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AMA

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

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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

Keeping an eye on the MBS Reviews

BY **AMA PRESIDENT PROFESSOR BRIAN OWLER**

The MBS Reviews Roundtable hosted by the AMA in Canberra last month produced a united front across the medical profession on how to participate in, and respond to, the Government's Reviews of the Medicare Benefits Schedule (MBS).

> "The AMA is concerned that the Reviews will be undertaken in the absence of an overarching vision and specific direction for the Australian healthcare system to guide the final outcomes"

The Reviews are due to report back to the Minister by the end of the year. In the meantime, the profession has some concerns that need to be aired – and have been, directly to the Minister.

The AMA is concerned that the Reviews will be undertaken in the absence of an overarching vision and specific direction for the Australian healthcare system to guide the final outcomes.

In addition, as there are no specific and quantifiable aims, other than delivering better patient outcomes, there is a risk that the scope of the reviews will extend into dangerous territory, whereby the fundamental structure of our healthcare system will be interfered with.

We have learnt that the Reviews will now also consist of groups to review "macro issues and rules", and that this will consider issues such as referral arrangements and the potential removal of surgical assistance fees.

Given that the referral arrangements are the most fundamental feature of our healthcare system, providing the gateway to clinically necessary tertiary care, it is incredible that such a change might be contemplated in an environment where the Government wants to reduce expenditure.

In addition, the surgical assistance fees support the very basis of vocational training in Australia. Removal of them will have a significant impact on the training opportunities and, therefore, the future medical workforce. It is equally incredible that a change to these arrangements is being contemplated.

On both these issues it is not clear what the objective is, and therefore why they would even be on the table for review.

The profession is very concerned that the working groups will not comprise a representative from the relevant specialist college, association, or society.

While working group members will be able to "confer with colleagues", it is more appropriate for professional organisations to be formally included in the working groups. We believe this is critical to professional buy-in to the outcomes of the Reviews, as well as continuity of the professions' participation in the ongoing maintenance and management of the MBS into the future.

The medical profession supports an MBS that facilitates patient access to evidence-based modern medical procedures and practice. This cannot occur if the review process is limited to removing obsolete and infrequently used items, and working groups are not able to consider and recommend the inclusion of new items on the MBS.

While there is scope to update items, this may not always be the best way to bring the MBS up to date, and the objectives of the Reviews will be only partly achieved.

In many cases, completely new items for procedures that have evolved in the 20-plus years since they were first included on the MBS will be the only sensible outcome.

If this is not resolved, the Reviews could thwart patient access to services that have been provided for several years, even though they are not explicitly catered for in existing items. If the rapid review questions are appropriately framed, these services should be substantiated by the relevant literature.

There must be capacity to include new items on the MBS as a result of the Reviews, which does not involve a full health technology assessment and consideration by the Medical Services Advisory Committee.

The AMA will be vigilant, to say the least.

Review of the National Registration and Accreditation Scheme

BY AMA VICE PRESIDENT DR STEPHEN PARNIS

On 7 August, Australia's Health Ministers released the report of the review of the National Registration and Accreditation Scheme (NRAS), together with their response. The report makes 33 recommendations. The Health Ministers have accepted nine, accepted 11 'in principle', not accepted six, and deferred a decision on seven pending further advice. Details can be found at http://www.coaghealthcouncil.gov.au/Publications/Reports

I will cover the issues most relevant to medical practitioners.

As background, this review commenced more than 12 months ago. The AMA made three submissions to the review (see https://ama.com.au/submission/submission-ama-submissions-review-national-registration-and-accreditation-scheme).

The AMA supports a NRAS that delivers:

- registration arrangements that enable medical practitioners, who are qualified and safe, to work anywhere in Australia;
- independent accreditation of medical education and training that meets international guidelines;
- medical practice registration standards set by the Medical Board, with clear jurisdiction over all health care provided by medical practitioners; and
- a notification process for the Medical Board to receive, consider and determine concerns about the health, performance or conduct of individual medical practitioners where there is a risk of harm to the public, and which is efficient and affords due process to the medical practitioner under review.

In respect of the first three points, we are satisfied that the scheme has met the expectations of the medical profession.

Improving the practitioner experience with notifications

The AMA didn't wait for the outcomes of the review to deal with the fourth point. The AMA provided senior, experienced clinicians to work with the Board and AHPRA to analyse the notification and investigation processes to streamline them to improve the practitioner experience. A full report of that work appears in *Australian Medicine* (issue 27.04 – April 2015). The work will continue, incorporating a Review recommendation that AHPRA investigators undergo specific education and training to ensure consistency and appropriateness of investigative standards and approaches (No. 28).

Health workforce reform

A significant aspect of the scheme that the AMA is very dissatisfied with is the influence on health workforce reform that is bestowed upon the Scheme under the objective to enable the continuous development of a flexible, responsive, and sustainable Australian health workforce, and '*to enable innovation in the education of, and service delivery by, health practitioners*'.

The AMA argued that some Boards, by acting as cheerleaders for their health practitioners by allowing expanded scopes of practice without proper training and education, have failed to meet the objective '*to provide for the protection of the public by ensuring only health practitioners who are suitably trained and qualified to practise in a competent and ethical manner are registered*'. The AMA argued that workforce reform should be independent of, and not driven by, the Scheme.

The Review report contains seven recommendations on health workforce priorities and innovation (1, 12, 13, 18, 22, 23 and 24). It proposed that the Professional Standards Advisory Council (PSAC) be created to "inform National Boards, AHPRA, and Accreditation Authorities on key health workforce reform priorities and health service access gaps," along with a Standing Committee within the Scheme to discuss that, and "consider the evidence and value of alternative innovations in the delivery of health education and training".

While the Health Ministers do not support the establishment of the PSAC, they consider the reform arrangements can be achieved through existing structures within the Scheme. This is far from satisfactory to the AMA.

In the interests of patient safety and a sustainabile healthcare system, the Scheme should support the workforce reform agenda by providing a robust forum for scrutinising the need and evidence for, and public debate of, changes to the roles and responsibilities of health professionals. We clearly have serious work ahead of us to ensure that, with the abolition of Health Workforce Australia, the expertise required to undertake health workforce reform policy is established outside the NRAS.

Review of the National Registration and Accreditation Scheme

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Mandatory reporting

The Review recommended that the National Law be amended to reflect the same mandatory notification exemptions for treating practitioners established in the Western Australian law. Health Ministers have not accepted this recommendation at this time – pending further research. The Review concluded that data are inconclusive, and that further research has been commissioned by National Boards and AHPRA on a preferred approach to managing mandatory notifications.

This is disappointing. It is critical that health practitioners are not deterred, for any reason, from seeking early treatment for health conditions. The inconsistency across the jurisdictions regarding mandatory reporting by treating practitioners is therefore an inherent problem.

AMA analysis of the publicly available data was that variation in the Western Australian law does not appear to have made a material difference to the rate of mandatory notifications, and this was affirmed by the Review. Bismark et al (MJA 201(7) 6 October 2014) was similarly unable to interrogate data provided by AHPRA to determine that the exemption in Western Australia was detrimental to public safety. Bismark found that 92 per cent of mandatory reporting was made by fellow colleagues and employers. Whether the further research that has been commissioned will have access to richer data that will give Health Ministers comfort to make the amendments is unknown.

Composition of Boards

Health Ministers have accepted recommendation 26 that a community member can be appointed as Chairperson of a National Board. The AMA maintains that the Medical Boards should be chaired by medical practitioners, in order to have the confidence of the profession.

Other recommendations

Other recommendations are focused on the nine health professions that are small in number and attract only a small number of notifications (because of their risk profile). The recommendations go to the costs of registration and accreditation, and propose amalgamation and streamlining for those professions.

The AMA will maintain a major focus on the NRAS and health workforce reform. We will continue to advocate for policies and assessment arrangements that protect patient safety, enhance quality care, and afford justice to Australian doctors.

Working groups are working

BY AMA SECRETARY GENERAL ANNE TRIMMER

> "In many cases, the working groups are able to draw on the knowledge and subject matter expertise beyond the membership of Federal Council"

The most recent meeting of Federal Council in August provided an excellent example of the benefits derived from the constitutional change to the AMA structure. With the separation of policy from governance, Federal Council now devotes its meeting time to development of, and debate on, substantial areas of medico-political policy.

The structure enables a more rapid response to policy issues as they arise, with an increased use of working groups brought together to focus on a discrete policy issue. In many cases, the working groups are able to draw on the knowledge and subject matter expertise beyond the membership of Federal Council. In the recent review of the AMA's *Position Statement on Climate Change and Health,* Federal Council was also able to draw on the broader membership, with input through a poll of members.

Federal Council considered two major policy issues at its August meeting – the MBS Review under the chairmanship of Professor Bruce Robinson, and the changes in business practice of the for-profit private health insurance sector. The AMA had brought together leaders from most of the medical colleges and specialist societies in the week leading into the Federal Council meeting to meet with Professor Robinson and to discuss shared concerns. These centred on the apparent lack of direct engagement with the specialist societies and medical colleges as the Review drills down into the detail of items on the MBS. The specialists were also concerned that the review appears to make no provision for review and listing of new items, leaving these to the time-consuming and expensive MSAC process.

The second major policy discussion, on the activities of the for-profit private health insurance companies, has attracted considerable media coverage as a result of the now-settled contract dispute between Medibank Private and the Calvary Hospital Group. The AMA has received numerous member communications highlighting the concerns that doctors have for the care of their patients where insurers have changed coverage or added exclusions, and the patient has not been aware of, or not understood, the impact of these decisions.

In recent Federal Council meetings, the specialist groups have reported on the challenges for that specialty. A consistent issue has been that of workforce mal-distribution which has resulted in an over-supply of specialists in many urban centres with associated underemployment, and a shortage of specialists in many rural and regional areas. These shifts raise considerable challenges for the future viability of the privately practising profession, as well as for those working in the public hospital system. Federal Council will consider the issue of workforce distribution in more depth at a future meeting.

Federal Council established a working group in May to review the structure and representation on the Council itself. While this piece of work was put to one side as part of the constitutional reforms in 2014, Federal Council is interested to ensure that it continues to be reflective of the membership and wider profession. The working group will report in November.

Medibank's too private actions rile doctors and patients

AMA President Professor Brian Owler says that Medibank Private's recent actions – highlighted by its contentious list of 165 'preventable events' and its rocky contract negotiations with Calvary Health – have nothing to do with quality.

