AUSTRALIAN
Medicine
The national news publication of the Australian Medical Association

Staring into the abyss

Public hospitals at 'crisis point', AMA warns, p3

INSIDE

ISSUE 28.00A - FEBRUARY 3 2016

AMA

AUSTRALIAN
Medicine

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

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

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

AMA LEADERSHIP TEAM

President
Associate Professor
Brian Owler

Vice President
Dr Stephen Parnis

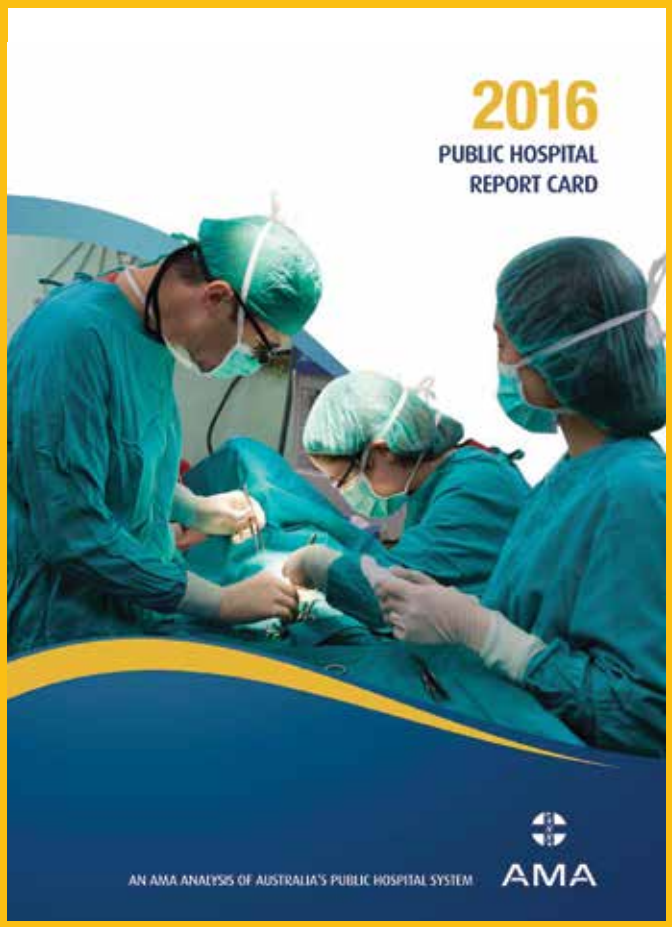
In this issue

National news

Health on the hill

World News

Hospitals struggle as Govt applies funding brakes



"The states and territories are facing a public hospital funding black hole from 2017 when growth in Federal funding slows to a trickle." – *Brian Owler*

Almost a third of Emergency Department patients in need of urgent treatment are being forced to wait more than 30 minutes to be seen, while thousands of others face months-long delays for elective surgery as under-resourced public hospitals struggle to cope with increasing demand.

The AMA's latest snapshot of the health of the nation's public hospital system shows that improvements in performance have stalled following a sharp slowdown in Federal Government funding, underlining doctor concerns that patients are paying a high price for Budget austerity.

"By any measure, we have reached a crisis point in public hospital funding," AMA President Professor Brian Owler said. "The states and territories are facing a public hospital funding black hole from 2017 when growth in Federal funding slows to a trickle."

The Federal Government will have slashed $454 million from hospital funding by 2017-18, and a downshift in the indexation of spending from mid-2018 will reduce its contribution by a further $57 billion by 2024-25.

Professor Owler said the consequences of Commonwealth cutbacks were already showing up in hospital performance, and the steep slowdown in funding growth in coming years will further exacerbate the situation.

"Public hospital funding is about to become the single biggest challenge facing State and Territory finances, and the dire consequences are already starting to show," the AMA President said. "Without sufficient funding to increase capacity, public hospitals will never meet the targets set by governments, and patients will wait longer for treatment."

The AMA's Report Card, drawing on information from the Australian Institute of Health and Welfare, the Council of Australian Governments Reform Council and Treasury, shows the performance of public hospitals against several key indicators has plateaued and, by some measures, is declining.

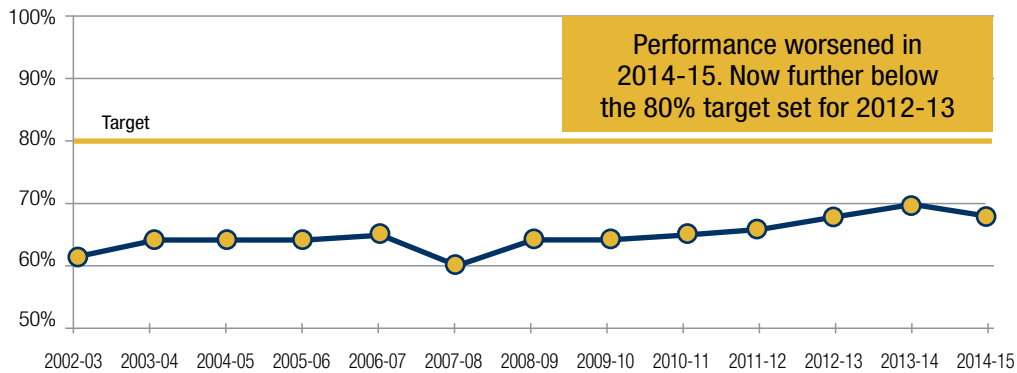
In terms of hospital capacity, the long-term trend toward fewer beds per capita is continuing. The decline is even more marked when measured in terms of the number of beds for every 1000 people aged 65 years of older – a fast growing age group with the highest demand for hospital services.

Continued on 4 ...

