raise $295 million over four years.

But AMA Vice President Dr Stephen Parnis said the Government had not provided any substantive evidence to back its claim FBT concessions were being used unfairly, and urged it to proceed with great caution in making any changes.

"The AMA is deeply concerned that the reforms canvassed in the exposure draft could significantly affect the ability of institutions, including public hospitals, to recruit and retain staff," Dr Parnis said, warning this could cause treatment waiting times to blow out.

"If the current supply of medical specialists decreases, we believe it is reasonable to predict a lengthening of waiting lists for elective surgery and outpatient clinics."

Public hospitals and not-for-profits have relied on the FBT concession to help them compete with the private sector for the services of doctors and other health workers.

Dr Parnis said that many practitioners chose to forego higher wages on offer in the private sector to work in public hospitals because of the chance to practice advanced acute care, undertake research and provide teaching and training.

But he said they still deserved to be fairly remunerated for their skills and experience, and the FBT tax concession helped to make the salaries hospitals could offer competitive.

The AMA has warned that putting a cap on the concession would have a number of serious unintended consequences for the health care system, particularly the supply of medical specialists.

In the short-term, any drift of medical specialists away from the public system will likely cause waiting lists for surgery to blow out.

In the longer term, because the health system relies on senior and experienced hospital medical staff to help train the next generation of practitioners, Dr Parnis said the loss of even some

of these workers to the private sector because of reduced tax breaks would undermine teaching capacity.

He said this was particularly worrying because it was coming at a time when the pressure on hospital teaching capacity had never been greater as a result of rapid growth in the number of medical graduates.

Several organisations have written to Treasury urging that the $5000 cap on entertainment expenses that are eligible for FBT exemptions be raised.

St John's Ambulance said it relied on the FBT exemption to help attract and retain skilled staff, and suggest the cap be increased to $20,000, while the Fred Hollows Foundation recommended it be set at $30,000.

The Salvation Army, meanwhile, warned a $5000 cap would hit the salaries of half its staff.

The Tax Institute recommended the cap be set at $15,000.

The tax change is due to come into effect from 1 April 2016.

ADRIAN ROLLINS

Govts ponder internship overhaul

Medical students in the final year of their degrees may be required to undertake prevocational training as part of two-year transition to practice arrangements under contentious changes to internships proposed by a Council of Australian Governments review.

The review, commissioned by the Australian Health Ministers' Advisory Council, found that although the current internship model was not broken, changes in health care and the way hospitals operate meant it "no longer fits the purpose of meeting the long-term health needs of the community".

In particular, the inquiry reported that many medical graduates were leaving university highly qualified but with limited experience in providing actual patient care and "no baseline of work-ready capabilities they are expected to meet".

Hinting at the possibility that medical graduates could face an entrance exam for internships, the review suggested graduates be required to satisfy "entry requirements that reflect... expectations of work-readiness" before commencing.

It said the current internship model in most cases provided for little experience outside of public hospitals, and was increasingly falling short of what was required because it gave graduates only "limited exposure to the full patient journey and range of patient care needs which are important in developing well-rounded doctors".

Instead, it has recommended that the current one-year internship be replaced with a two-year 'transition to practice' model in which the first year would continue to serve as a prerequisite for general registration, while the second could include entry into vocational training.

"We believe a two-year timeframe is more realistic to provide diverse experience, build a strong general foundation and more adequately prepare graduates for vocational training," the review said, noting that the "vast majority" of doctors currently complete a second general year that is unstructured and poorly aligned with the next stage of training.

More radically, it suggested that the two-year model include the final year of medical school and the first year of postgraduate training, though it acknowledged that this was a profound change that should initially be piloted across a range of medical programs and health service settings before being embraced.

Less controversially, the review said there was a need to improve the supervision of interns, to shift the basis of assessment to a demonstration of specific capabilities and performance, and to ensure that clinical experience is gained in a wide range of settings.

AMA President Professor Brian Owler said he was "delighted" the review had taken up the peak medical group's suggestions for improved supervision and assessment, as well as expanded prevocational experience in community, private and other non-traditional settings.

The push to expose interns to a wider range of experiences has come as figures reveal an increasing proportion of final-year medical students come from the nation's capital cities – a trend at odds with hopes to address the rural doctor shortage by increasing the number of aspiring doctors coming from country and regional areas.

> "... although the current internship model was not broken, changes in health care and the way hospitals operate meant it 'no longer fits the purpose'" - Health Minister

A survey by the Medical Deans of Australia and New Zealand found 76 per cent of final year students last year came from capital cities, up from 67 per cent in 2010.

There has been a growing effort to recruit more students from the country in the expectation that a higher proportion are likely to go on to practise in rural areas.

While approving plans to increase the breadth of intern experience, Professor Owler said there were "question marks" over the suggestion that the two-year transition to practice be split between university and the workplace.

"The AMA is yet to be convinced that there is any evidence or need to support such a radical change," he said.

The AMA President said the fundamentals of the current intern system were sound - a view backed by the review's conclusion that the existing milestones for medical registration should remain unchanged.

He said it was pleasing that the review had heeded the AMA's call that changes be made incrementally and based on evidence, including its adoption of the AMA's suggestion for an annual National Training Survey.

The review's findings and recommendations have been referred to a working group comprising representatives from the Medical Board of Australia, the Australian Medical Council, and all State and Territory Postgraduate Medical Councils.

Professor Owler said the working group should also include doctor in training representatives, and involve extensive stakeholder consultation.

ADRIAN ROLLINS

City dwellers hold up bulk billing rate

The bulk billing rate is continuing to climb despite the Federal Government's four-year Medicare rebate freeze, underlining concerns about the increasing financial pressure on the nation's GPs.

Eighty-three per cent of standard GP visits were bulk billed last financial year, up from 82.2 per cent in 2013-14, and 10 percentage points higher than a decade before.