Medibank Private and Calvary eventually signed a contract, but no details were made public.

The AMA acknowledges that commercial elements of the contract should remain confidential, but any arrangements to do with the list of 'preventable events' are in the public interest. Keeping them secret only fans suspicion and undermines trust.

"Medibank is using the cloak of quality to cut costs, to not pay for treatments and procedures, and this is going to put an enormous strain on our hospital system – not just in terms of the private system, but the public system as well", Professor Owler said.

"We know that there will be patients that won't be able to be readmitted should they develop problems with their wound or other complications, and they will have to go to the public hospitals.

"There are other patients that won't be able to afford the out of pocket expenses that Calvary will have to charge, and they will have to be going to public hospitals as well."

Professor Owler is warning that, if the issue was not stopped by the Government, it has the ability to threaten the balance between the public and private system right across the country.

"We've already seen Bupa and NIB line up behind Medibank Private," he said.

The AMA disputes that Medibank Private's list of 'preventable events' can be addressed as a quality issue, with studies showing a similar approach taken overseas has not produced any change in outcomes, and questions the various items that are on the list.

"Medibank is continuing to be mischievous with the truth, and they continue to refer to complications as 'mistakes'," Professor Owler said.

"These are not mistakes, these are complications that are unfortunate, but part of everyday medical practice.

"While there is a degree of preventability, they are not mistakes, they cannot be completely prevented.

> "Medibank Private is unfairly punishing the hospital, blaming the doctors and the nurses that are working and caring for patients in those private hospitals, and going to put an enormous strain on the public hospital system"

"Medibank Private is unfairly punishing the hospital, blaming the doctors and the nurses that are working and caring for patients in those private hospitals, and going to put an enormous strain on the public hospital system.

"The idea that the Government does not have a role in this dispute is ludicrous.

"First of all, this dispute is in part the creation of this Government.

"It was this Government's policy that actually put Medibank Private on the stock exchange, and created the biggest private health insurer where the responsibility was now the shareholders, and concentrating on returns to investors.

"The Government also has about $6 billion of skin in the game; they pay for the private health insurance rebate, they support private health insurance, and this move by Medibank Private continues to undermine it."

In welcome news, the Government has fast-tracked a review of preventable events being conducted by the Australian Commission on Safety and Quality in Health Care, and Medibank Private has indicated it will cooperate with this review.

JOHN FLANNERY

AMA slams Medicare misinformation

AMA President Professor Brian Owler has questioned comments from the Health Minister about the latest Medicare data that suggested the Government is setting the scene for Health budget cuts through the Medicare Benefits Schedule (MBS) Reviews, which are due to report to the Minister by the end of the year.

> "A first world country like Australia should embrace the fact that it can offer its citizens timely and affordable access to a full range of healthcare services"

Professor Owler said the Health Minister is being alarmist about health expenditure.

"The Government is misleading the public by talking about the number of Medicare services per patient as if they are all separate visits to doctors, which is wrong," Professor Owler said.

"A single visit to a doctor can result in several services being provided to the patient on the day.

"Contrary to the Minister's view that the Medicare data paints a complex picture, it is really quite simple. Growth in health expenditure will always occur, as the population increases and ages.

"A first world country like Australia should embrace the fact that it can offer its citizens timely and affordable access to a full range of healthcare services.

"This is essential to a productive nation. Good health keeps people in jobs. And good health keeps people actively contributing to their communities, which contributes to a strong economy.

"Rather than focusing on the number of items on the Medicare Benefits Schedule, the Government should be celebrating the positive health outcomes that the MBS delivers to the nation.

"Many of the items that have recently been added to the Schedule are a direct result of Government policies.

"The MBS should and must reflect modern medical practice.

"The medical profession is participating in the MBS Reviews that the Minister has commissioned.

"The profession will take the lead in identifying waste and inefficiency in the healthcare system."

Professor Owler said that it was the AMA's understanding that the MBS Reviews were not set up as a Budget cost-cutting exercise, but the Minister's recent media release contains language that suggests otherwise.

"By using terms such as 'Medicare usage had continued to skyrocket' and 'the cupboard needed a good clean', the Minister has clearly indicated that the 'blueprint' for the MBS Reviews will inevitably have a focus on the budget bottom line rather than a funding mechanism for supporting good health care," Professor Owler said.

"The Australian public would prefer the Government to set the strategic vision and direction for Australia's healthcare system, which in turn will guide the MBS Reviews."

Professor Owler said it is wrong for the Government to claim that health funding is out of control.

"Medicare expenditure increased by 5.6 per cent in 2014-15. Over the last seven years, this is the second lowest annual increase in Medicare expenditure. Last year (2013-14), was the lowest, at 3 per cent.

"The Government's Commission of Audit report stated that Medicare expenditure was expected to grow by 7.1 per cent per year until 2023-24, and continue growing. Yet the last two years have been well under that projection.

"The Commonwealth Government's total health expenditure is reducing as a percentage of the total Budget. In the 2014-15 Budget, health was 16.13 per cent of the total, down from 18.09 per cent in 2006-07.

"It reduced further in the 2015-16 Budget, representing only 15.97 per cent of the total Commonwealth Budget.

"The Reform of the Federation White Paper estimates '*that 10 per cent of patients account for around 45 per cent of MBS expenditure*'.

"This shows that the MBS is working as intended."

JOHN FLANNERY

AMA updates stance on Climate and Health

Following an extensive engagement process with members, the AMA updated its *Position Statement on Climate Change and Human Health (Revised 2015)*, which was last revised in 2008.

The updated Position Statement takes account of the most recent scientific evidence.

AMA President Professor Brian Owler said the AMA Position Statement focuses on the health impacts of climate change, and the need for Australia to plan for the major impacts, which includes reducing greenhouse gas emissions.

"It is the AMA's view that climate change is a significant worldwide threat to human health that requires urgent action, and that human activity has contributed to climate change," Professor Owler said.

"The evidence is clear - we cannot sit back and do nothing.

"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.

"The AMA believes that the Australian Government must show leadership on addressing climate change.

"We are urging the Government to go to the United Nations Climate Change Conference in December in Paris with emission reduction targets that represent Australia's fair share of global greenhouse gas emissions.

"There is considerable evidence to convince governments around the world to start planning for the major impacts of climate change immediately.

"The world is facing a higher incidence of extreme weather events, the spread of diseases, disrupted supplies of food and water, and threats to livelihoods and security.

"The health effects of climate change include increased heat-related illness and deaths, increased food and water borne diseases, and changing patterns of diseases.

"The incidence of conditions such as malaria, diarrhea, and cardio-respiratory problems is likely to rise.

"Vulnerable people will suffer the most because climate change will have its greatest effect on those who have contributed least to its cause and who have the least resources to cope with it.

"*The Lancet* has warned that climate change will worsen global health inequity through negative effects on the social determinants of health, and may undermine the last half-century of gains in development and global health," Professor Owler said.

The AMA Federal Council last month passed a policy resolution acknowledging the need for the healthcare sector to reduce its carbon footprint through improved energy efficiency, green building design, alternative energy generation, alternative transport methods, sustainable food sourcing, sustainable waste management, and water conservation.

The *AMA Position Statement on Climate Change and Human Health* (Revised 2015) is available at https://ama.com.au/position-statement/ama-position-statement-climate-change-and-human-health-2004-revised-2015

JOHN FLANNERY

Empowering General Practice

The AMA Submission to the Government's Primary Health Care Review highlights the robustness of the Australian health system, particularly the crucial role of general practice, and stresses the need to build on the proven track record of general practice with significant new investment.

AMA President Professor Brian Owler said that the Review must focus on strengthening the parts of the system that deliver quality, accessible, and affordable care to the community, most notably general practice.

"This is not the time to throw the baby out with the bathwater," Professor Owler said.

"In terms of both cost and health outcomes, the Australian health system is performing very well by world standards, and general practice delivers outstanding public health outcomes from modest Government investment.

"We must avoid radical change for change's sake.

"Some of the potential reforms raised in the Primary Health Care Advisory Group's (PHCAG) discussion paper have been tried or are in place in other countries, and there is only very limited evidence about any significant positive impact.

"General practice in the UK, for example, has been the subject of several rounds of funding reforms, and the GP workforce in the UK is now being reported as demoralised and suffering from extreme shortages.

"We do not want or need to repeat the same mistakes here. It is concerning that some of the failed UK experiments are still on the table here for PHCAG consideration.

"For the Review to have genuine credibility, the Government must change its reform language – it must start talking about primary care reform as an investment, not a cost or a saving to the Budget bottom line.

"There is no doubt that extra investment in general practice will deliver long term savings to the Government, and improve the sustainability of the health system.

"The Government needs to take a long term view and make this investment now, in the knowledge of savings in later years, better patient outcomes, and less pressure on our hospital system.

"Significant new investment in general practice and the urgent need to lift the current freeze on the indexation of Medicare patient rebates must be priorities for the Review, or they will be priority issues for voters at the next election," Professor Owler said.

With the growing burden of chronic disease and the long term impact this will have on the health system, the AMA is encouraging the PHCAG to consider reforms that will better support these patients in accessing high quality GP-led care.

The AMA Submission highlights a number of areas for change, including:

- provided there is no overall reduction in funding, reform of existing Medicare chronic disease items to strengthen the role of the patients usual GP, cut red tape, streamline access to GP referred allied health care services and reward longitudinal health care;
- the adoption of pro-active models of care-coordination for patients with higher levels of chronic disease and who are at risk of unplanned hospitalisation - similar to the Coordinated Veterans' Care program that has been established by the Department of Veterans' Affairs;
- the introduction of an incentive payment through the Practice Incentives Program to support quality improvement, informed by better data collection;
- the introduction of non-dispensing pharmacists in general practices to help improve medication management, particularly for patients with chronic disease;
- an enhanced role for private health insurers to fund targeted programs that support general practice in caring for patients with chronic disease;
- the utilisation of Primary Health Networks to support GPs in providing care for patients, particularly in improving the connection between primary and hospital care; and
- better use of technology, including the use of point of care testing.

While the AMA Submission promotes a number of reforms, it also emphasises that fee-for-service should remain the primary source of funding for General Practice.

Professor Owler said that the fee-for-service model works well for the majority of patients in the Australian context.

"Fee-for-service provides patients with autonomy and choice, and access to care based on clinical need as opposed to the potential for rationed care that arises under some other funding models," Professor Owler said.