Hospitals struggle as Govt applies funding brakes

... from p3

Percentage of Triage Category 3 (urgent) Emergency Department patients seen within recommended time (<30 minutes) – Australia



Sources: The State of our Public Hospitals (DoHA, 2004 – 2010); AIHW Australian Hospital Statistics: Emergency department care (2010-11 – 2014-15)

In 1993, there were almost 30 beds for every 1000 older people, but by 2013-14 that had virtually halved to around 17 beds.

Alongside a relative decline in capacity, there are signs the hospitals are struggling under the pressure of growing demand.

In emergency departments, often seen as the coalface of hospital care, the proportion of urgent Category 3 patients seen within the clinically recommended 30 minutes fell back to 68 per cent in 2014-15 – a two percentage point decline from the previous year, and a result that ended four years of unbroken improvement (see graph above).

The national goal that 80 per cent of all ED patients are seen within clinically recommended times appears increasingly unlikely, as does the COAG target that 90 per cent of all ED patients be admitted, referred or discharged within four hours. For the last two years, the ratio has been stuck at 73 per cent.

The outlook for patients needing elective surgery is similarly discouraging.

The AMA report found that, although there was slight reduction in waiting times for elective surgery in 2014-15, patients still faced a median delay of 35 days, compared with 29 days a decade earlier.

It appears very unlikely the goal that by 2016 all elective surgery patients be treated within clinically recommended times will be achieved. Less than 80 per cent of Category 2 elective surgery patients were admitted within 90 days in 2014-15 – a figure that has barely budged in 12 years.

The Commonwealth argues it has had to wind back hospital spending because of unsustainable growth in the health budget.

But Professor Owler said the evidence showed the opposite was the case.

The Government's own Budget Papers show total health expenditure grew 1.1 per cent in 2012-13 and 3.1 per cent the following year – well below long-term average annual growth of 5 per cent.

Furthermore, health is claiming a shrinking share of the total Budget. In 2015-16, it accounted for less than 16 per cent of the Budget, down from more than 18 per cent a decade ago.

"Clearly, total health spending is not out of control," Professor Owler said, and criticised what he described as a retreat by the Commonwealth Government from its responsibility for public hospital funding.

"There is no greater role for governments than protecting the health of the population," he said. "Public hospitals are the foundation of our health care system. Public hospital funding and improving hospital performance must be a priority for all governments."

The issue of hospital funding is set to loom large when the nation's leaders meet in March to discuss reform of the Federation.

Already, several premiers are pushing for an overhaul of taxation arrangements to provide the states with a better growth revenue stream than the Goods and Services Tax.

NSW Premier Mike Baird and South Australian Premier Jay Weatherill have proposed an increase in the GST with revenue raised used to help compensate low income families, cut direct taxes and increase health funding.

ADRIAN ROLLINS

Patients face $100 x-rays

The Federal Government is coming under pressure over concerns its cuts to bulk billing incentives will leave patients needing x-rays, ultrasounds, MRIs and other diagnostic imaging services hundreds of dollars out-of-pocket.

Estimates by the Australian Diagnostic Imaging Association (ADIA) suggest general patients who are currently bulk billed will face significant up-front costs, from up to $101 for an x-ray to as much as $532 for an MRI, if the Government's plan to wind back bulk billing incentives for diagnostic imaging and axe them for pathology services is approved.

When the changes were unveiled in the Mid-Year Economic and Fiscal Outlook in December, AMA President Professor Brian Owler condemned them as "a co-payment by stealth".

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

His concerns have been borne out by the ADIA's analysis, which shows the Medicare rebate for an x-ray will be cut by $6 under the changes, while the rebate for an ultrasound will be $12 less, that for a CT scan will be $34 lower, $43 less for a nuclear medicine service, and $62 less for an MRI.

The Association said the effect of these cuts would be amplified by the fact that, under Medicare, patients have to pay the full cost of the service upfront before being able to claim the rebate.

In practice, this will mean that a general patient having an x-ray will be required to pay between $54 and $101 before being able to claim their Medicare rebate.

Patients requiring an MRI will face the biggest upfront charge, ranging from $422 to $532.

Even after receiving their rebate, patients will still be left out-of-pocket. The ADIA calculates that, for an x-ray, patients will ultimately lose between $6 and $56, while those needing an MRI will take a financial hit of between $62 and $173.

Continued on p6 ...

Patients face $100 x-rays

... from p5

General patient diagnostic imaging expenses as a result of bulk billing incentive cuts

	X-ray	Ultrasound	CT scan	Nuclear Medicine	MRI
Rebate cut	$6	$12	$34	$43	$62
Upfront costs	$54-101	$117-206	$323-434	$407-463	$422-532
Out-of-pocket costs	$6-56	$12-101	$34-145	$43-99	$62-173

Source: Australian Diagnostic Imaging Association

ADIA President Dr Christian Wriedt said the changes were introduced without consultation and, by potentially deterring people from seeking early diagnosis and treatment, represented "bad policy".

"This will make it much more difficult for many patients to receive the life-saving level of care they need," Dr Wriedt said. "We are talking about services that are absolutely essential to diagnosing and treating many conditions, and we're making it harder for people to get. More people, especially those with chronic, serious conditions, will not be properly assessed."

Shadow Health Minister Catherine King said patients with serious, ongoing conditions such as cancer and heart complaints would be hardest hit.

"Patients with serious conditions never need just one scan," Ms King said, citing the example of someone with thyroid cancer.

She said a confirmed diagnosis involved having an ultrasound and thyroid function test, a follow-up ultrasound and pathology tests, and a final round of head or body scans.

"All up, that comes to around $1000 in upfront charges," Ms King. "Patients will eventually get much of this back from Medicare, but they will still be left with hundreds of dollars in out-of-pocket expenses."

Health Minister Sussan Ley has so far pushed back against such concerns, pointing out that the Government has not touched Medicare rebates and arguing that bulk billing incentives – introduced by Labor in 2009 – were an unjustified handout to providers.