Sydneysiders were the most likely to be bulk billed – more than 96 per cent of GP visits in western and south-west Sydney were covered entirely by the Medicare rebate, compared with around 84 per cent in Melbourne, 83 per cent in Adelaide, about 80 per cent in Brisbane, 76 per cent in Perth, and just 57 per cent in Canberra – the nation's lowest reading.

Not only are patients in west and south-west Sydney the least likely to face a charge to see their GP, they tend to see their GP more often than other Australians. As a result, Medicare expenditure per person in these areas is well above the national average.

Updated National Health Performance Authority figures, released on 19 November, show people in south and west Sydney saw their GP, on average, 7.5 times in 2013-14, and cost Medicare between $340 and $345 per person. The national average that year was $258.

Medicare expenditure on GP visits per person was much lower in rural areas – down to as little as $200 in country WA – reflecting the relative scarcity of GPs in these regions.

People in country Western Australia saw their GP, on average just 4.1 times in 2013-14, and 75.5 per cent of visits were bulk billed.

The competitive pressure caused by a high concentration of GPs in urban areas is helping holding up bulk billing rates in the big cities.

But the AMA has warned that an increasing proportion will be forced to begin charging patients as the Medicare rebate freeze bites.

The four-year freeze came into effect in mid-2014 and will hold remuneration from Medicare flat while other costs, particularly staff wages, utility charges, rent and equipment, continue to rise.

The National Health Performance Authority provides a detailed breakdown of bulk billing rates, GP and specialist visits and expenditure, and after-hours attendances, by Primary Health Network and 300 smaller areas covering the whole of the continent.

The latest report, *Medicare Benefits Schedule GP and specialist attendances and expenditure in 2013-14*, can be viewed at: http://www.myhealthycommunities.gov.au/

ADRIAN ROLLINS

INFORMATION FOR MEMBERS

MEDICINE INGREDIENT NAME CHANGES FROM APRIL 2016

Some medicine ingredient names used in Australia are changing to bring them in line with names used internationally. There will be a four year transition period, expected to start from April 2016.

Some changes are minor, for example, amoxycillin to amoxicillin. Other changes are more significant, for example, colaspase to asparaginase.

When changes are significant, the medicine labels will need to use both the old and new ingredient name for four years from April 2016.

A list of affected medicine ingredients is available on the TGA website.

The TGA will develop education material and tools to support the medicine ingredient name changes to make sure medicines continue to be used safely.

GEORGIA MORRIS

Nation's cut-price health system 'performs well': OECD

Australia's health system has been given a big tick by the Organisation for Economic Co-operation and Development for delivering world-class life expectancy and cancer survival rates despite below-average funding.

In its latest *Health at a Glance* report, the OECD reported that Australia's average life expectancy of 82.2 years was the sixth highest among the world's richest countries, and its record on breast and colorectal cancer survival was "among the best".

Significantly, given the Federal Government's claims of unsustainable growth in health spending, the Organisation reported that Australia's expenditure was 8.8 per cent of gross domestic product, below the OECD average of 8.9 per cent.

"Australia performs well in terms of overall population health status," the OECD said. "[It] achieves good outcomes relatively efficiently."

But, echoing AMA arguments for increased investment in general practice, the Organisation said the country could cost-effectively achieve even better outcomes if it cut down on the number of patients with chronic health problems who end up in hospital.

It found that Australia had among the highest rates of avoidable hospitalisations for patients with asthma and chronic obstructive pulmonary disease among its member countries, and recommended a greater emphasis on treatment by family doctors.

"Effective treatment for these conditions can be delivered at a primary care level, negating the need for hospital admissions that are not in the best interests of patients, and are more costly for the health system," the OECD said. "A well-organised primary health care system emphasises health promotion and prevention, and educating patients about self-management of chronic disease."

Its comments are in line with AMA calls for greater support for GPs in managing patients with chronic conditions and providing health promotion and preventive care, and came a day after the release of a major report showing there has been a blow-out in the demands faced by GPs from an ageing population with increasingly complex health needs.

The Bettering the Evaluation and Care of Health (BEACH) report from Sydney University's Family Medicine Research Centre found that older patients were seeing their GP more often, and with a wider array of health problems.

Because of this, doctors are having to spend more time with each patient – on average, a little less than 15 minutes – heightening the financial strain caused by the increasingly inadequate Medicare rebate, which has been frozen by the Federal Government until mid-2018.

The BEACH researchers said GPs were playing a crucial 'gatekeeper' role in preventing duplication and ensuring the coordination and continuity of care patients receive from hospitals, specialists, allied health professionals and other providers, and recommended greater support for them in carrying out the role.

With the incidence of patients with multiple complex and chronic health complaints set to increase as the population ages, AMA President Professor Brian Owler said the Government needed to lift its investment in general practice.

Out-of-pocket costs among highest

In line with AMA concerns that the Government is increasingly abrogating its health responsibilities and dumping more of the cost of care on to patients, the OECD found that Australians face above average out-of-pocket costs.

It reported that 20 per cent of health spending comes directly from the pockets of patients – much more than is faced by patients in other countries with Government-funded health systems like the United Kingdom, Canada and New Zealand – and jumped by 1 percentage point between 2008 and 2012.

The OECD warned that in such an environment, there was a heightened risk that increasing the barriers to access to care could "unduly affect" the sickest and most vulnerable.

In conclusions that endorse the AMA's successful campaign last year and early this year against Coalition Government proposals for an up-front patient charge to see GPs, the OECD said that "co-payments remain a blunt policy instrument that can have many unintended consequences, particularly when the prevailing economic conditions are simultaneously reducing incomes for many citizens".

"The risk remains that citizens forego needed care that can have long-term adverse health outcomes," it said.

"Given the current level of out-of-pocket payments in Australia, there is a need to ensure that policy options aimed at improving the appropriate use of care do not unduly affect the most vulnerable, and the overall burden of out-of-pocket payment in the community more generally."

ADRIAN ROLLINS

Early drinks call as alcohol toll hits 500,000

Emergency doctors are calling for the nationwide adoption of early closing and pub lock-out laws amid estimates that 500,000 people a year end up in hospital because of the effects of alcohol.