"It also supports the doctor-patient relationship, with patients receiving a Medicare rebate to support them in accessing GP services."

The AMA Submission to the Primary Health Care Review is at https://ama.com.au/submission/ama-submission-primary-health-care-review

JOHN FLANNERY

AMA in the news

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

PRINT

Annual budget for each patient under GP plan, *Adelaide Advertiser*, 5 August 2015

The Primary Health Care Advisory Group published a discussion paper, outlining radical changes to GP care and inviting comment by September 3. AMA President Professor Owler said the discussion paper challenged the profession to consider new payment models, and this is something that will require an ongoing discussion.

Happy little home brew puts Vegemite in the firing line, *Sunday Times*, 9 August 2015

Australia's iconic Vegemite could be ripped from supermarket shelves in remote communities because of claims it is being brewed into booze. Professor Owler said the impact of home brew could be devastating, with alcohol abuse still one of the greatest health issues facing Australia.

State of bad health, *The Herald Sun*, 13 August 2015

Stress, poor role models, and beliefs that bullying is character building are blamed for the culture of intimidation and harassment in Australia's surgical ranks. Professor Owler called for gender balance in senior roles to help promote more inclusive workplaces, saying quotas were one of the most effective tools available.

Women also harass men: senior doctors, *Sydney Morning Herald*, 13 August 2015

Sexual harassment goes both ways in the surgical room, according to senior doctors, who say that female doctors and nurses do not hesitate to use their sexuality to ahead. Professor Owler said now was not the time for senior doctors to try to justify their actions, rather they should encourage a behavioural change in medicine.

Safety advocates call to put brakes on road toll, *Northern Territory News*, 15 August 2015

Autonomous emergency braking is the new focus for cutting the death toll on Australian roads. ANCAP and the AMA have launched a joint campaign on AEB, claiming the technology could be as important as seatbelts in cutting the road toll.

Doctors ordered, *The Saturday Paper*, 15 August 2015

Professor Owler planned to visit Nauru to see for himself whether health care in the Australian-run detention centre was up to scratch - but attempts were delayed.

Medibank insurance strategy under fire, *Australian Financial Review*, 20 August 2015

Doctors and other medical professionals are turning up the heat over an increasingly bitter dispute with Medibank Private over hospital insurance cover. Professor Owler said the idea that the Government does not have a role in this dispute is ludicrous.

Detention boycott debated by doctors, *Sydney Morning Herald*, 20 August 2015

Responsibility for the health care of asylum seekers in detention should be stripped from the Department of Immigration and Border Protection to steer off the prospect of a doctor boycott. Professor Owler said he did not support a boycott.

Medibank row: Feds urged to intervene, *Canberra Times*, 20 August 2015

Professor Owler has ramped up calls for the Government to intervene in Medibank Private's bitter dispute with Calvary hospitals. He said they can continue to stay out of the game, or they can get involved and start to fix up some of the mess they created.

Doctor Pot holds clinic, *Canberra Times*, 29 August 2015

Doctors are facing increasing pressure from patients demanding answers on whether cannabis might ameliorate their pain and, if so, where can they find it. AMA Vice President Dr Stephen Parnis said we accept there is a legitimate place for treating some problems with cannabis.

Medirank, *The Daily Telegraph*, 28 August 2015

Medibank wants hospitals to sign a contract where it would refuse to pay for more than 165 preventable and sentinel events. Professor Owler is concerned the new contracts are heading towards a US-style managed care system.

$220m bill for dodgy GP visit, *The Sunday Telegraph*, 30 August 2015

GPs have raised concerns about a home doctor service providing free bulk billed home visits after 4pm, that is costing taxpayers $220 million a year. AMA Chair of General Practice Dr Brian Morton said it is not free. It is paid for by all taxpayers and should be respected for that.

AMA in the news

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'Secret' deal on hospital care, *Adelaide Advertiser,* 31 August 2015

The public must be told the terms of a controversial contract deal between Medibank and Calvary hospitals so patients know if the fund will not pay for certain events. Professor Owler criticised as unacceptable the secrecy surrounding the 11th-hour agreement.

A king hit on games boxing, *Courier Mail*, 4 September 2015

The AMA wants boxing banned from the Olympic and Commonwealth Games, but Australia's top boxers claim it would send the game underground. Professor Owler said the aim of boxing is inherently dangerous, and sometimes fatal.

Ley cops Medicare blast, *West Australian*, 4 September 2015

Doctors have accused the Abbott Government of softening the ground for cuts to health after it released alarmist figures on rising Medicare costs. Professor Owler said Ms Ley was treating the one million-a-day claims figure as if they were separate visits to the doctor.

Doctors want protection from ice rage, *The Canberra Times*, 4 September 2015

The AMA has warned crystal methamphetamine is making the work of doctors more dangerous, and called for additional security in hospitals. AMA President Professor Owler said doctors nationwide had noticed a significant rise in the number of people using ice, and associated symptoms such as aggression and psychosis.

RADIO

Dr Stephen Parnis, 612 ABC Brisbane, 13 August 2014

AMA Vice President Dr Stephen Parnis talked about the risks of travelling overseas for treatment. Dr Parnis said cosmetic surgery and dental surgery are the main reasons people travel for medical treatments.

Professor Brian Owler, 2UE Sydney, 20 August 2015

AMA President Professor Owler talked about allocating medical resources to ailing patients. He said most health resources are used to prolong people's lives, in the last few months of life, and sometimes when patients are unable to indicate whether they would like the action taken.

Professor Brian Owler, 6PR, 4 September 2015

The AMA is calling for combat sports that encourage violence to be banned. Professor Owler said, while these sports continue, the AMA wants to ensure there are trained medical personnel who can look after the participants.

Dr Stephen Parnis, 612 ABC Brisbane, 4 September 2015

Dr Parnis talked about a ban on combat sports. He said the AMA is opposed to sports where the primary goal is interpersonal violence to stop the opponent continuing.

TELEVISION

Professor Brian Owler, Ten Eyewitness News, 12 August 2015

A new report has revealed half of Australians have a chronic disease, and one in five have multiple illnesses. Professor Owler is calling for an investment in health care. Health Minister Sussan Ley says throwing money at the problem isn't the answer.

Professor Brian Owler, The Today Show, 13 August 2015

Professor Owler speaks to the Today Show about the emergency breaking system available in Europe and America that the AMA would like to see become standard in all new cars sold in Australia.

Professor Brian Owler, Channel 7, 25 August 2015

Doctors have hit out at a suggested extension of the GST to health care, not long after the controversial GP co-payment was dumped. Federal Treasurer Joe Hockey said such a measure could help fund tax cuts. Professor Owler said it would impact those with chronic and complex disease.

Professor Brian Owler, Channel 10, 3 September 2015

Australia's Medicare bill has doubled in the past decade and the Federal Government says we can't afford such an increase. Professor Owler said the Health Minister is using the figures to develop a narrative around how she needs to cut costs in health.

AMA in action

From Medibank and Calvary's tense contract negotiations, to the health impacts of climate change, and lobbying to have lifesaving technology installed in all new Australian cars, the AMA has been active on many fronts in recent weeks.

More than 70 medical leaders from all specialties were brought together by the AMA to discuss the profession's participation in the Government's Medicare Benefits Schedule Reviews. Getting everyone in the one room was important to ensure an informed and united approach.

The AMA and the medical colleges were opposed to the Medibank Private contracts as an attempt by the fund to direct patient care. Doctors were deeply concerned that the new contracts are heading towards a US-style managed care system, where insurers can dictate which doctor you can be referred to, and what treatment you have.

AMA President Professor Brian Owler met with Senators and Members of Parliament who held concerns that Medibank Private's actions would negatively impact their constituents and their local hospitals.

The AMA President and Vice President helped bring the Medibank contract negotiations issue to a head when they took the issue to the media in a doorstop interview at Parliament House.

The AMA and the Australasian New Car Assessment Program joined forces to lobby governments and car industry leaders to make Autonomous Emergency Braking standard in all new cars sold in Australia.

ODETTE VISSER

Professor Owler and CEO of ANCAP Nicholas Clarke at the AEB launch

Professor Owler and Dr Parnis talking to media at Parliament House about Medibank and Calvary Hospital

Professor Owler on The Today Show

Professor Owler meeting with Shadow Minister for Health Catherine King

Professor Owler with Autism Awareness CEO Nicole Rogerson and Executive Manager Elisabeth Sarian

Professor Owler with Michael McCormack MP Member for Riverina NSW

Professor Owler with Rowan Ramsey MP Member for Grey SA

Professor Owler with The Member for Denison Andrew Wilkie MP

Professor Owler with Victorian Senator Ricky Muir of the Australian Motorist Enthusiast Party

Professor Owler with West Australian Senator Zhenya Wang of the Palmer United Party

Big Tobacco after data on Aussie kids' attitudes

A global tobacco giant has been accused of using freedom of information laws to obtain taxpayer-funded research showing Australian school children and teenagers' attitudes to smoking and alcohol.

Public health advocates are concerned that 'Big Tobacco' may use the data to hone their marketing of cigarettes to teenagers, as well as to fight plain packaging laws, which are now being implemented across the globe.

British American Tobacco (BAT) is trying to access data from the Victorian Cancer Council Australian Secondary Students' Alcohol and Drug Survey.

The lawyer seeking the Victorian information for BAT was recently successful in obtaining the Cancer Institute NSW research into adults' attitudes to smoking, by using the FOI Act.

According to the *Sydney Morning Herald,* the Institute felt legally compelled to disclose the data, which effectively gave Big Tobacco access to millions of dollars worth of taxpayer funded research for the price of an FOI application.

The information was then used by the tobacco company last year in Britain to contest plain packaging laws.

The Victorian Cancer Council is currently fighting the FOI application in the Victorian Civil and Administrative Tribunal.

Victorian Cancer Council CEO Todd Harper said that they are doing everything they can, and are concerned that handing over the data would breach confidentiality and have a chilling effect on future research.

"If this information were to be used for commercial purposes, for instance to hone or localise tobacco or alcohol marketing and pricing strategies to appeal to the young, provision of such information would be highly detrimental to Victoria's children," Mr Harper said.

A spokesperson for BAT told the *Sydney Morning Herald* that the company was seeking information to bolster its case that, instead of Australian youth smoking rates going down because of plain packaging, that they're going up.