But Dr Wriedt said Medicare rebates for diagnostic imaging services had not been indexed for 17 years, ratcheting up the financial pressure on providers and leaving them with little choice but to pass the bulk billing incentive cuts through to patients.

He said the Government's strategy was to push more costs on to consumers.

"Let's not kid ourselves. This is a cash grab and a co-payment by stealth," he said. "They [the Government] know that this will hurt people, and particularly the most vulnerable in our communities, and yet they're pushing ahead."

But the Government's plan might yet fall afoul of the Senate, where it will have to rely on the support of cross-bench senators to get the measure passed.

At least one has flagged she will join Labor in opposing the changes.

Independent Tasmanian Senator Jacqui Lambie has threatened to vote against all Government legislation in order to prevent cuts to bulk billing incentives for pathology and diagnostic imaging services.

Realisation that the cuts could result in women being charged for pap smear tests provoked widespread outrage, and almost 190,000 have signed a Change.org petition protesting the measure.

Senator Lambie said it was time the Government stopped its "sneaky attacks on Medicare".

"Australian women should not have to pay more for vital cancer health checks," she said. "Over my dead body will I allow the Liberals to try and sneak through more changes and cuts to our Medicare system. I will vote to block all their legislation in the Senate until they stop playing with our Medicare system."

ADRIAN ROLLINS

WHO declares Zika virus a threat of 'alarming proportions'

Health authorities are on high alert to prevent a mosquito-borne virus linked to thousands of birth defects in South America getting a toehold in Australia.

Though there is no evidence the Zika virus, which health experts suspect has infected millions in Brazil and surrounding countries in recent months, has been transmitted in Australia, authorities are concerned about the possibility someone infected with the disease overseas may travel to central and northern Queensland, where mosquitos capable of carrying the disease are found.

> "The level of alarm is extremely high … a causal relationship between Zika virus infection and birth malformations and neurological syndromes is strongly suspected" – *WHO Director General, Margaret Chan*

"There is very low risk of transmission of Zika virus in Australia, due to the absence of mosquito vectors in most parts of the country," the Health Department said, but added that "there is continuing risk of Zika virus being imported into Australia… with the risk of local transmission in areas of central and north Queensland where the mosquito vector is present".

Australia's preparations come amid mounting international alarm over the rapid spread of the virus and fears it is linked to an increased incidence of serious birth defects including abnormally small heads and paralysis.

World Health Organisation Director-General Dr Margaret Chan said the virus was "spreading explosively" in South and Central America since being first detected in the region last year, and the WHO's Emergency Committee has been convened to consider declaring the outbreak a Public Health Emergency of International Concern.

The virus, which is closely related to the dengue virus, was first detected in 1947, and there have only ever been 20 confirmed cases in Australia – six of them in 2015 alone, and all of them involving infection overseas.

Only about 20 per cent of those infected with the Zika virus show symptoms, and the disease itself is considered to be relatively mild and only lasts a few days.

But there is no vaccine or treatment, apart from rest, plenty of fluids and analgesics, and Dr Chan said the speed of the virus's spread and its possible link to serious birth defects meant the threat it posed had been elevated form mild "to one of alarming proportions".

"The level of alarm is extremely high," Dr Chan said. "Arrival of the virus in some places has been associated with a steep increase in the birth of babies with abnormally small heads and in cases of Guillain-Barre syndrome.

A causal relationship between Zika virus infection and birth malformations and neurological syndromes has not yet been established, but is strongly suspected."

But there are concerns, yet to be scientifically verified, that the virus may cause microcephaly (small or under-developed brain) in unborn infants.

In Brazil, a four-fold increase in the number of cases of microcephaly last year coincided with widespread outbreaks of the Zika virus, increasing suspicions of a link.

An investigation by the Brazil Ministry of Health found that of 35 cases of microcephaly recorded in a registry established to investigate the outbreak, 74 per cent of mothers reported a rash illness during their pregnancy. More than 70 per cent of the babies were found to have severe microcephaly, and all 27 that underwent neuroimaging were found to be abnormal.

"The possible links, only recently suspected, have rapidly changed the risk profile of Zika, from a mild threat to one of alarming proportions," Dr Chan said. "The increased incidence of microcephaly is particularly alarming, as it places a heart-breaking burden on families and communities."

The Department of Foreign Affairs and Trade has issued a travel advisory recommending that pregnant women considering travelling to countries where the Zika virus is present to defer their plans.

Continued on p8 ...

WHO declares Zika virus a threat of 'alarming proportions'

... from p7

"Given possible transmission of the disease to unborn babies, and taking a very cautious approach, pregnant women should consider postponing travel to Brazil or talk to their doctor about implications," the Department said.

The Brazil outbreak has drawn particular attention given that hundreds of thousands of athletes, government officials and tourists are expected to travel to the country later this year for the Olympic Games.

DFAT has issued similar travel advice for all 23 countries where the virus has been identified - almost all of them in Southern or Central America, except for the Pacific island nation of Samoa, and Cape Verde, off the north-west African coast.

All other travellers are advised to take precautions to avoid being bitten by mosquitos, including wearing repellent, wearing long sleeves, and using buildings equipped with insect screens and air conditioning.

The Health Department has issued advice for clinicians to consider the possibility of Zika virus infection in patients returning from affected areas, and said authorities were ready to act if it appeared in areas where mosquitos capable of transmitting it were present.

"In the event of an imported case in areas of Queensland where the mosquito vector is present, health authorities will respond urgently to prevent transmission, as they do for dengue," the Department said.

ADRIAN ROLLINS

INFORMATION FOR MEMBERS

Road Safety

The 2016 Australasian Road Safety Conference 2016 (ARSC2016), the premier road safety conference for Australia, New Zealand and the Asia Pacific, will be held in Canberra from 6 to 8 September this year.

Hosted by the Australasian College of Road Safety (ACRS), Austroads, and The George Institute for Global Health, the theme for 2016 is "Agility, Innovation, IMPACT".