Echoing AMA calls for a national strategy to tackle alcohol-related harm, the Australasian College for Emergency Medicine has urged other states and territories to follow the lead of the New South Wales government in cracking down on the availability of alcohol in late-night entertainment districts.

The College made its call after conducting a study which showed a high proportion of emergency department patients are affected by alcohol.

The study, which involved screening 9600 patients presenting at eight emergency departments in Australia and New Zealand during a one-week period in December last year, found that 8.3 per cent of all visits were related to alcohol, and the proportion jumped to one in eight presentations during peak periods.

Chair of the College's Public Health Committee, Associate Professor Diana Egerton-Warburton, said the scale of the problem was surprising and disturbing.

"That equates to more than half a million alcohol-related patients attending EDs every year across Australia and New Zealand," A/Professor Egerton-Warburton said. "It confirms that alcohol is having a huge impact on our emergency departments."

Last year, a National Alcohol Summit organised by the AMA heard that the damage caused by alcohol – ranging from street violence, traffic accidents and domestic assaults through to poor health, absenteeism and premature death – cost the community up to $36 billion a year.

AMA President Professor Brian Owler told the Summit that alcohol misuse was one of the major health issues confronting the country: "Alcohol-related harm pervades society. It is a problem that deserves a nationally consistent response and strategy."

While the Queensland Government has joined NSW in pushing for earlier closing times and lock-outs, Professor Owler said the Commonwealth needed to take the lead in developing a coherent and comprehensive strategy to tackle alcohol-related harm that went well beyond calls for individuals to take more personal responsibility to address the nation's drinking culture and increase investment prevention.

Previous studies by the College of Emergency Medicine have shown the high prevalence of alcohol among patients seeking treatment at inner-city hospital emergency departments on Friday and Saturday nights.

But A/Professor Egerton-Warburton said the most recent study was aimed at gaining a broader understanding of the role played by alcohol in ED presentations by extending the time-frame to a week, and including outer metropolitan, rural and regional hospitals in the sample.

She said the results underlined just how pervasive alcohol-related harms were, and how the effects of this ripple through the health system.

"One drunk person can disrupt an entire ED," A/Professor Egerton-Warburton said. "They are often violent and aggressive, make staff feel unsafe and impact negatively on the care of other patients."

She said the sheer volume of alcohol-affected patients going through emergency departments meant that they were much more disruptive than patients on the drug ice.

A/Professor Egerton-Warburton said evidence showed that early closing and lock-out laws worked, resulting in a 38 per cent reduction in serious injuries related to alcohol.

"This is a rare opportunity to take policy action that we know works.

"Other jurisdictions should follow NSW, and now Queensland, in introducing early closing times and reducing the availability of alcohol.

"Policy makers have the power to reduce the tide of human tragedy from alcohol harm."

The AMA National Alcohol Summit Communique can be viewed at: https://ama.com.au/media/ama-national-alcohol-summit-communique

ADRIAN ROLLINS

Atlas charts course to improved care

The first detailed national appraisal of variations in health practice has found that Australians are among the world's heaviest users of antibiotics and antidepressants, and within the country there are major differences in the use of common drugs and treatments for everything from colonoscopies and cataract surgery to antipsychotic medicines for the elderly and hyperactivity drugs for the young.

In what is seen as the first step toward addressing unwarranted variations in the care patients receive, the Australian Commission on Safety and Quality in Healthcare has released a report identifying wide discrepancies in the use of everyday medicines and procedures.

Among its findings, the *Australian Atlas of Healthcare Variation* has revealed that children in some parts of the country, particularly in NSW, are seven times more likely to be prescribed drugs for ADHD than those in other areas, while cataract surgery, hysterectomies ans tonsillectomies were three times more common in some areas than others, and patients in some parts were 30 times more likely to undergo a colonoscopy.

AMA President Professor Brian Owler said that, by reflecting how the delivery of health care was organised, the Atlas provided a useful illustration of differences in access to care.

But he highlighted the fact that the Commission itself made no claim about the degree to which differences in care was unwarranted.

"The Atlas is a welcome starting point for further research and examination of health service distribution," Professor Owler said. "It is not proof that unnecessary or wasteful care is being provided to Australians, and should not be interpreted that way."

The Commission said that some variation was "desirable and warranted" to the extent that it reflected differences in preferences and the need for care.

It added that "it is not possible at this time to conclude what proportion of this variation is unwarranted, or to comment on the relative performance of health services and clinicians in one area compared with another".

Senior clinical adviser to the Commission, Professor Anne Duggan, said the average frequency of various services and procedures provided in the Atlas were not necessarily the ideal, and observed that "high or low rates are not necessarily good or bad".

Nonetheless, she said the weight of local and international evidence suggested much of the differences observed was likely to be unwarranted.

"It may reflect differences in clinicians' practices, in the organisation of health care, and in people's access to services," Professor Duggan said. "It may also reflect poor-quality care that is not in accordance with evidence-based practice."

Many of the variations identified in the Atlas have been linked to wealth and reduced access to health care in disadvantaged areas.

Professor Duggan said the less well-off tended to have poorer health and so a greater need for care, while some procedures are used more often in wealthier areas.

She said the Atlas showed that rates of cataract surgery were lowest in areas of disadvantage, and increased in better-off locales.

But Professor Owler said the example showed the need to be very careful in drawing conclusions about the reasons for variation.

He said the Atlas showed that the incidence of cataract surgery was highest in the remotest parts of far north Queensland.

"This is because there are no public services available, with private ophthalmologists delivering eye care to Indigenous communities, which is covered by Medicare," the AMA President said.

He said identifying variation in health care was essential, but this was the first step before determining the causes of variation.

"The Atlas doesn't tell us what should be the best rates for different interventions and treatments."

In addition to identifying variations in health care within the country, the Atlas also explored how the care provided in Australia compared internationally.