"Any evidence to prove the latter needs to be highlighted so that other countries around the world don't make the same mistake. Any such evidence is also relevant to the Government's Post Implementation Review into plain packaging, which is still underway," the spokesperson said.

"In this context any such request for an FOI to obtain this information is both reasonable and legitimate. Importantly, none of the FOI applications sought any personal data or information in respect of children or adolescents," the spokesperson said.

In a statement provided to *Medical Observer,* the company said that "it is illegal to sell tobacco to children and tobacco advertising has been banned for decades. Children are not, and never will be, our audience and we have always made this clear."

The survey collects information from students aged 12-17 about their smoking and drinking practices, including what brands they prefer.

The Assistant Minister for Health, Fiona Nash, said the Government would not back away from plain packaging regardless of tactics by tobacco companies to discredit it.

"If tobacco companies are obtaining research on young people through State FOI legislation to increase their sales to children, then I am appalled," Ms Nash said.

Professor of Health Policy at Curtin University Mike Daube said the FOI application for the school survey data takes the tobacco industry into new lows.

"The companies claim that they have no interest in children – yet they are going to extraordinary lengths to access research data about children and tobacco, alcohol and drugs," Professor Daube told the *Sydney Morning Herald*.

"This use of FOI legislation by the world's most lethal industry raises another issue of enormous concern. If Big Tobacco can use FOI to harass a Cancer Council, what is to stop them using FOI to obtain information from any researchers employed by universities, or to tie them up in endless legal battles?"

KIRSTY WATERFORD

Lyme disease – no evidence it is endemic in Australia

The latest research from Murdoch University has found no evidence that Lyme disease exists in Australia, but the research has revealed that a new Australian tick species warrants further investigation.

The researchers found that no Lyme disease-associated bacteria were found in Australian ticks, but found organisms in one Australian tick, collected from a wild echidna, that caused relapsing fever.

Lead researcher Professor Peter Irwin and his team collected more than 20,000 ticks from across the country to study the bacteria they carry and their potential to cause disease.

Professor Irwin told ABC News that his research to date had not been able to show conclusively that Australian ticks carry the Lyme disease-causing bacteria, but has found organisms in one tick that could trigger a similar illness.

“Borrelia is the name of the bacteria that causes Lyme disease, but there are several different types,” Professor Irwin said.

“One of the types is associated with a disease known as relapsing fever, and we found the DNA bacteria of that type in one tick.

“As the name suggests, relapsing fever causes fevers that come and go, and a wide range of other symptoms, in people, some of which have similarities with Lyme disease, such as extreme fatigue and nausea.”

The Department of Health has welcomed the ground-breaking research.

In 2013, Chief Medical Officer Chris Baggoley set up the Clinical Advisory Committee on Lyme disease to work out how to diagnose and treat “Lyme disease-like syndrome”. The Committee has since ceased. It found that a conclusive finding of a bacterium that could cause Lyme disease- like syndrome in Australia has yet to be made.

The Department of Health will remain engaged with Professor Irwin to consider the implications of this research for human health in Australia. They anticipate that research on ticks taken from humans will be published later in 2015.

Professor Irwin emphasised that it is not yet appropriate to link the bacteria he found in the ticks to them causing disease in humans. He said, however, it is reasonable to consider a possible link between bacteria and disease if the bacteria that are found have a close relationship to known pathogens. Nothing can be assumed without further research.

KIRSTY WATERFORD

INFORMATION FOR MEMBERS

Funding grants for managers in the health care industry

The Australian School of Applied Management is seeking submissions for its scholarship grant initiative for Health Sector Employees interested in focusing on elevating the performance of management across the broader health sector.

The initiative aims to provide health care sector employees across Australia with grants for leadership development at two levels.

1. **Mid-level through to senior level** and high potential leaders can apply for $8,000 individual grants to undertake the Australian Applied Management Colloquium.
2. **High potential and emerging mid-level managers** can apply for $4,100 individual grants to undertake the Accelerated Management program.

As funding is limited the National Scholarship Committee advises that interested parties should submit applications at their earliest convenience. For more information about the Organisational Scholarship Grant program contact 03 9270 9000, email info@asam.edu.au or visit http://www.asam.edu.au/

Medicinal cannabis may no longer be a pipe dream

Political momentum to allow medicinal cannabis crops to be grown commercially in Australia is building, with a Senate Committee unanimously endorsing a Bill that would remove current restrictions.

All members of the Senate Legal and Constitutional Affairs Committee have recommended that the Regulator of Medicinal Cannabis Bill be passed into law, with amendments.

The Bill was introduced last year by Greens Senator Richard Di Natale and co-sponsored by Liberal Senator Ian McDonald, Labor Senator Anne Urquhart and Independent Senator David Leyonhjelm.

Greens Leader Richard Di Natale, who previously worked as a GP, said the Senate Committee's unanimous endorsement of his Private Member's Bill was a significant step towards achieving medicinal cannabis reform.

"The next step is to secure sufficient time in the Parliament to bring this Bill to a vote," Senator Di Natale said.

"I call on [Prime Minister] Tony Abbott to allow this Bill to be debated during Government business. Given that the Bill has co-sponsors from all sides of politics, I hope that we can work together to make this happen."

Senator Di Natale said the Committee recommended some amendments to strengthen the Bill, which he and his co-sponsors would consider, but stressed this should not be used as an excuse for major delays.

"This issue is not about politics, it's about getting medicine to people who need it. We have an opportunity to relieve the pain and suffering of many Australians if we can just come together and show Parliament at its best."

Senator McDonald has predicted the Regulator of Medicinal Cannabis Bill is likely to pass Federal Parliament by the end of the year.

The Committee's recommendations are designed to amend the Bill to resolve all conflicts with various pieces of existing legislation including the Therapeutic Goods Act and the Narcotics Act, as well as State and Territory laws.

The AMA believes medicinal cannabis should be regulated in the same ways as other therapeutic narcotics.

The Senate report has acknowledged the legislative conflicts that arise from regulating medicinal cannabis differently to other therapeutic narcotics.

The AMA is wary of more complex regulation for medical practitioners, and would favour simple solutions to the complex issues considered by the Senate committee.

ODETTE VISSER

INFORMATION FOR MEMBERS

Information regarding payments under the previous GP Rural Incentives Program

On 1 July the GP Rural Incentives Programme (GPRIP) moved to the new classification system, the Modified Monash Model, which entailed the introduction of new eligibility criteria for doctors and new payment levels.

The AMA recently sought advice from the Department of Health regarding the Department's process for issuing final payments under the previous GP Rural Incentives Program, which ceased on 30 June 2015.

The Department advised that those doctors that completed four active quarters at the end of June 2015 will receive their payments as normal from August 2015. Those doctors that have more than one but less than four active quarters at 30 June 2015 will receive a final pro-rata payment in November 2015.

To enable the payment of service provision under 12 months, the Department of Health and the Department of Human Services are making significant changes to the current payment system model. The Department has advised that these changes have caused the delay in the dates when payments were expected to occur.

As of 1 July 2015, assessment of payments under GPRIP will be based on the new criteria. The first payments under the new arrangements will occur from June 2016 to eligible medical practitioners who have completed the required number of active quarters.

For more information visit the Department's Rural and Regional Health Australia website.

NSW prison smoking ban allows staff to continue with the habit

New Zealand started it, the Northern Territory followed, and now most of Australia has banned smoking in prisons. New South Wales is the latest to have joined the ranks to ban smoking in correctional facilities. However, NSW's recently introduced ban isn't without controversy, as prison officers are exempt.

> "Implementing smoke-free prisons was always going to be a serious challenge and it has gone incredibly well and without major incident"

An Australian Institute of Health and Welfare report, 'The health of Australia's prisoners 2012,' released mid 2013, found that four out of five prisoners reported that they smoked with 78 per cent saying they smoked daily.

Smoking bans in prisons are complex, and around the world have been controversial and difficult to implement. New Zealand introduced a blanket ban on smoking in correctional facilities in July 2011, but the New Zealand High Court ruled that the ban was unlawful in December 2012. After a lengthy legal battle, Correctional Services amended legislation, which reinstated the blanket ban.

New Zealand Corrections Department Chief Executive Ray Smith said that, since the introduction of smoke-free prisons, the work environment had improved for staff and prisoners, with better air quality and fewer fires.

"Implementing smoke-free prisons was always going to be a serious challenge, and it has gone incredibly well and without major incident. We are the first national prison service to achieve this," Mr Smith said.

Prisoners were given 12 months to quit smoking before the blanket ban was introduced in July 2011.

Northern Territory prisons have been smoke-free since July 2013, modelling their approach closely on New Zealand's successful introduction of smoke-free prisons. The Northern Territory introduced a 12 month plan prior to the ban to encourage staff and inmates to quit smoking. Better access to services to help staff and inmates to quit smoking was provided, and a comprehensive, rather than a partial, smoking ban was introduced.

Much of the rest of Australia followed in the Northern Territory's footsteps with Queensland, Tasmania, and Victoria introducing total bans on smoking in correctional facilities. South Australia is trialling bans at the Adelaide Remand Centre later this year, while the ACT has committed to phasing out smoking in prisons, but continues to be elusive with a timeline for the ban. Western Australia currently has no intention to ban smoking from correctional facilities, but they have banned smoking indoors.

NSW's ban on smoking at correctional facilities was introduced mid-August, but a loophole in the legislation allows staff who live in correctional centres to smoke in designated areas - a move likely to be resented by many prisoners who are being forced to quit.

Inmates' families have been told by NSW Corrective Services that they won't be permitted to smoke anywhere on the grounds of a correctional centre, which includes car parks or inside their cars, during visits.

The smoking ban legislation was amended to allow smoking areas to be declared for staff living in NSW's 84 prison residences by the Minister for Corrections David Elliot a week before the implementation.

A Corrective Services spokesman told the *Sydney Morning Herald* that staff who live on Corrective Service NSW sites will be able to smoke while off duty in a designated area outside their accommodation and not visible from any correctional centre.

Monarch University researcher Anita Mackay, who has studied smoking bans in prisons around the world, said that she hasn't come across a situation where there is a complete ban for imprisoned people, while staff are able to smoke. Given that the justification is to protect the health of staff, it doesn't really align.

KIRSTY WATERFORD

OBITUARY: Dr Patricia Mackay

Dr Patricia Mackay's outstanding contribution to the Australian community for more than 50 years, particularly her advances in patient safety and surgery, will be remembered following her death earlier this month.