The Conference will have a special focus on harnessing the latest research, technology and policy innovations to produce the best road trauma reduction outcomes possible

The AMA continues to make an important contribution to the ongoing national campaign to reduce road fatalities and road trauma.

As a neurosurgeon, AMA President Professor Brian Owler frequently witnesses the tragic consequences of speeding, and has a strong personal commitment to improving road safety.

Professor Owler has been the face of New South Wales' Don't Rush campaign since 2010. This prominent advertising campaign has contributed to a reduction in speed and fatigue-related injury and death in that state.

But speeding, fatigue and risk-taking behaviours continue to contribute to too many lives being lost and harmed on Australian roads.

The annual economic cost of road crashes in Australia is enormous — estimated at $27 billion — and the social impacts are devastating.

Doctors play an important role in terms of assessing whether patients are fit to drive. Illness and disease may impair someone's ability to drive, temporarily or permanently.

The AMA website has a link to the National Transport Commission publication *Assessing Fitness to Drive: medical standards for licensing and clinical management guidelines. A resource for health professional in Australia (March 2012 as amended up to 30 June 2014)*, which can be used by doctors to help assess the fitness of a patient to drive.

Australia Day honours

Former AMA President Dr Brendan Nelson and former Treasurer Peter Ford are among almost 30 AMA members recognised for their outstanding service to medicine and the community in the 2016 Australia Day honours.

Dr Nelson, who led the AMA between 1993 and 1995 before entering federal politics and rising to become Defence Minister in the Howard Government and Opposition leader after the Coalition's defeat in 2007, served as Australia's ambassador to the European Union before returning to Australia to become Director of the Australian War Memorial.

Dr Nelson has been made an Officer (AO) in the general division of the Order of Australia, in recognition of distinguished service to Federal Parliament, the advancement of Australia's international relations and service to major cultural institutions.

Several other AMA members were similarly honoured, including Monash University Pro Vice Chancellor Professor David Copolov, anaesthetist Professor Kate Leslie, clinical immunologist Professor Robyn O'Hehir, ophthalmologist Professor Minas Coroneo and gastroenterologist Professor Finlay Macrae.

Adelaide GP Dr Ford, who served in several senior roles within the AMA including as Federal Treasurer, was awarded an Order of Australia (AM) for his work representing the medical profession and promoting the delivery of health care for the elderly.

Another GP, Dr Vlasis Efstathis, was also awarded an AM for services to community health and medicine. Dr Efstathis has been a GP since 1972 and was team leader of the tsunami relief effort in Banda Aceh in 2004.

Former Royal Australian and New Zealand College of Obstetricians and Gynaecologists President Dr Ted Weaver, was awarded a Medal in the general division of the Order of Australia, as was Australian National University Adjunct Associate Professor Rashmi Sharma, who told *Medical Observer* the honour showed that "little GPs in the suburbs can sometimes be recognised".

The following AMA members were recognised in the Australia Day honours:

Officer (AO) in the general division

Professor David Copolov

Professor Minas Coroneo

Professor Katherine Leslie

Professor Finlay Macrae

The Honourable Dr Brendan Nelson

Professor Robyn O'Hehir

Member (AM) in the general division

Mr Ian Carlisle

Dr Jay Chandra

Dr Timothy Cooper

Dr Vlasis Efstathis

Dr Peter Ford

Professor Mark Frydenberg

Dr Michael Gardner

Dr Myrle Gray

Dr Paul Mara

Dr Peter Pratten

Dr Lyon Robinson

Dr Brian Spain

Dr Roderic Sutherland

Dr John Vorrath

Associate Professor David Watson

Associate Professor Julian White

Medal (OAM) in the general division

Dr Creston Magasdi

Dr John Paradice

Adjunct Associate Professor Rashmi Sharma

Dr John Tucker

Dr Edward Weaver

ADRIAN ROLLINS

GP guide aims to end prostate confusion

The number of men undergoing unnecessary prostate cancer tests and procedures is expected to drop following the development of evidence-based clinical guidelines.

In a major step toward resolving decades of confusion and uncertainty regarding the detection and treatment of prostate cancer – the second most common cancer in men – the National Health and Medical Research Council has approved a set of clinical guidelines that can be used by GPs and patients to inform decisions about whether to test for the condition.

The detection and management of prostate cancer has been dogged by controversy amid concerns that shortcomings in the widely-used prostate specific antigen (PSA) blood test has led to over-diagnosis and treatment, leaving many men with serious side-effects including impotence and incontinence.

To cut through the uncertainty and provide clear evidence-based advice to practitioners and patients, Cancer Council Australia and the Prostate Cancer Foundation of Australia (PCFA) undertook a three-year process in which they convened representatives from all the disciplines involved in testing, including urologists, pathologists, GPs, radiation and medical oncologists and epidemiologists, to develop consensus guidelines.

The result, *PSA Testing and Early Management of Test-detected Prostate Cancer: Guidelines for health professionals*, has been approved by the NHMRC as providing evidence-based recommendations for the use of PSA tests and managing patients following a positive reading.

The Cancer Council and PCFA said they hoped the guidelines would help doctors "navigate the daily professional dilemma of informing men about the risks and benefits of testing, and prevent scenarios where PSA tests are conducted without patient consent".

The test for PSA in the blood is considered an unreliable marker of prostate cancer and so is not considered appropriate for use in population screening.

But, in the absence of an effective alternative, many men choose to have it anyway.

The problem is that false-positives can lead to a patient having an invasive biopsy procedure, exposing them to the risk of serious side-effects.

The NHMRC estimates that for every 1000 men aged 60 (and who do not have an immediate relative with prostate cancer) who take the test annually for 10 years, two will avoid a prostate cancer death before 85 years.