While acknowledging that differences in the type and quality of data made it difficult to draw direct comparisons, the Atlas nonetheless reported that Australia has "very high" rates of antibiotic use compared with some countries, and Professor Duggan said that, among rich countries, Australia was second only to Iceland in the extent of use of antidepressants.

Professor Owler said that, with the publication of the Atlas, the challenge now was to develop a process to identify variations in practice that were "actually unwarranted, not just assumed to be", and to develop and fund strategies to reduce them by supporting clinically appropriate care, such as by providing clinical services where they are needed.

To view the Atlas, visit: http://www.safetyandquality.gov.au/atlas/

ADRIAN ROLLINS

Medical briefs

No sugar tax in sight

The Federal Government has signalled it is unlikely to implement a sugar tax or other financial incentives to influence eating habits.

Convening the first meeting of its Healthy Food Partnership, Rural Health Minister Fiona Nash – who also has oversight of food policy – indicated that although the Federal Government wanted to encourage consumers to make healthier food choices, it would not seek to "force feed" them.

"Government can't force feed healthy food to its citizens," Senator Nash said. "It is up to individuals to take responsibility for what they eat. Government's role is to educate and provide tools to help people make healthy choices."

The Partnership includes representatives from food manufacturers and producers, industry groups, the Public Health Association and the Heart Foundation.

Senator Nash said it had been formed to come up with strategies to increase the consumption of fresh fruit and vegetables, as well as to reformulate food to make it healthier, and to "deal with" issues of portion and serve sizes.

Organ donations on the rise

There was a 10 per cent increase in the number of deceased organ donors in the first nine months of the year.

Australian and New Zealand Organ Donation Registry figure show there were 320 deceased donors between January and September, and there were 907 transplant recipients - including 48 who received multiple organs.

AMA President Professor Brian Owler said the increase was encouraging but, with about 1600 people waiting for a transplant at any one time, many more donors were needed.

Professor Owler encouraged people to think about becoming a donor, and urged families to respect the wishes of those who chose to become a donor.

Rural health talks

Rural Health Minister Fiona Nash has convened a meeting of 17 organisations representing rural health professionals, students and instructors as part of an effort to boost health services in the bush.

Senator Nash said a key focus of discussions was ways to increase the number of doctors and other health professionals working in rural and regional areas.

The Minister said that it was not just more doctors who were needed in rural areas, but the whole gamut of other health professionals, including nurses, physiotherapists and dentists.

Fmr NSW Health Minster joins Medical Deans

Former New South Wales Deputy Premier and Health Minister, Carmel Tebbutt, has become head of the peak body representing the nation's Medical Deans.

Ms Tebbutt, who entered NSW Parliament in 1998 and served in a variety of ministerial portfolios while in government, did not contest the 2015 State election.

She is married to Federal Labor frontbencher Anthony Albanese.

Online credential check for overseas doctors

Overseas medical graduates looking to work in Australia will now have their qualifications verified through a web-based system that will also allow them to keep electronic records of education, training and licensing credential following an agreement struck by the Australian Medical Council and the US-based Educational Commission for Foreign Medical Graduates.

Continued on p19 ...

Medical briefs ... from p18

Under the deal the AMC, which provides a centralised service for specialist medical colleges and other organisations to check the credentials of international applicants, requires overseas medical graduates (OMGs) to have their qualifications and experience verified by the Commission from primary sources through its Electronic Portfolio of International Credential (EPIC) program.

The AMC said the EPIC program provided it with a secure, web-based platform for authenticating the credentials of applicants, and enabled paperless processing and record-keeping.

The Commission said OMGs could use EPIC to build a "digital portfolio" of verified credentials accessible anywhere, and could be used to satisfy the requirements of regulators, potential employers and other organisations.

Put cancer drugs on fast track

The Federal Government should speed up approval processes for new cancer drugs and look at developing a national medicines register, a Senate inquiry has recommended.

An investigation into the availability of specialist cancer drugs said that the current trend toward a larger range of treatments that are targeted at small populations of patients is likely to continue, putting increasing pressure on the medicines approval process.

Senator Catryna Bilyk, who was a member of the inquiry, told Parliament that there was increasingly a personalised medicine approach in which the genetics of tumours are established and high-throughput screening of existing medications is undertaken to determine which drugs that show activity against the tumour. This is used by oncologists to inform their treatment.

"More targeted medicines and therapies have the ability to increase the range of treatment options for cancer patients, resulting in improved quality of life and survival for many patients," Senator Bilyk said.

But such treatments can be very expensive, and often patients face a lengthy wait before they can get subsidised access while regulators, medical experts and ministers assess them for efficacy and cost effectiveness.

The inquiry recommended a comprehensive review of the system, including looking at fast-track processes used overseas, and suggested the Government consider setting up a national register of cancer medicines.

National registration for paramedics

The Federal Government has opposed a move to establish a single national registration scheme for paramedics.

A majority of the nation's health ministers agreed to include paramedics in the National Registration Accreditation Scheme at a meeting in Adelaide last month, overriding the objections of Federal Health Minister Sussan Ley.

The move is seen as consistent with a push to establish nationally-recognised qualifications across a range of occupations.

But New South Wales has reserved its right to opt out of the process, and, according to a communique from the meeting, Ms Ley argued it was "not consistent with the principles of the NRAS as a national regulatory reform".

ADRIAN ROLLINS

Your AMA Federal Council at work

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

Name	Position on council	Activity/Meeting	Date
Dr Gino Pecoraro	AMA Federal Councillor, Representative for Obstetricians and Gynaecologists	Diagnostic Imaging Advisory Committee	18/11/2015
Dr David Rivett	AMA Federal Councillor, Chair of Council of Rural Doctors	Rural Health Stakeholder Roundtable	13/11/2015
Dr Andrew Mulcahy	AMA Federal Councillor, Representative for Anaesthetists	MBS Reviews Workshop	27/10/2015
Dr Stephen Parnis	AMA Vice President	MBS Reviews Workshop	27/10/2015
Dr Robyn Langham	AMA Federal Councillor	Antimicrobial resistance strategy stakeholder forum	17/11/2015
Dr Chris Moy	AMA Federal Councillor	AHPRA Prescribing Working Group	5/11/2015
Dr David Rivett	AMA Federal Councillor	IHPA Small Rural Hospitals Working Group	16/11/2015
Dr Tony Bartone	AMA Federal Councillor	NMTAN - chronic disease subcommittee	5/11/2015

Win an Apple iPad Pro.