Born in New Zealand in a small town south of Dunedin, Dr Mackay started her medical journey at the Otago Medical School. In an interview with Dr Christine Ball in 2008, Dr Mackay said that at medical school she was assigned to undertake a caesarean section by herself, and despite the obstetrician saying she shouldn't worry about anaesthetic because the baby was dead, the baby turned out to be alive. Dr Mackay said this moment made her career.

Dr Mackay made the move to Australia to take the post-graduate examination. She started as a clinical assistant at the Alfred and Royal Melbourne Hospital. Dr Mackay had a long and proud history at the Royal Melbourne Hospital. She was the first female appointed as Head of Anaesthesia in 1984, a position she held until 1992. Dr Mackay established the first acute pain management unit in Victoria while at the Royal Melbourne Hospital.

She was among a small group of anaesthetists who founded the Australian Patient Safety Foundation and started the Anaesthetic Incident Monitoring Study, a national anonymous collection of incidents with the objective of finding out things that went wrong. The study continues to this day.

Dr Mackay held Secretary and Treasurer positions before taking on the role as President of the Australian Society of Anaesthetists from 1966-1968. She served as Chair of the Victorian Consultative Council on Anaesthetic Mortality and Morbidity from 1991 until 2005.

In 1999, the AMA granted a life membership to Dr Mackay, and she was awarded the AMA Women in Medicine Award in 2001. She was also awarded the Australian and New Zealand College of Anaesthetists Medal. In 2008, Dr Mackay was awarded a Medal of the Order of Australia - for service to medicine in the field of clinical anaesthesia, particularly as a contributor to the improvement of quality and safety of patient care, and to the community.

Dr Mackay made remarkable contributions to medicine, especially her efforts in patient safety. She was a wonderful role model for generations of anaesthetists, both male and female, and her passion and dedication to the profession will not be forgotten.

KIRSTY WATERFORD

General practice and the rise of chronic illness

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

The Federal Government has established an advisory group, chaired by former AMA national President Dr Steve Hambleton, to 'improve the health care system for people with chronic and complex problems.' The Primary Health Care Advisory Group stands beside two other reviews – one of the Medical Benefits Schedule and the other of the Pharmaceutical Benefits Scheme – that together comprise the *Healthier Medicare* initiative. Other reviews are examining mental health services and private health insurance. Each has an admirable representation of practitioners.

The Primary Care Group wisely is to concentrate on care for people with complex problems because they are the ones whose care needs most attention: you could argue that care for acute, self-limited problems in general practice is well served employing a fee-for-service model, but this is hard to apply to the care of those who need continuing and linked-up care for years.

The discussion paper published in August is exceptionally well-written, brief and clear, and invites comment. It has four themes – what does effective care look like; what role might new technology (for self-care, apps and so forth) play in the care of people with chronic problems; how will we know if we are winning; and what is the best way to pay for primary care in this context?

The payment mechanisms are likely to provoke discussion as they include capitated payment, pay-for-performance, and payment to practitioners working for a salary. This is good because these forms of payment feature in many of the successful models that have been put in place in the US and Europe. Fee-for-service fundamentalism really has no place when considering the care of patients with chronic and complex problems.

Another impressive document that contains material of relevance to the work of the Primary Care Advisory Group came from the Royal College of General Practitioners in 2013. It is entitled *The 2022 GP: Compendium of Evidence*. It is intensely and reassuringly practical and humane in what it has to say.

The UK document said that patients with long-term conditions make up about 30 per cent of the population, 50 per cent of all GP consultations, 64 per cent of all outpatient appointments, and 70 per cent of all in-patient bed days, and 70 per cent of the total health spend in England.

The challenges for general practice, it says, include an increasing and changing workload, workforce pressures, protecting time for caring, delivering out-of-hours care, and managing work-related stress. Not all the challenges facing twenty-first century health care fall upon GPs (thank goodness), but in responding to them the RCGP document sees realistically how a general practitioner can help.

Much care at present is in fragments and the elements – specialists, pharmacists, GPs and physios – don't integrate optimally. Here the GP can play a facilitator role if supported financially to do so. Likewise they can help – again, if paid – in helping patients engage in their own care as far as they are able.

One feature of the UK paper that appeals to me is the attention given to community matters, including equity, social structures that limit the prevention of chronic disease, and participation by the GP in the life of the community. I realise all these things occur in Australia and I am not star-struck by what happens in the UK, but it is refreshing to read a document that gives emphasis to these matters. For example, it summarises the story of the 100 "General Practitioners at the Deep End" who work in practices 'serving the most socio-economically deprived populations in Scotland'. The group is supported by the RCGP, the Scottish Government Health Department, and the General Practice Department at the University of Glasgow. It is commendably heroic.

The RCGP offers a brief and pointed conclusion. "For general practice to play its critical role in the future [health service]. It is important that there are enough GPs; that doctors have sufficient time both inside and outside the consultation to provide the interventions needed; and that they receive sufficient training to develop the capabilities required to deliver the high-quality services that patients, carers, and families rightly expect."

Leading the horse to water

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

> "A National Statement on Health Literacy produced by the Australian Commission on Safety and Quality in Health Care highlights that health literacy in this country is a real problem"

A question raised in the Primary Health Care Advisory Group (PHCAG) discussion paper about patient responsibility got me thinking that this is a concept to which very little attention is paid in this country. Has access to universal health care, in particular the perception of "free" medical care, dulled the impact of medical advice or the need to act on it? Or are there other factors at play?

There is an expectation that, if people are armed with facts and quality information about what is good or bad for them, that they will act rationally and do what is in their best interests. Yet even when people are fully informed it does not necessarily mean they will make better choices.

There are two aspects at play here that need to be addressed. One is related to health literacy, the other to motivating behavioural change. While it can reasonably be argued you can't have one without the other, it would be short-sighted to believe that improving the first will eliminate the need for the second.

A National Statement on Health Literacy produced by the Australian Commission on Safety and Quality in Health Care highlights that health literacy in this country is a real problem – with only 40 per cent of adults equipped with a level of health literacy that enables them to assess the safety of a product, to understand health messages, and to be able to make good health care choices.

Low health literacy is related to lower uptake of preventive measures, lower medication compliance, higher rates of adverse outcomes, hospitalisations and emergency care, and higher health care costs, for the individual and for the system.

Improving Australians' health literacy will be a fundamental requirement in enabling Australians to take more responsibility for their health.

The question then becomes how do we do this? The Commission says we need to embed health literacy into systems, ensure effective communication, and integrate it into education.

Certainly, a whole system approach is required. However, we see little support or recognition from the Government about the positive role of general practice. We can do much more to help patients, but funding does not support longer consultations. Reform of primary health care will require greater investment in GP time as well as in team care.

Assuming we can make the systematic changes needed to improve health literacy, how do we also motivate people to make better choices with their future health in mind? Motivating and supporting behavioural change will also need to be a fundamental objective of any reforms to primary health care. Positively changing patient behaviours will also require multi-dimensional solutions. Some may involve carrots, some sticks. Some of these may need to be financial, others may need to be more internal. For example, we need to make healthy living more the accepted norm. We need to make health messages simple and relevant – they need to cut through and drive action. Timing is an important factor here – ie right advice at the right time. Finally, people need to understand the consequences and costs of preventive inaction – personally and as a community.

The PHCAG has a big challenge ahead of them. Their recommendations need to convince the Government, health care providers, and the community to make some difficult but necessary changes if we are to realise the rewards better health will bring.

How safe are the new safety nets?

BY **AMA PRESIDENT PROFESSOR BRIAN OWLER**

New safety net arrangements are planned to commence from 1 January 2016. In the 2014-15 Federal Budget, the Government announced a new (single) Medicare Safety Net for out-of-hospital services to replace the Original Medicare Safety Net, Extended Medicare Safety Net (EMSN), and the Greatest Permissible Gap. At the time of writing, the legislation was yet to be introduced in the Parliament.

The single Medicare Safety Net has four key components:

- new thresholds for patients:
  - > $400 for concession card holders (down from $638.40);
  - > $700 for confirmed singles (must register with the Department of Human Services) (down from $2,000) or families receiving FTB(A) (up from $638.40); and
  - > $1,000 for unconfirmed singles or families, including single parents (down from $2,000).
- limits on the amount of out-of-pocket costs that accumulate to the new thresholds;
- limits on the Medicare Safety Net benefit payable, once the relevant threshold has been reached; and
- will apply uniformly to all Medicare services (i.e. will be replacing the current EMSN benefit caps that apply to more than 500 items, which include all consultations, obstetrics, assisted reproductive technology services, some pregnancy related ultrasounds, and 38 surgical procedures).

Although the new safety net eligibility thresholds have been lowered, it will become more difficult for patients to reach the thresholds. The amount of the patient's out-of-pocket cost that accumulates towards the new threshold will be the lower of either:

- the fee charged, less the MBS rebate; or
- 150 per cent of the MBS fee, less the MBS rebate.

Similarly, once the thresholds are reached, the amount of benefit will be less than the current arrangements. The benefit is calculated in the same way as the accumulation. The below example illustrates how both the accumulation and benefit amounts will be calculated using an initial specialist consultation (MBS item 104).

Because the accumulation cap is lower than the out-of-pocket cost, the accumulation amount allowed is $55.58, whereas the safety net benefit amount is 80 per cent of the out-of-pocket cost ($53.80), as it is lower than the benefit cap.

The current safety net arrangements, particularly the EMSN, were introduced just over a decade ago as a result of Medicare rebates no longer reflecting the true cost of providing medical care.

The AMA does not support the proposed changes to the safety net arrangements. In the past three years, we have had a range of Government attempts to reduce health expenditure. While the various GP co-payment proposals have been withdrawn, the MBS indexation freeze continues. The fate of the Medicare Safety Net changes rests with the Parliament. All these measures represent the Government winding back its financial assistance to patients for their health care costs.

The new Medicare Safety Net will reduce the affordability of, and therefore patient access to, medical services for the sickest people in our community. It will affect people who need mental health treatments that are not available in the public sector, and those who have cancer treatment provided in the community.

With higher out-of-pocket costs, patients will delay seeking treatment, or not seek treatment at all. I encourage members to work with their specialty organisations to calculate and explain to Members of Parliament how the safety net changes, if passed, will impact on their patients. I also welcome your examples, which will enable me to advocate against the changes.