But a further 87 will, as a result of a false-positive test, have an unnecessary biopsy. As a result of the biopsy, 28 will experience side-effects including impotence and incontinence, and one will be hospitalised.

The risk of a false-positive and the attendant unnecessary yet serious complications means that the decision to have a PSA test is not a straightforward one, and PCFA Chief Executive Officer Associate Professor Anthony Lowe said the new guidelines were intended to help doctors and patients navigate the decision to maximise the benefits of the test and minimise the harms.

"Contention about the PSA test has made it difficult for health professionals to take a consistent, evidence-based approach to the test," A/Professor Lowe said. "While the debate has played out, thousands of men have continued to take the test, as it's the only available biomarker to assist doctors in assessing a man's prostate cancer risk."

Cancer Council Chief Executive Officer Professor Sanchia Aranda said use of the guidelines should result in less over-treatment associated with PSA testing.

"The PSA test is an imprecise test, and has the potential harms as well as benefits," Professor Aranda said. "Use of the guidelines will hopefully reduce the level of over-treatment and guide improved management of men with early stage prostate cancer until we have a better biomarker."

Among other advice, the guidelines recommend:

- an end to rectal examination of asymptomatic men by GPs;
- no PSA test for men unlikely to live another seven years because of other health complaints;
- harms of PSA tests may outweigh potential benefits for men older than 70 years; and
- for men aged 50 to 69 years who decided to have PSA testing, tests should be conducted every two years, not annually.

The guidelines can be downloaded from: www.pcfa.org.au and wiki.cancer.org.au/PSAguidelines

ADRIAN ROLLINS

Medical practices to be hit in under-pay crackdown

Medical practices have been put on notice to expect a visit from Fair Work inspectors in the coming months to ensure staff are receiving appropriate pay and allowances.

The workplace watchdog has announced it will be carrying out spot checks to examine conditions for receptionists, managers and other staff at 600 health and residential care workplaces around the country, including medical practices.

Fair Work Ombudsman Natalie James said on average more than 3000 people a month from the health care and social assistance sector contacted her organisation concerned about pay and work arrangements, and the forthcoming campaign of inspections had been developed with "intelligence and advice from key stakeholders".

Ms James said Fair Work inspectors will be checking to make sure employers are paying correct minimum hourly rates, penalty rates, allowances and loadings and providing appropriate meal breaks. They will also be ensuring compliance with record-keeping and pay-slip obligations.

The blitz reflects ongoing concern about the behaviour of some employers in the sector, which includes not only medical practices but allied health services and residential care operators.

Since 2010, the watchdog has recovered more than $7 million on behalf of 5300 underpaid workers in the industry, which employees more than 1.4 million, almost 80 per cent of them women, and includes around 10,000 457 visa holders.

In the past three financial years, the Ombudsman has taken seven matters concerning employers in the sector before the courts, and a further 43 have been issued formal Letters of Caution about their workplace practices, putting them on notice that further contraventions may result in enforcement action. Eight received on-the-spot fines for technical infringements.

Ms James said one of the campaign's aims was to ensure employers were aware of their responsibilities.

For medical practices, the Ombudsman will focus on employees covered by the Health Professionals and Support Services Award.

The AMA has advised practice owners unsure of their obligations under the award or their record keeping requirements to contact their local State or Territory AMA for advice.

ADRIAN ROLLINS

INFORMATION FOR MEMBERS

Searching for a hero

The Integrated Family and Youth Service (IFYS) are looking for a superhero. More precisely, a doctor who spent time in foster care as a child who would be willing to share their story.

Drawing on the fact that many superheroes depicted in popular literature, most notably Superman, were raised by foster parents, IFYS has developed a campaign called (with tongue firmly planted in cheek) 'Raise the next Superhero', to recruit foster families for the hundreds of children who enter care every month.

If you are a doctor who spent time in foster care while growing up, and would be willing to share your story, please contact Letitia at communications@ifys.com.au

Concerns persist over rural health fix

The Federal Government has rebuffed calls for an increase in the quota of medical students who come from rural backgrounds despite concerns initiatives to boost medical services in country areas will continue to fall short.

The Government has been accused of sending mixed messages on its rural medical workforce policy after using some of the funds freed up from cutting almost $600 million from health and aged care workforce spending to fund new programs intended to improve rural training opportunities.

It used its 2015-16 Mid Year Economic and Fiscal Outlook (MYEFO) to unveil a $93.8 million Integrated Rural Training Pipeline intended to improve the retention of postgraduate prevocational doctors in country areas.

The Pipeline includes the establishment of 30 regional training hubs (which will receive $14 million a year); at least $10 million a year for a Rural Junior Doctor Training Innovation Fund to foster new training approaches; and $16 million a year to fund up to an extra 100 places in the Specialist Training Program through to 2018.

Minister for Rural Health Fiona Nash said the funds for the initiative had been obtained by improving the targeting of existing health workforce programs and activities.

“The Australian Government invests more than $1 billion a year in programs to build the health workforce,” Senator Nash said, citing as an example the fact that, in 2014, almost 80 per cent of clinical placements were in metropolitan areas.

A further $130 million of health workforce spending is to be redirected into an expansion of the Rural Health Multidisciplinary Training program, with particular focus on addressing workforce shortages and increasing support for training in nursing, midwifery and allied health.

“Our objective is to provide the most effective support for health students to train in areas of need,” Senator Nash said.

But the impact of the announcement has been tempered by concerns that the overall effect of the changes is a net loss of funding for health workforce programs.

Health Minister Sussan Ley admitted as much when, in a statement released on 15 December, she confirmed that only a proportion of the $461.3 million the Government expects to save by “rationalising” existing workforce programs would go to fund the new initiatives, with the rest “being sensibly invested into Budget repair”.

Prior to the release of MYEFO, the AMA had urged the Government to make it mandatory that one in every three medical students be recruited from a rural background, and that the proportion required to undertake at last a year of clinical training in a rural area be increased from 25 to 33 per cent.