Australian Medicine/Medical Journal of Australia Reader Survey 2015

Grab a chance to win Apple's new top-of-the-line iPad Pro, with a 12.9-inch Retina display, nearly double the CPU performance of iPad Air 2, refined Multi-Touch technology and a 32GB drive.

At *Australian Medicine* and the *Medical Journal of Australia* we value the views of our readers.

Please take a few moments of your time to answer a few simple questions about what you like and don't like about the magazines, and how we can better meet your needs and interests, by completing the *Australian Medicine/Medical Journal of Australia* Reader Survey 2015 (https://www.surveymonkey.com/r/CBWXVKK).

By taking part in the survey, not only will you have an important say in the future shape and direction of *Australian Medicine* and the *Medical Journal of Australia*, but you can also be in the running to win Apple's new iPad Pro, with a 12.9" screen and a 32GB drive.

To take part in the survey, and to have a chance at winning Apple's latest iPad, go to the following link: **https://www.surveymonkey.com/r/CBWXVKK**

Thank you for your feedback and ideas, which will help *Australian Medicine* and the *Medical Journal of Australia* better meet the needs and interests of our readers.

Notifications – towards a better complaints process

BY AMA VICE PRESIDENT DR STEPHEN PARNIS

Being the subject of a complaint is never a pleasant experience, and can often be very traumatic for doctors and their families.

But it is clear that the notification system overseen by the Australian Health Practitioner Regulation Agency has been unnecessarily lengthy and distressing for many, and the AMA has been working with both AHPRA and the Medical Board of Australia to improve the way it operates.

At a workshop in March, five AMA representatives met with officials from AHPRA and the Medical Board to work on ways to improve the practitioner experience when a notification is made about them to the Board.

We reviewed de-identified case examples to identify where processes fail practitioners, and to explore improvements. Extensive background information – decision making protocols, guidance and policies, as well as current data on timelines, volumes and outcomes - were used as reference material during the analysis.

I reported in detail on the outcomes of the workshop in the 16 March edition of *Australian Medicine* (see https://ama.com.au/ausmed/when-complaint-made-%E2%80%93-improving-ahpra-notification-experience). It resulted in a number of recommendations and changes for improving the way the system operates, which are set out below.

Regulatory principles

The regulatory principles that the Board and AHPRA staff use to guide their investigations and decision making would be included in the guide for practitioners and be attached to the initial letter that the practitioner receives about a notification (the principles can be viewed at: http://www.ahpra.gov.au/About-AHPRA/Regulatory-principles.aspx).

Initial assessment response

Tthe letter inviting an initial response from the practitioner would include details about when they will be notified of any further developments, including any decision for no further action or investigation, or any other action that is available to Board. The letter would also include contact details for a person to handle further inquiries.

The letter would reassure the practitioner that the process was not intended to punish practitioners, is part of arrangements for protecting the public, and that due process would be followed.

Reflective lessons

In cases where investigations result in no further action, the Medical Board would examine the factors that were known at the time of notification and consider how these might inform the notifications vetting process.

The Board would also consider what more could be done to help the practitioner understand the issue that contributed to the notification, and the action they could take to improve the quality of their practice.

Investigations beyond 12 months

Where the notification process takes longer than a year, there would be more frequent updates for practitioners about how their matter was progressing and the reasons for delay.

This would be supplemented with the publication of more general information for the public about the most common reasons for lengthy delays.

Transparency about decisions where a board member is professionally associated with the practitioner being reviewed

The Medical Board and AHPRA have clear processes in place to manage potential conflicts of interest. AHPRA and the Board undertook to explain to practitioners how such issues are dealt with.

Expert reports

Practitioners would be provided with a copy of any expert report obtained regarding them, except when there were specific risks associated with doing so.

Continued on p20 ...

Notifications – towards a better complaints process

... from p19

Assessment costs

The Medical Board undertook to clarify that travel costs incurred by practitioners attending assessments as directed by the Board would be paid by it.

Reworking letters to practitioners - the letters sent to practitioners would be improved to provide more and better information about the process.

Feedback from practitioners

AHPRA undertook to explore cost-effective ways to elicit practitioner feedback about how they feel they were treated during an investigation.

It was an extensive to-do list, but pleasingly there is already signs that the practitioner experience is getting better.

AHPRA's Annual Report, released on 2 November, paints a picture of improved performance:

- a 25 per cent reduction in open notifications;
- average time for assessment cut from 142 to 73 days;
- the number of investigations taken longer than 12 months fell by 18 per cent to 360;
- the closure rate for investigations has improved for three consecutive years;
- there has been a 32.8 per cent fall in administrative complaints about its work, down to 469;
- there has been a 55 per cent decline in complaints referred by the National Health Practitioner Ombudsman;
- 80 per cent of panel members completed a training program to deliver more consistent decision-making nationally;
- a national three-day training program for all AHPRA investigators was established to strengthen consistency in approach and performance in managing notifications; and
- customer service teams resolved 93.6 per cent of telephone calls at first contact.

This shows that, with goodwill and a spirit of collaboration, the AMA can work constructively to bring about improvements.

To continue these efforts, in February AMA representatives will again meet with the Board and AHPRA to explore further areas for improvement.

To help us, I invite you to contact me to share your views and experiences.

Please drop me an email at vicepresident@ama.com.au

Health on the hill

POLITICAL NEWS FROM THE NATION'S CAPITAL

Hand hospitals, GP over to the states: OECD

The states and territories would assume exclusive responsibility for hospitals and primary care while the Commonwealth would steer policy and funding and oversee quality and performance under a far-reaching shake-up of the health system proposed by an international review.