A	B	C	D	E	F
Counting the amount towards the new threshold to reach the Medicare Safety Net					
Doctor's Fee	MBS Fee	85% MBS Rebate	Out-of-Pocket Cost (Dr's fee less 85% MBS rebate)	Accumulation Cap (150% of MBS fee less 85% MBS rebate)	Accumulation Amount (i.e. E is lower than D)
$140.00	$85.55	$72.75	$67.25	$55.58	$55.58
Calculating the Medicare Safety Net Benefit amount					
Doctor's Fee	MBS Fee	85% MBS Rebate	80% of Out-of-Pocket Cost (Dr's fee less 85% MBS rebate)	Safety Net Benefit Cap (150% of MBS fee less 85% MBS rebate)	Safety Net Benefit Amount (i.e. D is lower than E)
$140.00	$85.55	$72.75	$53.80	$55.60*	$53.80

Bashing the bonded prematurely - and Medibank Private malevolence

BY DR DAVID RIVETT, CHAIR, AMA RURAL MEDICAL COMMITTEE

Following the release of Senate Estimates data showing that, of 6,295 bonded students, 37 are completing their return of service and 307 have withdrawn, derisive comments have flowed about the intentions of bonded students to go rural.

However on further questioning by the AMA, however, the Department has revealed: *"A total of 326 participants withdrew from the BMP scheme in the period from its inception in 2004 to June 2015. This includes 305 participants who left the Scheme before completing their medical degrees at university."*

So, if we put these non-graduates aside, we have a very small number of withdrawals.

Can the Scheme be described as a huge failure? No. And to be fair in assessing it, we need more data. Why did the 305 undergraduates leave their campuses? Was it rural kids stressed financially at urban-centric training? Was it undergraduates admitted to medicine on the basis of a commitment to go rural, but intellectually challenged by a medical degree? Was it the appalling lack of respect for medical practice shown by the current Government? Or was it just a reflection of a normal drop-out rate from medical degree courses? We simply do not know. An exit survey and more data on medical school dropout rates would help put the situation in context.

Sadly, following the release of the Senate Estimates figures, the Coalition ditched the Bonded Scholars Support Scheme, a high quality program instrumental in ensuring top quality rural doctors come out of the pipeline. ACRRM has stated it will try to continue providing support, but it is a small College and will struggle without the now withdrawn Government spend on this initiative. These had been dollars well spent, I am told by many BMP students. And the Scheme had given them a feeling of collegiality and support beyond its educative worth.

Currently, I am in Hobart getting training as a supervisor of registrars. On picking up *The Mercury,* I read *"Medibank is asking private hospitals to sign a new contract where it refuses to pay for nearly 200 events, including death during childbirth, suicide in a hospital, or when a person falls in hospital and breaks a bone."*

What is the world coming to? Has profit become the overriding mantra of our society, leaving common decency and caring to perish in the wilderness? I could say more but not in a non-libellous manner. Thankfully, the AMA President and Federal Council are more than a little annoyed by such a crass drive for profits above caring for people, and will fight vigorously to restore decency in health insurance.

The stick, the carrot, and rural medicine

BY DR DANIKA THIEMT, CHAIR, DOCTORS IN TRAINING COMMITTEE

We have a beautiful country. We have beaches, wildlife, and wonders of the world at our back door. To top it all off, we have access to some of the best health care in the world. We are the lucky country. Mostly.

Some of the most beautiful parts of Australia are the ones with the worst access to health care. While the residents of inner city Sydney gaze out over the harbour, those living only hours away are desperate for General Practitioners to care for their children. As the residents of Perth worry about the rumour of a cloudy day, outback Western Australia is desperate for staff to run their Emergency Departments. In a land as lucky as ours, our rural and remote communities are still desperate for doctors, and we seem no closer to a solution.

> "Packing up and going to work in the country is simply not that easy in the world of vocational training"

In recent months, rural and remote medicine has been at the forefront of AMA advocacy. With changes to the medical rural bonded program, we have been lobbying the Government for ongoing support and a match of the new 12 month return of service obligation (RoS) for all bonded students and doctors. AMACDT have taken our Regional Training Network Position Statement to Health Ministers, calling for support for vocational training in rural and remote Australia. As I type this, I am en route to a Department of Health meeting to discuss how health scholarships are best used to attract an enthusiastic and robust rural workforce.

As a firm believer in 'having it all', I've been thinking long and hard about how doctors in training can impact rural and remote medicine whilse also maintaining quality teaching and training. As the doctors of tomorrow, this issue will affect us. It will affect our families, our patients, and the health system we all work in. Packing up and going to work in the country is simply not that easy in the world of vocational training, yet doctors in training need to be a part of the solution and, in the meantime, a part of the discussion. How do we ensure that all Australians have access to world-class health care? How do we open up rural and remote training and allow our vocational trainees to be a part of the solution?

The carrot and the stick

Current rural workforce initiatives can be crudely simplified into carrots or sticks, and studies after studies have shown that doctors in training are all about the carrot. A positive rural encounter, financial incentives, and rural vocational training experiences are all examples of how DiTs become engaged in rural medicine. More importantly, they are examples of how doctors come to remain in rural areas and become a part of the rural workforce.

Recent budget announcements have seen the abolition of the Medical Rural Bonded Scholarship and the HECS Reimbursement Scheme, two such 'carrots' targeting doctors in training. Sadly, there has been no compensation provided for the loss of these schemes intended specifically to increase the presence of rural and remote medical practitioners. While carrots are seen as favourable, they do not always amount to an increased rural workforce. Financial incentives need to be coupled with supportive environments, positive rural experiences, and the opportunity to train outside of metropolitan Australia.

The 'stick' measures are a little more controversial. Bonded medical places (BMP) have been a staple of medical school places since 2004. With 25 per cent of all CSP places allocated to bonded places, there are now 6,225 students and doctors attached to a RoS obligation of up to six years. This program was to be the cure to all problems, forcing Australian doctors to spend time in 'areas of need' in return for their place in medical school. Predictably, participants have subsequently reported a lack of positive connection with rural Australia and often demonstrate an unwillingness to participate in rural life. After a decade of investment by the Federal Government, fewer than 40 BMP recipients (less than one per cent) have commenced their return of service obligation. With the announcement of the 2015 budget that RoS obligations have been reduced to 12 months for all new participants, it seems that the stick is getting shorter, but we now seek to secure this for all bonded participants. Is a disinterested and unengaged rural workforce really the ultimate aim, or does this approach need to be reconsidered?

The stick, the carrot and rural medicine

... from p25

A whole new world

When you really think about it, should this conversation be about carrots and sticks, or should it be about changing the donkey all together? Without an innovative whole of profession approach, the distribution issue is unlikely to be solved. Do we forge on with carrots and sticks and hope that the increasing workforce is forced to reshuffle, or do we engage our profession and start to think innovatively?

Whatever the solution might be, we know that is needs to be flexible. It needs to be easy to enter, and there needs to be an option for graceful exit. There needs to be access to appropriate supervision and training, and we need to enable the rural workforce to accommodate vocational trainees. We know that financial incentives work, but these should be coupled with adequately resourced and supported workplaces. Doctors should not be forced to practise rural medicine, but should be attracted to all the benefits a rural experience has to offer.

Rural medicine is not a punishment. It is not a place to force on specialists who have established lives in urban Australia. It is a unique and valuable experience all on its own, and we need to ensure that those who choose this experience are not at a disadvantage.

I can't give you a solution, but I can confiscate the stick and the carrot and encourage you to think about what rural medicine can and should be. This is where our solution lies.

Ridding medicine of inequities

BY NICKY BETTS, MEDICAL STUDENT, UNIVERSITY OF WESTERN SYDNEY

I have been delighted to be involved with Out for Australia, an organisation working for young LGBTIQ professionals to feel comfortable in the workplace. The opportunity has provided myself, a medical student, a tentative step into the corporate world due to the commerce, economics and law grounding of the organisation. I have attended LGBTIQ events generously sponsored by companies such as Westpac, Goldman Sachs, and NAB, through which I have experienced the aggressive push for corporate diversity firsthand.

These companies promote diversity in recruitment, and have LGBTIQ networks to embrace and support their employees. Beyond the Australian Lesbian Medical Association (ALMA), it is difficult to identify these groups or recruitment practices in health care. Does medicine as a profession, and its employers, not see the value in actively encouraging and facilitating the diversity that the corporate world does?

Metrics such as the Australian Workplace Equality Index have encouraged corporates to do what they do best – reach the top. PricewaterhouseCoopers, a leader of the Index, prides itself on initiatives including facilitating transitioning in the workplace and promoting gender-neutral information with clients.

Diversity makes business sense, with research showing that a 1 per cent increase in gender diversity correlates with a 3 per cent gain in revenue. The same increase in racial diversity shows a 9 per cent gain. Benefits extend to improved reputation and innovation. Diversity within these companies does not arrive passively – to reap the benefits, concerted effort is made.

In contrast, diversity is not publicly prioritised in health services. There are certainly resource differences between the private and public sector, but promoting and supporting diversity and networks does not have to be costly. Leadership and prioritisation is required.

For minority employees, promoting diversity in the workplace is important. Many individuals stay in the closet at work due to fears of discrimination. Media attention has highlighted that medicine can be a difficult field for minorities in craft groups. It is therefore not a stretch to consider the trepidation that exists for LGBTIQ individuals. The Australian Psychological Society recently presented research noting that “informal” discrimination regarding LGBTIQ individuals, including jokes or exclusion, remains prevalent in the workplace despite improvements in legal rights and societal opinions.

This is particularly important when LGBTIQ individuals experience higher rates of mental health issues than the general population. Promotion and facilitation of diversity is key for employees to feel happy and safe to be themselves. Individuals feel more confident, motivated, and are more productive when they are in an environment accepting of their sexuality.

Most importantly, diversity in medicine affects our patients. Healthcare inequities exist among minority groups, including LGBTIQ individuals. Having a diverse spread of healthcare professionals can improve healthcare outcomes. Promotion of diversity in health care may lead to improvements in quality & culturally competent care for minorities, shift culturally homogenous health research practices to more broadly reflect the population, and provide a diverse leadership base to push further inclusion of minority groups in the health care profession and agenda.

It is also a matter of safety in understanding. I have experienced this personally in the form of a procedurally routine pregnancy test intentionally skipped after noting I had dated women in casual conversation. Any sexual and reproductive history was overlooked, which could have (theoretically) provided reason to administer the test. A shift towards a more diverse workplace is key for equitable and safer health care through greater understanding.