The AMA has welcomed the expansion of the Specialist Training Program, but President Professor Brian Owler said that country areas were still struggling to attract and retain sufficient locally-trained doctors despite record numbers of medical graduates.

“The ‘trickle down’ approach to solving workforce maldistribution is not working,” he said. “Australia has enough medical students, and the focus must now shift to how to better distribute the medical workforce.”

The AMA President said there was good evidence that medical students from a rural background, or those who undertook extended training in rural areas, were more likely to take up practice in the country upon graduation.

The AMA said less than 28 per cent of commencing domestic medical students came from a rural background, and recommended that the Government increase the current intake target from 25 to 33 per cent.

Professor Owler said significant action was needed, with a recent survey showing less than a quarter of domestic medical graduates lived outside the nation’s capital cities.

“The implementation of more ambitious targets may prove challenging in the short term, but there is evidence that this approach would be more successful in getting more young doctors living and working in rural Australia,” he said.

But the Government has so far resisted the suggestion.

Instead of increasing the rural medical student quota, universities have been directed to set their own targets for rural background students.

A Health Department spokesperson told *Medical Observer* that, even without a higher quota, a third of medical students in 2014 were of rural origin.

ADRIAN ROLLINS

Claims patients paying the cost of de-listing 'mistake'

Osteoarthritis patients have been left badly out-of-pocket because of a basic Federal Government error in which it confused the cost of a pack of painkillers with the two-pack dose sufferers are usually prescribed, according to the peak pharmacist body.

The Pharmacy Guild of Australia claims that in deciding to delist Panadol Osteo from the Pharmaceutical Benefits Scheme, the Government only considered the price per pack, disregarding the fact that osteoarthritis patients are typically prescribed two packs per month.

In recommending that Panadol Osteo be de-listed, the Pharmaceutical Benefits Advisory Committee said this was on the basis that the drug was available at a price no higher than the-then concessional co-payment of $6.10.

The Guild said that although the price per pack was less than this amount, the fact that patients used two packs in a month meant the criteria set by the PBAC had been breached.

"The result of this flawed decision is that the vast majority of Australia's 1.9 million osteoarthritis sufferers are now having to pay significantly more for their essential pain medication," the Guild said, warning that for many pensioners their annual costs for the medication would triple.

"The Government's declared purpose of the de-listing was to make medicines more affordable for patients. Demonstrably, this is not the case with Panadol Osteo.

"An elementary error has been made and it is now time to rectify it."

The claim is the latest development in the drama surrounding the Government's decision to delist the painkiller from the PBS.

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

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

But the Guild said its analysis showed that the same patients would now pay between $11.90 and $15.00 for the same purchase, even before a decision by manufacturer

GlaxoSmithKline to jack up the price by 50 per cent from the start of the year.

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

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

Health Minister Sussan Ley has attacked GlaxoSmithKline over the price rise, rejecting attempts to link the increase to Panadol Osteo's de-listing.

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

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

Ms Ley has asked that the Australian Competition and Consumer Commission look into the matter.

ADRIAN ROLLINS

Look no further than GPs for Medical Home

> "Evidence suggest patients with a usual GP or Medical Home have better health outcomes, and 93 per cent of Australians have a usual general practice, and 66 per cent have a family doctor"

GPs already perform many of the functions of a Medical Home, and should be at the centre of any move to formalise such an arrangement in Australia, the AMA has said.

As Health Minister Sussan Ley contemplates the findings and recommendations of the primary health review led by former AMA President Dr Steve Hambleton, the AMA has issued a Position Statement advising that any proposal to adopt a Medical Home approach in Australia must have GPs at its core.

Internationally, the term Medical Home is used to refer to a model of primary care that is patient-centred, comprehensive, team-based, coordinated, accessible and focused on quality and safety.

AMA Vice President Dr Stephen Parnis said in Australia these attributes were already embodied in general practice.

"The concept of the Medical Home already exists in Australia, to some extent, in the form of a patient's usual GP," Dr Parnis said. "If there is to be a formalised Medical Home concept in Australia, it must be general practice. GPs are the only primary health practitioners with the skills and training to provide holistic care for patients."

Evidence suggest patients with a usual GP or Medical Home have better health outcomes, and 93 per cent of Australians have a usual general practice, and 66 per cent have a family doctor.

Dr Parnis said the Medical Home concept had the potential to deliver improved support for GPs in providing well-coordinated and integrated multi-disciplinary care for patients with chronic and complex disease, and it made sense for this to be the focus of Government thinking on adopting the Medical Home idea in Australia.

"You can't just transplant models of health care from other countries without acknowledgement of local conditions and what is already working well," he said.

"Australia needs to build on what works, and ensure that a local version of the Medical Home is well-designed and relevant."

The AMA said this should involve additional funding to enable GPs to deliver comprehensive and ongoing care, including patient education, improved coordination and targeting of services, and activity that does not require face-to-face contact.

Establishing a Medical Home arrangement in Australia was likely to involve formally linking a patient with their nominated GP or medical practice through registration, and the AMA said this should be voluntary for both patients and doctors.

In addition, the peak medical group said fee-for-service must remain the predominant funding mechanism for doctors, though it acknowledged that the Medical Home could also involve a blended funding model that rewarded the delivery of services over a period of time.

The AMA Position Statement on the Medical Home can be viewed at: https://ama.com.au/position-statement/ama-position-statement-medical-home

ADRIAN ROLLINS

Guns in hospitals 'a very bad idea': AMA President

Knee-jerk calls to arm hospital security guards with guns following a double-shooting at Nepean Hospital would be "a very dangerous path to go down", AMA President Professor Brian Owler has warned.

Speaking after a violent attack in which a drug-affected patient managed to get hold of a gun during a struggle with a police officer and security guards at the Nepean Hospital's emergency department, Professor Owler said that although security arrangements should be reviewed in light of the incident, bringing more guns into hospitals was not the answer.