As the states warn of the devastating effects of Federal Government cutbacks to hospital spending, the Organisation for Economic Cooperation and Development has recommended an end to the complex and confusing split of responsibility for health care between the two levels of government.

In its annual Health Care Quality Review of Australia, the OECD said that although the nation's health system achieves good health outcomes for the amount of funding it receives – the sixth longest life expectancy among rich countries with only average health expenditure – the country could do better if it simplified lines of responsibility and boosted the role of GPs.

"Australia achieves good health outcomes relatively efficiently, with health expenditure at 8.8 per cent of GDP, about the same as the OECD average," the Review said. "[But] the health system features a complex split of federal and state and territory funding and responsibilities which can make it difficult for patients to navigate their way through."

Under current fragmented and nonsensical arrangements, both levels of government carry responsibility for overseeing health care quality, the OECD found.

But, within this, states are given the lead role as hospital "system managers" while the Commonwealth retains prime responsibility for primary health care.

It said arrangements for supervising private care were just as labyrinthine, with the states carrying responsibility for licensing private hospitals while health funds were regulated by the Federal Government.

"Better rationalised responsibilities, by making states and territories responsible for primary care, for example, would help ease some of the system's complexity, as well as the tension that sometimes exists between the two levels of government," the review said.

For decades the nation's public hospitals have been caught up in outbreaks of the "blame game" between the Commonwealth and the states over funding, and medical students battling for limited intern places are the latest victims of the blurred lines of responsibility.

The OECD said the states should assume responsibility for hospitals and primary health, leaving the Commonwealth to oversee quality and performance.

The OECD said it made sense for the Federal Government to play the lead role in steering health policy and overseeing quality and performance, noting the work of agencies like the Australian Commission on Safety and Quality in Health Care and the Independent Hospital Pricing Authority.

It said Australia also stood out among its peers for having a consolidated national registration scheme for practitioners.

"Greater harmonisation of quality monitoring and improvement approaches would make the states more comparable, providing opportunities for health services to be benchmarked against a larger pool of peers, and to draw lessons that could help improve health care quality," the OECD said.

The Organisation said quality could be further enhanced by strengthening primary health care, particularly given the growing number of patients with chronic health problems.

It said an "unusual division" had developed between primary care and community health, adding to the fragmentation of the system, while the slow adoption of e-health made it difficult to coordinate care among different providers.

The OECD also took aim at the fee-for-service payment model, which it said did little to promote the integration of care, and decried that the Practice Incentive Program, as a pay-for-performance scheme, remained largely under-developed.

"[It] consists of few incentives that are tied to quality and patient outcomes," the Organisation said, and expressed surprise at the lack of data collected on primary health care quality and outcomes: "[this] provides general practitioners with very limited opportunity to compare their performance with that of their peers".

ADRIAN ROLLINS

Food stars changing habits

The nation's food ministers are hailing the success of the breakthrough front-of-packet health star labelling system amid evidence that it is changing eating habits and

Continued on p24 ...

Health on the hill

POLITICAL NEWS FROM THE NATION'S CAPITAL

... from p23

encouraging the production of healthier foods.

The Australia and New Zealand Ministerial Forum on Food Regulation was told that 55 companies have adopted the voluntary Health Star Rating system since it was introduced last year, and it is now displayed on more than 1500 food products.

In a sign that the labelling system is exerting an influence, the health ministers noted that "a number of major companies have reformulated some of their most popular products to make them healthier, achieving a higher star rating".

They were also encouraged by evidence it may be leading to better food choices.

The results of a consumer study presented to the ministers found one in six consumers were changing their shopping behaviour based on the system, and awareness of it had grown from 33 per cent in April to 42 per cent in September.

The system was introduced in controversial circumstances last year when Chief of Staff to the-then Assistant Health Minister Fiona Nash ordered the system's website pulled down just hours after it was launched.

It was later revealed that at the time he retained an interest in a consultancy that had major food manufacturers among its clients, and he was forced to resign.

The website was eventually reinstated late last year.

But although the system is considered to be an advance in food labelling standards, the AMA has said that it should be mandatory, and public health experts are critical of its central message that "the more stars, the healthier the food".

Professor of Public Health Nutrition at Deakin University, Mark Lawrence, and Christina Pollard of the Curtin University School of Public Health argue that, because it only applies to packaged foods, the system misses the fresh foods, particularly fruits and vegetables, that people should eat most.

And, in an article in *The Conversation*, they warned that it encouraged food manufacturers to make minor tweaks to their products which would earn them more stars without making significant different to nutritional value, while avoiding using the system altogether for products that would rate poorly.

ADRIAN ROLLINS

Hospital cuts cloud reform outlook

The states are seeking to exert increasing pressure on the Federal Government over its $57 billion cut to public hospital funding amid speculation of a radical overhaul of Commonwealth-State health arrangements.

Queensland Health Minister Cameron Dick told a meeting of the nation's health ministers last month that the Coalition Government's decision to rip up the National Partnership Agreement on health services and reduce the indexation of Commonwealth hospital payments to population plus inflation would cut $11.8 billion from the State's hospital system – the equivalent of 4500 doctors, nurses and allied health professionals.

This follows claims from the Victorian Government that the Commonwealth's decision will rip $17.7 billion from its health system over the next decade, while New South Wales has figured a $16.5 billion loss, South Australia $4.6 billion, Western Australia $4.8 billion and Tasmania $1.1 billion.

Victorian health officials told a Senate inquiry the impact of the Federal Government's cuts would be equivalent to shutting down two major hospitals and axing 23,000 elective surgery procedures every two years.

"[It] would equate to the level of service delivery of two health services the size of Melbourne Health [which operates the Royal Melbourne Hospital]," acting Victorian Health Department Secretary Kym Peake told the inquiry.

The big cuts form a challenging backdrop for discussions of reform to Federal-State relations that include proposals for Commonwealth public hospital funding to be replaced by a "hospital benefit payment" that would follow individuals, similar to Medicare.