There is a need for structural support and strategies for diversity. In business, to be effective in diversity, CEOs must encourage it in their day-to-day practice and make it a priority of the company at all levels. In medicine, all levels, including student leaders, universities, CMOs, and hospital CEOs, must actively promote and support diversity if we are to see our workforce reflect the world around us.

Diversity is valuable to doctors, patients, and employers in the medical workforce. Through promotion and support of diversity through communities and recruitment practices, we can see change we are looking for in terms of more equitable health care for all.

Productivity Commission Review of the Workplace Relations Framework

BY DR ROD McRAE, CHAIR, AMA COUNCIL OF SALARIED DOCTORS

You will no doubt be aware that the Productivity Commission has recently released its draft report reviewing the current workplace relations framework in Australia. As salaried employees, this is of interest to us all, even if there was nothing in the report specifically targeting doctors.

The Commission found that Australia's labour market performance and flexibility is relatively good by global standards, but that several deficiencies need to be addressed.

The Commission stressed that changes to the Federal workplace policy were about repairing faults in the existing system, rather than replacing it. This is a good start but, as with any 'review', it needs to proceed with caution and not allow any self-interested group to dominate the outcome and sweep away decades of hard-won conditions.

Of concern is a proposed cut to Sunday penalty rates in some industries. However, the Commission specifically pointed out that the rate cuts would not include employees in emergency services, such as paramedics and nurses. This is a welcome observation, as those support staff in the hospital and health system are vital to the work of doctors in public hospitals. Any erosion of their conditions is likely to impact on morale and staffing. Those of us who work in public hospitals are well acquainted with unsociable hours. The removal of any incentive to work those hours is likely to have a significant impact on patient care. Let us hope that does not become a concern in the future.

However, the major concern for us in the Report is the Commission's view that a possible new type of agreement that spans individual and enterprise agreements – the 'enterprise contract', – should replace the current system, which is aimed at promoting collective bargaining. The report states that it would 'allow for greater opportunities for individual bargaining arrangements' and it would 'effectively amount to a collective individual flexibility arrangement'.

This would permit employers to vary an award for entire classes of employees, or for a group of particular employees, without having to negotiate with each party individually or to form an enterprise agreement. Effectively, it enables an employer to make individual agreements across entire classes of employees. While it may sound attractive, these changes would be profound and could impact severely on the current collective bargaining culture protecting salaried employees.

If it sounds familiar, that's because you are probably remembering the Queensland SMO contracts debacle. The move away from collective bargaining, whatever name you give it, leads to chaos, reduced pay and conditions, and a heavy-handed approach to negotiations on the part of the employer.

Also of concern is draft recommendation 16.2, which states that the Australian Government should amend the Fair Work Act 2009 to introduce a new 'no-disadvantage test' (NDT) to replace the 'better off overall test' (BOOT) for assessment of individual flexibility arrangements. Again, the effects of this change in wording could be profound.

The BOOT allows for enterprise agreements that do not meet certain minimums, as long as the employee receives an offset that means they are better off overall. It is an important broad analysis of a proposed enterprise agreement from the employee's perspective .

The Commission's proposed NDT may sound similar, even a mere semantic step from the BOOT, but there is no information yet as to what that test would look like, or what it would consider. If a change is recommended, it is usually for a reason, and the Commission's report does not provide much detail on it, other than to describe it as 'holistic' and a 'straightforward remedy'. More information is needed on this.

As salaried doctors, most of us are subject to enterprise agreements of some type. This provides us with a degree of certainty about our salary and conditions and the important strength of collective bargaining. Having to fight for basic conditions is time and effort wasted, which could be expended on patient care.

The Commission's report includes other areas of concern as well. No doubt some of its recommendations will be well received, and they are just recommendations at the moment. But we need to ensure that collective bargaining, which is spearheaded by ASMOF, remains a well-protected right.

It is likely that some of the recommendations will become election issues in 2016, with the Government and the unions facing off over them. I encourage you to look at the report and related information (available at: http://www.pc.gov.au/inquiries/current/workplace-relations) and remain vigilant about its processes and outcomes.

AMA Fees List and Federation health reform options

BY AMA PRESIDENT PROFESSOR BRIAN OWLER

Among its responsibilities, the Health Financing and Economics Committee (HFE) is tasked by Federal Council to develop policy and make recommendations on healthcare financing and funding arrangements, the delivery and structure of health care, and the management of the AMA List of Medical Services and Fees (AMA List).

> "As part of an increasing trend to including restrictions on MBS items, the Department of Health is introducing contraindications for where particular MBS items cannot be used"

At its meeting on 23 July 2015, HFE considered what should be the AMA's policy in relation to Government caveats and restrictions on MBS items and the AMA List.

As part of an increasing trend to include restrictions on MBS items, the Department of Health is introducing contraindications for where particular MBS items cannot be used. What is particularly concerning is that the Department has introduced these caveats without any formal assessment process, such as the Medical Services Advisory Committee (MSAC).

HFE considered whether the AMA List should simply contain a description of the medical service and not include any clinical indications or contraindications in the item descriptors where they have not been formally evaluated.

On HFE's recommendation, Federal Council agreed on 22 August 2015 to amend the AMA's existing policy resolution on where the AMA List does not need to align with the MBS to also cover this situation. This means the AMA List will not include clinical indications or contraindications on medical items that have not been identified by a formal assessment process.

In relation to the Reform of the Federation process, HFE drew on its previous discussions of health financing and public hospital funding issues in assessing the health reform options put forward in the Government's discussion paper (released 23 June 2015).

The rationale for these options includes the false perception that health expenditure is unsustainable, or even out of control. In fact, the Government's own figures for health expenditure establish there is no crisis. In the 2014-15 Commonwealth Budget, health was 16.13 per cent of total Commonwealth Budget funding, down from 18.09 per cent in 2006-07. It reduced further in the 2015-16 Budget, representing only 15.97 per cent of the total Commonwealth Budget.

HFE found the five reform options in the discussion paper were barely sketched out and largely uninspiring. They range from the States and Territories being fully responsible for public hospitals to the Commonwealth establishing a health purchasing agency.

HFE agreed that governments should be requested to develop improved health reform options in collaboration with the AMA and other health stakeholders.

These should start with recognition of the need for sufficient resources for the health system, the role of the private sector in providing healthcare services, and the need for coordination and cooperation across governments. Federal Council passed a resolution to this effect on 22 August 2015.

Two other matters considered at HFE's July meeting will require further discussion and development before proposals are put to Federal Council. This includes the use of health outcomes information, and what makes outcomes valid for measuring and reporting in context. Possible publication of average fees charged for Medicare items also needs careful consideration, including working through samples of actual MBS data.

Opinion: Collaboration is fundamental to improving patient care

BY PETER ARONEY, CEO, DOCTORS' HEALTH FUND

> "The implication that adverse events are always due to inadequate safety and quality measures is both flawed and dangerous"

What is so frustrating to me about the current media storm around the safety and quality of health care is that the debate has been side-tracked by partisan positioning, leaving the real question unanswered.

Undeniably, the safety and quality of health care is an important issue, but we should not allow a unilateral portrayal of adverse events to dominate the important discussion of healthcare funding.

Health care is complex and the cause and effect of adverse events are often subtle. The implication that adverse events are always due to inadequate safety and quality measures is both flawed and dangerous – particularly if tied to a kind of punitive approach to funding.

The Australian Commission on Safety and Quality in Health Care and the Independent Hospital Pricing Authority combined review of international funding models found no material impact on outcomes when safety and quality measures were incorporated into hospital funding. Additionally, it warned that these conditions, acquired during hospitalisation, could not necessarily have been prevented and do not imply that care was suboptimal.

Therefore, for me the real question that insurers, doctors, patients, hospitals, and regulators need to be asking is: how can all parties best collaborate to optimise patient health outcomes whilse maintaining the affordability of health care?

At Doctors' Health Fund, part of a mutual medical indemnity insurer, we have a unique perspective and that makes us carefully consider our role.

Our experience suggests private health insurers have a wealth of information that could provide useful insights into the efficacy, cost, and utility of health care. When used in healthcare planning this would mean more informed decisions about, and support for, efficacious and affordable health care.

We believe in an effective healthcare system that leverages its information to support better health outcomes, and is adaptable to the unique complexities of each patient.

To secure this effective healthcare system, we must heed the cautionary warning of the current dispute; progress without open and honest collaboration with all parties is destined to fail.

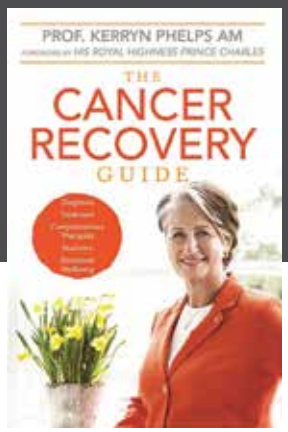
The way forward is for all parties to come together and work towards the continued funding of proven, evidence-based, best-practice health care that measures and supports positive long-term outcomes for patients.

As only one voice, in a conversation of hundreds, we do not know the answer, but we do know sidelining parties from this conversation is not an option. We are concerned by moves towards a more adversarial approach.

We strongly believe our role, as an insurer, is to support the pivotal role of doctors in health care and help facilitate the discussion required to fund an effective healthcare system.

I am looking forward to the recommendations from Dr Hambleton's Primary Health Care Advisory Group regarding the collaborative approach to innovative care and funding models for improved patient outcomes.

At Doctors' Health Fund, we will continue to use our resources to advocate on behalf of patients and doctors. We support our members, as both providers and patients, in their freedom to choose their healthcare provider, and we continue to promote a collaborative approach to funding.



The Cancer Recovery Guide

by Prof. Kerryn Phelps AM

2015, Pan Macmillan Australia
ISBN 9781743535677, 544 pages

REVIEWED BY **DR PETER THOMAS**

Does not disease rule our existence?, Thoreau asked in 1851. In the medically unenlightened days of the mid nineteenth century, he may well have been right. In the early twenty-first century, with medical wonders now freely available yet unimagined then, is the answer still in the affirmative? It probably is, as a diagnosis of cancer is usually life altering and imparts a "nameless dread" in the quietly desperate man, as the author of this book suggests. Along with dementia, cancer is the existential fear of humankind. Of course, once the early threat to physical wellbeing has passed, a degree of normalcy in life may be achieved. Helping to attain and maintain this welcome state for as long as possible is the purpose of this book.