"Calls for people to be armed in our emergency departments, I think, is a very bad way to go," he said. "We need less guns, not more, in our society and, as we saw through this incident, it actually raises the dangers for people, including the doctors, nurses and other patients."

The Sydney Morning Herald has reported that the shooter was a 39-year-old former nurse who had ongoing problems with the drug ice.

According to the report, the man had been arrested earlier in the day, and was taken to Nepean Hospital on Tuesday evening after sustaining injuries including a suspected broken jaw.

While at the hospital's emergency department, it is alleged he threatened a female doctor, prompting police to be called. When the first officer on the scene, Senior Constable Luke Warburton, attempted to arrest the man, a scuffle broke out during which the man seized the police officer's gun and fired two shots, hitting Senior Constable Warburton and a security guard, before being subdued.

Senior Constable Warburton was left in a critical condition after being shot in the upper thigh, but was later stabilised. The security guard was shot in the leg and was listed as being in a stable condition.

The man has been charged with shooting with intent to murder, discharging a firearm to resist arrest, and detaining for advantage.

Professor Owler said the incident was "very alarming", and highlighted both the influence of the drug ice in increasing the risk of violence in emergency departments, and the dangers of having guns in hospitals.

The AMA President said that although assaults and attacks in hospital emergency departments was not a new problem, "ice has really raised the level to a greater height…the drug really causes people to be very difficult to control, particularly when they're in these episodes of psychosis".

He said it was not uncommon for doctors and nurses to need the help of hospital security guards in helping to control, and occasionally to restrain, such patients until they could be sedated.

But Professor Owler said guns were not the answer.

"We need to…review the security, particularly [to] make sure that there are ample security guards in our emergency departments, and that there are Rapid Response teams that can subdue people when they are in these sorts of situations," he said.

But he warned that arming security guards would be "a very dangerous path to go down, and I think this incident illustrates exactly why that is.

"What we need to do is make sure that we have ample security, that we have the proper resources so that we can protect our doctors and nurses.

"That doesn't mean more guns, we need to look at other ways that we can protect them."

ADRIAN ROLLINS

Anti-vax dodge dismissed by Commonwealth

The Federal Government has confirmed that a form being circulated by anti-vaccination campaigners attempting to circumvent new 'No Jab, No Pay' laws has no legal standing, backing AMA advice that doctors are under no obligation to sign it.

Social Services Minister Christian Porter has written to AMA President Brian Owler confirming that medical practitioners were under no obligation to sign the form, which asks doctors to acknowledge the 'involuntary consent' of a parent to the vaccination of their children, and which is deemed to be ineffective in any case.

"I am able to advise you that under the No Jab, No Pay Act, immunisation providers are not obligated to sign such declarations," Mr Porter wrote. "This statutory declaration is not relevant evidence for the purposes of family assistance payments, [so that] even if such a form were signed by a doctor...it would not in any circumstances make the relevant parent eligible for payments that would otherwise be suspended."

The form has been circulated by anti-vaccination campaigners following Federal Government welfare changes aimed at denying certain welfare payments to parents who refuse to vaccinate their child.

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

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

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

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

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

But Mr Porter said the aim of the new laws was to boost immunisation rates "by providing a level of encouragement and incentive for families to more thoroughly inform themselves about the importance of immunising their children".

The Minster said the Government recognised the right of parents to decide not to vaccinate their children, but the new laws meant there would be consequences.

"An individual is not prohibited in any way from maintaining their vaccination objection; it is simply the case they will not receive some of their family assistance," he said. "This is a relatively small financial cost, particularly when compared to the cost that the spread of crippling, debilitating and deadly diseases has on our health system and community."

"It is the Government's view that when an individual decides not to vaccinate their child, they are putting their child and the community at risk of infectious diseases."

Last month, the AMA's senior legal adviser John Alati advised that, where there was no medical reason for vaccination exemption, the doctor's job was to outline the relevant facts about immunisation and to provide vaccination where consent was given. Where it was withheld, "the doctor should not perform the procedure as it might constitute trespass to the person".

His advice was backed by Mr Porter, who said that "the appropriate path for a doctor or medical profession who may be requested to sign [the form being circulated by anti-vaccination campaigners] is simply to vaccinate where there is consent, and decline where consent is absent".

ADRIAN ROLLINS

Wollongong academics disown anti-vax views

Health academics at the University of Wollongong have affirmed the lifesaving benefits of immunisation after their institution become embroiled in controversy over the decision to award a doctorate for a thesis questioning the safety and efficacy of mass vaccination programs.

Sixty-five senior medical and health researchers including Professor of Public Health Dr Heather Yeatman, Dean of Medicine Professor Ian Wilson, and Professor Alison Jones, Executive Dean of the Faculty of Science, Medicine and Health, have jointly signed a public statement backing the evidence supporting vaccination and its importance in preventing disease.

"The evidence is clear," the statement said. "Immunisation protects children and saves lives.

"While individuals may express opinions, the international scientific evidence overwhelmingly supports immunisation to protect children from infectious diseases."

A series of reports in *The Australian* newspaper revealed that Dr Judy Wilyman, described as an "anti-vaccination campaigner", had been accepted for a PhD after submitting a thesis in which she criticised the National Immunisation Program (NIP).

In her thesis, Dr Wilyman argued that the implementation of mass vaccination programs like the NIP coincided with "the development of partnerships between academic institutions and industry" and notes the involvement of organisations including the World Bank, the International Monetary Fund, the Bill and Melinda Gates Foundation and UNICEF in urging population-wide immunisation.