Government discussions of changes to the private health insurance industry have included reference to option two in the Reform of the Federation Discussion Paper, which proposes a Medicare-style payment for hospital services, regardless of whether they are provided in the public or private system.

Under the arrangement, the price of hospital procedures would be set by an independent body and the Commonwealth would pay a proportion. For patients in the public system, the states would be expected to make up the difference, while in private hospitals the gap would be covered either by insurers or the patients themselves.

Continued on p25 ...

Health on the hill

POLITICAL NEWS FROM THE NATION'S CAPITAL

... from p24

States would retain responsibility and operational control of public hospitals and would be able to commission services from the private sector, while the Commonwealth would discontinue the private health insurance rebate.

But the Federal Government is likely to encounter significant resistance to such a change from the states unless it comes up with more money.

The revenue raised from the GST, which is funnelled directly to the states, has been growing far more slowly than expenditure, tightening the squeeze on state budgets and their health funding.

When it was introduced in 2000, GST applied to 55 per cent of spending, but since then its share has shrunk to 47 per cent this year, and consultancy Deloitte Access Economics estimates it will apply to just 42 per cent by 2024-25.

The squeeze on funding has shown up in disappointing public hospital performance.

The latest report from the Australian Institute of Health and Welfare shows that hospitals are struggling to make headway in the face of increasing demand for emergency care.

The proportion of urgent patients receiving treatment within the recommended time fell back in 2014-15 to just 68 per cent – well short of the target of 80 per cent.

The goal for all emergency department visits to be completed within four hours, which was meant to be achieved this year, has also been missed.

The results bear out warnings made by the AMA earlier this year that the Commonwealth's funding cuts for hospitals would undermine the delivery of care.

Launching the AMA's annual Public Hospital Report Card, President Professor Brian Owler said the Federal Government's cuts had created "a huge black hole in public hospital funding".

"It's the perfect storm for our public hospital system," he said. "There's no way that states and territories can even maintain their current frontline clinical services under that sort of funding regime, let alone build any capacity we actually need to address the shortfalls now."

Health Minister Sussan Ley rejected the warnings at the time, but the latest evidence of declining performance are likely to make it increasingly difficult for the Government to win State backing for an overhaul of funding arrangements without more money on the table.

ADRIAN ROLLINS

INFORMATION FOR MEMBERS

Essential GP tools at the click of a button

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

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

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

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

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

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

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

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

Research

New treatment to overcome peanut allergies in children

BY JANE TREMBATH, SOUTHERN HEALTH NEWS / 4TH OF NOVEMBER, 2015

This story was first published by The Lead, South Australia.

A new study is successfully helping children to overcome peanut allergies by exposing them to peanuts and desensitising them to their allergy.

For the past four years, paediatric allergist Dr Billy Tao has been developing a novel two-step desensitisation process at Flinders Medical Centre (FMC) in South Australia.

The first step involves boiling peanuts for an extended length of time to make them less allergenic.

The boiled peanuts are given to patients to partially desensitise them, and then once the patient shows no signs of allergic reaction, roasted peanuts are given to the children to increase their tolerance in the second step of the process.

Dr Tao said the low-cost and effective two-step process resulted in less adverse events than previously used single-step desensitisation methods – also known as oral immunotherapy.

"With traditional methods, a lot of people ingesting increasing amounts of roasted peanut flour or similar products start to react – so much so that many have to drop out and can't finish the treatment," Dr Tao said.

The FMC trial is carried out over a year or longer and includes patients aged between 10 and 15 years.

Of the 14 participants, 10 have already completed the first step and are now eating varying amounts of roasted peanuts, while four continue to eat boiled peanuts and are progressing well.

"One patient who had to be administered three adrenaline injections after consuming peanuts is now eating several roasted peanuts every day without problems," Dr Tao said.

Studies show the number of children living with peanut allergy appears to have tripled between 1997 and 2008, and as many as one in every 200 children will have severe allergy to nuts.

Allergy symptoms can vary from very mild (including tingling mouth, puffy lips and welts around the mouth) to moderate symptoms (facial swelling, body rash, runny nose and red eyes, abdominal pains and vomiting); while severe reactions include trouble breathing, looking pale and unwell, and anaphylaxis.

Very occasionally death may result from a most severe reaction.

Dr Tao's idea for hypo-allergenic (less allergenic) nuts to be consumed first was based on an observation by German researcher Professor Kirsten Beyer, who in 2001 noted that peanut allergies were less prevalent in China than the western world because the Chinese ate boiled peanuts rather than peanut butter or roasted peanuts. She found that boiling peanuts for 20 minutes made them less allergenic than roasted peanuts.

Dr Tao said that a partnership with Dr Tim Chataway, Head of the Flinders Proteomics Facility, and Professor Kevin Forsyth from the FMC Paediatrics Department, proved that peanuts boiled for at least two hours were less allergenic and the pair designed a study using this immunotherapy approach.

Dr Tao hopes his research could one day be carried out in a doctor's clinic and then at home and avoid the need for hospital-based treatment.

However he strongly warned people against 'do-it-yourself' desensitisation at home and stressed that patients should be seen by an allergist and individual care plans developed.

Among those who have already undergone Dr Tao's new desensitisation method is 16-year-old Shehan Nanayakkara, who was diagnosed with a severe peanut allergy at the age of three.

"We first realised Shehan had an allergy when friends gave him a peanut butter sandwich and he had to be rushed to hospital... there have been many accidents since then," father Asanka said.

"During one round of allergy testing he ended up in the Intensive Care Unit – that time I thought I'd lost him.

"I approached Dr Tao to help and at first Shehan ate boiled peanuts, working his way up to consuming 13 a day, and now he eats five normal roasted peanuts daily, mixed in with his meals.

"It's been a big relief because children and teenagers don't care too much about what they eat and just eat whatever, and there has always been that worry that something might happen - now we can relax a bit because Shehan has some tolerance."