The tools and techniques to achieve this are many, undreamt of in Thoreau's time, and some unimagined as recently as twenty years ago. They cover conventional and complementary medicine, oriental medicine and philosophy, psychology, psychiatry, reliance on faith, and many more. Naturally, some are controversial. All are explored in varying degrees of detail in this book.

The book is offered in six parts that follow the journey of a patient with cancer, from diagnosis through emotional confusion and changed expectations, specific treatments and their side effects, adjunctive therapies, and lifestyle changes. A seventh part explores the commoner cancers. The chapters are strong, and are written by an expert who displays genuine empathy and understanding. However, some detail is too precise in some sections to appeal to many readers, especially lay; e.g. "acetyl-L-carnitine should be avoided with taxane chemotherapy".

The section on adjunctive therapies, with divisive topics such as high dose intravenous vitamin C, and botanical agents with strange names and claims, is detailed and will stir a variety of emotions in the breast of medical readers depending on their age and attitude; acceptance, wry amusement, and rejection would not be unexpected. The author acknowledges this, but (correctly) feels the book would be incomplete if the contentious stuff was left out.

There are extensive references but there are many unattributed claims for herbal, mineral and vitamin efficacy based on empirical observations, and some are confusing. For example, what should the worried cancer patient make of bald comments such as; "avoid excessive B vitamins as they can cause jitteriness that exacerbates anxiety. Calcium and magnesium work together and can help with anxiety". Also, some minutia on the need for extra-soft toothbrushes and avoidance of toothpicks in certain instances might be considered overreach, but this level of detail probably does assist the patient who may not be capable of gaining such insights intuitively.

Parade-ground commands such as "Stop smoking. Right now. Avoid all tobacco products. Forever." are fine in context but the methods to achieve this end are scattered through the book. Such fragmentation is not uncommon and is acknowledged by the author, but it does prevent an easy flow to the reading.

The author warns against the dangers of self-prescribing but an anxious (desperate) patient, on the advice offered here, will be tempted to self- medicate; after all, there are more suburban herbal remedy and health shops than there are integrative medicine clinics.

Despite such caveats, Professor Phelps is to be commended for her timely and welcome work. The cancer mainstream is changing rapidly, and later editions will surely reflect this.

Canadian doctors unwilling to aid in assisted dying

Earlier this year, the Supreme Court of Canada struck down laws banning physician-assisted suicide for patients with "grievous and irremediable" medical conditions. Despite the change, a new survey indicated only 29 per cent of Canadian physicians would be willing to assist a gravely ill patient who wants to end their life.

The poll conducted by the Canadian Medical Association (CMA) found that 63 per cent of doctors wanted no part in assisted dying, while a further eight per cent remained unsure.

In August 2014, the CMA altered its long-established opposition to doctors' assisting in suicides. Its new policy allows physicians, within the bounds of laws, "to follow their conscience when deciding whether to provide medical aid in dying."

President of the CMA Dr Chris Simpson said the challenge is to create rules and regulations that ensure patients have access to the end-of-life care they want, up to and including hastened death, while ensuring the autonomy of doctors and not forcing them to engage in care that clashes with their religious and moral beliefs.

The CMA is developing its position on the complex and emotionally charged issue of physician-assisted death. At a recent meeting, CMA's General Council debated whether physicians who oppose assisted death have a legal and professional obligation to refer patients to someone who is willing to provide the service.

More than 75 per cent of delegates agreed that physicians should provide information to patients on all end-of-life options available to them, but should not be obliged to refer.

Practically, most assisted deaths will be carried out by general practitioners who were the most open to the idea. In a smaller poll, of the 372 GPs questioned, 65 per cent said they would be willing to provide an assisted death if there were clear rules.

The Canadian Federal Court gave Federal lawmakers a year to come up with new legislation after it said it was unconstitutional to deny gravely ill patients a choice in how they die. The current Government has stalled on the development of new legislation so it is likely that, from February 7 next year, assisted dying will become legal in Canada.

Vice President of the CMA Jeff Blackmer said the Court's deadline puts a lot of pressure of physicians. He said it will be essential to provide training and information to physicians so they can have informed discussions with patients, and also so they have the technical skills to perform an assisted death if they so choose. Dr Blackmer said, come February 7, he's not sure they will be ready to help people with assisted death.

KIRSTY WATERFORD

INFORMATION FOR MEMBERS

REMEMBER TO RENEW YOUR MEDICAL REGISTRATION BY 30 SEPTEMBER

Registration renewal for medical practitioners with general, specialist and non-practising registration is due by 30 September 2015. Renewal applications received during October will incur a late payment fee.

The registration fee of $724 covers the registration period for most practitioners from 1 October 2015 to 30 September 2016.

Westlake Vineyards – the North Rides Again

BY DR MICHAEL RYAN

Passionate enthusiastic winemakers keep my interest in wine reviewing as Australian markets continue to be homogenised by the big players. It's comforting to know that a product can be consistent from year to year, but it becomes an epiphany when the winemaker conjures up a wine that Bacchus would be smitten by.

Darren Westlake and his wife Suzie Kalleaske share the common philosophy of letting the vineyard and the vintage express themselves. The Kalleske name resonates amongst six generations of winemaking in the Barossa. Darren is proud of his convict heritage, as it personifies the adage of" having a go" in the face of adversity. Darren is a fitter and turner by trade, and worked for Grant Burge as a cellar hand and assistant winemaker. He often welded the odd pipe together.

The Westlake vineyards began being planted in 1999, and are the most northern vineyards of the Barossa region. The Jaeneshes Block, lightly covered in red clay and quartz soils, is in the Moppa sub region, and the Higgins Block, thicker red clay, is in Koonunga. The clay ensures that the vine only absorbs water slowly and results in more controlled berry ripening with acids, sugars, and flavours being enhanced.

Picking is done with optimal flavor and structure in mind. Whilst the Barossa fruit-driven and high alcoholic wines have their place, the most respected wines always have an element of finesse, class and structure. Westlake wines epitomise this and there is truth in Darren's analogy to creating wines akin to the philosophy of Pinot Noir:" An iron fist in a velvet glove."

WINES TASTED

1. 2012 Westlake Elezear Barossa Shiraz

The Eleazar patch is 15 acres of prime producing land in the Jaensches Block. The warm 2012 vintage was responsible for massive Barossa Shiraz. Darren and Suzie consciously picked early, putting faith in the structure of the wine. The colour is inky dark purple. The nose exudes prunes and dates balanced with licorice and herbal notes. Some black olive notes add to this heady mix. The palate is well weighted with fine tannins aided by maturation in American and French oak. A complex yet elegant wine that will be around for kids' 21sts.

2. 2012 Westlake Albert's Block Barossa Shiraz

This is fruit from the remainder of the Jaensches block. Deep purple colour with a bouquet of red currants, violets, and herbal notes. A slightly leaner wine compared to the Eleazar, but still exuding quality fruit and structure.

3. 2013 Westlake Eleazar Barossa Shiraz

2013 was a slightly cooler vintage allowing the balance of fruit and acid and tannins to develop harmoniously. Deep purple colour. The nose exudes dates and damson plums. Brambly herbal notes with hints of aniseed and tobacco fill out the bouquet. Elegant balance of a voluptuous palate and fine grained tannins. This could be a gold medal winner.

4. 2013 Westlake Albert's block Barossa Shiraz

Purple in colour. Slightly restrained aromas of prunes red currants with vanillin oak nuances. A building palate enhanced by tannins and acid that results in a lip smacking wine. All the better for an hour in the decanter.

King of the Mountain – 2015 Bathurst 1000

BY DR CLIVE FRASER

October is the time of year for some great sporting events.

There are grand finals in the NRL and the AFL, but for those who prefer motorised competition, there is also the Supercheap Auto Bathurst 1000 on Sunday October 11th.

As 2016 will see the end of Australian automotive manufacturing, it will be interesting to see how the religious fundamentalism that exists amongst the supporters of Ford and Holden plays out over the next few years.

But I think the Bathurst race has enough momentum to go on long after the demise of locally produced cars.

As this year's race approached, I thought I'd take the 200 kilometre pilgrimage from Sydney to the Bathurst motoring Mecca.

The biblical analogies are everywhere with visitors approaching Bathurst on The Great Western Highway from the east directed to the Mount as you approach the town – Mount Panorama, that is.

A left turn at William Street takes you straight past the Charles Sturt University on to Murray's Corner and Pit Straight.

At that point, you are actually on the real Bathurst race track.

My instructions were to only tackle the track in an anti-clockwise direction.

That was good advice because even though it is a two-way suburban road no one seems to go the other way around.

Even the large number of pedestrians out for a stroll on a Sunday afternoon all seemed to be only going one way.

Besides, I'd studiously watched every race from beginning to end for decades and I must have watched thousands of laps by now, all anti-clockwise.

Recently re-surfaced, the bitumen is in beautiful condition and I didn't see a lot of burnt rubber on the road, unlike many secluded streets near my house where hoons practise their burn-outs.

Sixty km/h is absolutely the speed limit for the next 6.2 kilometres as the track wanders past houses, sporting clubs, and even a vineyard.

For years, my only view of the track has been straight ahead at anything up to 300 km/h, so it was a real change to see normal suburban houses on either side.

And whilst I was tackling the track in a Korean hire car, there was no shortage of Mustangs, Commodores, and V8 utes in hot pursuit.

I couldn't help smiling as I headed up Mountain Straight behind an old Escort panel van as I watched the driver ahead of me swerve from side to side as he warmed up his tyres on the track.

Driver etiquette obliges you not to ever overtake anyone on your Sunday circuit, lest the pedal goes to the metal and an impromptu race begins.

As of 2014, the V8 Supercar Bathurst lap record is set at 2.07.4812 achieved by Paul Dumbrell in a VE Commodore, eight seconds faster than the fastest ever lap by a motorcycle.

A Formula One vehicle did circuit the track in 1.48.88 in 2011, but no "car" of any description has ever come around the track in under two minutes.

To do so would see an average speed of 186 km/h on the straights and around the 23 bends.

My lap time was a shade under 15 minutes with plenty of time to stop and take a few photos.

Real estate fronting the track seemed quite affordable with a house on an acre worth about $600,000.

Mount Panorama, Bathurst – it seemed like a nice neighbourhood.

Maybe I might even move there!

Safe motoring,

Doctor Clive Fraser
doctorclivefraser@hotmail.com

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