Govts doing little to tackle climate health threat

More than half of governments around the world are yet to develop national plans to protect their citizens from the health effects of climate change despite increasing warnings it will cause more extreme weather, spread disease and put pressure on food and water supplies.

As leaders from around the world meet in Paris for UN climate talks, an international survey of 35 countries, including Australia, has found a general lack of focus and urgency around the looming threat of climate change to health, with most governments doing little work on likely effects and how to mitigate them.

The survey results underline calls from the AMA, the World Medical Association and other national medical organisations for the health effects of climate change to be made a priority at the climate talks.

AMA President Professor Brian Owler said that while much of the Paris talks will be about carbon emission targets, there should be equal emphasis on equipping health systems to cope with the extra burden of problems created by climate change.

"Climate change will dramatically alter the patterns and rate of spread of diseases, rainfall distribution, availability of drinking water and drought," Professor Owler said. "The incidence of conditions such as malaria, diarrhoea and cardio-respiratory problems is likely to rise."

He said the Paris Conference was "the perfect place" to develop and implement plans to deal with these effects.

The AMA President's comments came as a survey coordinated by the World Federation of Public Health Associations (WFPHA) found almost 80 per cent of governments are yet to comprehensively assess the threat climate change poses to the health of their citizens, two-thirds had done little to identify vulnerable populations and infrastructure or to examine their capacity to cope, and less than half had developed a national plan.

The result underlines the importance of repeated AMA calls for the Federal Government to do much more to prepare for the effects of climate change, which Professor Owler said were "inevitable".

Earlier this year the AMA released an updated Position Statement on Climate Change and Human Health that warned of multiple risks including increasingly frequent and severe extreme weather events, deleterious effects on food production, increased pressure on scarce water resources, the displacement of people and an increase in health threats such as vector-borne diseases and climate-related illnesses.

"There are already significant health and social effects of climate change and extreme weather events, and these effects will worsen over time if we do not take action now," Professor Owler said.

"Nations must start now to plan and prepare. If we do not get policies in place now, we will be doing the next generation a great disservice.

"It would be intergenerational theft of the worst kind — we would be robbing our kids of their future."

In May, the AMA and the Australian Academy of Science jointly launched the *Climate change challenges to health: Risks and opportunities* report that detailed the likely health effects of climate change and called for the establishment of a National Centre of Disease Control to provide a national and coordinated approach to threat.

The WFPHA said the results of its survey, released little more than two weeks before the United Nations Climate Change Conference in Paris, should serve as a wake-up call for governments to do much more.

"The specifics of these responses provide insight into the lack of focus of national governments around the world on climate and health," the Federation said.

Disturbingly, the survey found that Australia was one of the laggards in addressing the health effects of climate change, having done little to assess vulnerabilities and long-term impacts, develop an early warning system or adaptation responses, and yet to establish a health surveillance plan.

On many of these measures, the nation was lagging behind countries like the United States, Sweden, Taiwan, New Zealand and even Russia and China.

Climate and Health Alliance Executive Director Fiona Armstrong, who helped coordinate the survey, said the results showed the Federal Government needed to place far greater emphasis on human health in its approach to climate change.

"As a wealthy country...whose population is particularly vulnerable to the health impacts of climate change, it is very disappointing to see this lack of leadership from policymakers in Australia," Ms Armstrong said.

Public Health Association of Australia Chief Executive Officer Mike Moore said the increasing number and ferocity of bushfires and storms underlined the urgent need for action.

"It is time to ensure that health-related climate issues are part of our national planning and budgeting if we are to pre-empt many avoidable illnesses and injuries," Mr Moore said.

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

ADRIAN ROLLINS

INFORMATION FOR MEMBERS

AMA INDIGENOUS PEOPLES MEDICAL SCHOLARSHIP 2016

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

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

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

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

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

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

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

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

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

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

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

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

Applications close 31 January 2016.

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

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

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

AMA Member Benefits

AMA members can access a range of free and discounted products and services through their AMA membership. To access these benefits, log in at **www.ama.com.au/member-benefits**

AMA members requiring assistance can call AMA member services on
1300 133 655 or **memberservices@ama.com.au**

UpToDate: UpToDate is the clinical decision support resource medical practitioners trust for reliable clinical answers. AMA members are entitled to discounts on the full and trainee subscription rates.

doctorportal Learning: AMA members can access a state of the art CPD tracker that allows CPD documentation uploads, provides guidance CPD requirements for medical colleges, can track points against almost any specialty and provides access to 24/7 mobile-friendly, medical learning.

Learning.doctorportal.com.au

Fees & Services List: A free resource for AMA members. The AMA list of Medical Services and Fees assists professionals in determining their fees and provides an important reference for those in medical practice.

Careers Advisory Service: Is your one-stop shop for expert advice, support and guidance to help navigate your medical career. Get professional tips on interview practice, CV reviews, and application guidance to get competitive edge to reach your career goals.

Amex: As an AMA member, receive no-fee and heavily discounted fee cards including free flights and travel insurance with range of Amex cards.*

Volkswagen: AMA members are entitled to a discount off the retail price of new Volkswagen vehicles. Take advantage of this offer that could save you thousands of dollars.

AMP: AMA members are entitled to discounts on home loans with AMP.

Hertz: AMA members have access to discounted rates both in Australia and throughout international locations.

Hertz 24/7: NEW! Exclusive to the AMA. AMA members can take advantage of a $50 credit when renting with Hertz 24/7.

OnePath: OnePath offers a range of exclusive insurance products for AMA members.

Qantas Club: AMA members are entitled to significantly reduced joining and annual fees for the Qantas Club.

Virgin Lounge: AMA members are entitled to significantly reduced joining and annual fees for the Virgin Lounge.

MJA Bookshop: AMA members receive a 10% discount on all medical texts at the MJA Bookshop.

Not a member?

Join now,
www.join.ama.com.au/join

You can find the full range of AMA member benefits here:
ama.com.au/member-benefits