"Whilst the Government claims serious adverse events to vaccines are rare this is not supported by adequate scientific evidence due to the shortcomings in clinical trials and long-term surveillance of health outcomes of recipients," she argues. "A close examination of the 'Swine Flu' 2009 vaccine and the vaccine for human papillomavirus (HPV), intended to prevent cervical cancer, shows shortcomings in the evidence base and rationale for the vaccines. This investigation demonstrates that not all vaccines have been demonstrated to be safe, effective or necessary."

The social sciences researcher called for "independent research" into the safety and efficacy of current vaccines, and added that it was important to have "comprehensive evidence that it is safe to combine multiple vaccines in the developing bodies of infants".

Dr Yeatman said large-scale immunisation programs began in the 1930s and "immunisation provides an important safeguard against infectious disease when children go to school or play with others".

According to Immunise Australia, mass immunisation had led to a 99 per cent plunge in deaths from vaccine-preventable disease.

"For more than 50 years, children have been immunised and it is one of our best success stories in public health," she said.

Wollongong University has staunchly defended its decision to grant Dr Wilyman a PhD, on the grounds of academic freedom.

But, following sustained criticism, it has launched a review of the process involved in awarding PhDs – though it will not include that presented to Dr Wilyman.

ADRIAN ROLLINS

High fail rate raises training doubts

Assessment standards for aspiring psychiatrists are under scrutiny after less than a quarter of trainees passed a new written test.

AMA Vice President Dr Stephen Parnis has written to the Royal Australian and New Zealand College of Psychiatrists urging it to review new training and assessment arrangements after just 23 per cent of psychiatry trainees undertaking the Modified Essay Question Written Exam in August last year were awarded a pass mark.

Dr Parnis told the College the AMA had been contacted by several trainees who were "very distressed", and had expressed significant concerns about very low pass rates for the first two groups of students sitting exams under the competency-based training program introduced in 2012.

"I understand this pass rate is much lower than experienced under the former training program," Dr Parnis wrote, noting widespread concern among trainees that they had received insufficient support in meeting the new assessment standards, and questioning whether the exams had been "appropriately calibrated".

"With any major overhaul of a training program, the AMA believes that it is very important for colleges to be sensitive to emerging issues, and seek to address them as a matter of urgency," the AMA Vice President said.

Trainees complained that supervisors and Directors of Training appeared unsure about the appropriate time to sit exams, what the newly-imposed standard of 'junior consultant' might mean in practice, and how they should prepare differently when re-sitting an exam.

Dr Parnis also expressed concern that the College had set tight limits on the number of times a trainee can sit the exams, with those who fail to meet these requirements being asked to show cause.

"This can be incredibly stressful in the best of circumstances, and it would be most unfair on the initial cohort of trainees if they were subject to these rules and it is [subsequently] shown that there are inherent problems in assessment processes," he said.

Dr Parnis said the AMA was generally supportive of the College's move toward a competency-based training framework, and had been reassured by the involvement of trainee representatives in monitoring and advising on the changes.

But the experience of the trainees showed the new arrangements needed to be reviewed, he said.

"While it is obviously early days for the new assessment arrangements, the low pass rates appear to warrant further consideration and potential remedial action."

ADRIAN ROLLINS

INFORMATION FOR MEMBERS

Essential GP tools at the click of a button

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

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

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

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

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

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

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

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

Players banned as Court rules Essendon doped

Thirty-four current and former Essendon Football Club players have been slapped with two year bans after being found to have taken a prohibited supplement, ending the long-running drugs saga that has blighted the Australian Football League and ended several high-profile careers.

In the final determination on the explosive issue, the Court of Arbitration for Sport has overturned the AFL Anti-Doping Tribunal's ruling that it was "not comfortably satisfied" the players had been administered the performance enhancing drug Thymosin Beta 4 during the 2012 season.

The ruling means that 12 currently listed Essendon FC footballers will not be able to play this year, including captain Jobe Watson, midfielders Dyson Heppel and Heath Hocking, and experienced defenders Michael Hurley and Tayte Pears. Several former players who have moved on to other clubs, including Jake Carlisle and Patrick Ryder, have also been suspended, as have retired stars including record games holder Dustin Fletcher and Mark McVeigh.

The scandal has already claimed the scalp of former coach James Hird, while the sports scientist who oversaw the supplements program, Stephen Dank, was last year handed a lifetime ban from all sports.

In most cases, the ban will apply through to 13 November this year, taking into account delays caused by factors outside player control and time served by those who accepted provisional suspension in 2013.

While the CAS heard the same evidence as had been presented to the AFL tribunal, it applied a different burden of proof – comfortable satisfaction.

In appealing the AFL tribunal's decision, the World Anti-Doping Agency (supported by the Australian Sports Anti-Doping Authority) did not have any test results to directly prove doping.

Instead, it used evidence gathered by ASADA, including text messages outlining a plan to dope the Essendon football team with Thymosin Beta 4, testimonies from players and officials, and a scientific analysis of substances sourced for the team.

ASADA said the evidence proved that the players had been injected with a prohibited substance "as part of a team program designed to give Essendon an unfair advantage in the 2012 season".

ASADA Chief Executive Officer Ben McDevitt described the episode as "the most devastating self-inflicted injury by a sporting club in Australian history".

Mr McDevitt hailed the Court's decision and said there was no way the players could have escaped sanction.

"There were very little grounds for the players to claim they were at no significant fault," Mr McDevitt said.

He said they had all received anti-doping training and "were well aware that they are personally responsible for all substances that entered their body".

"Unfortunately, despite their education, they agreed to be injected with a number of substances they had little knowledge of, made no enquiries about the substance, and kept the injections from their team doctor and ASADA."

The anti-doping boss said that in 30 dope tests conducted by ASADA during the period, none of the players divulged that they were receiving the injections despite being explicitly asked whether they had taken any supplements.

"At best, the players did not ask the questions, or the people, they should have," Mr McDevitt said. "At worst, they were complicit in a culture of secrecy and concealment."

Recently elected Essendon FC President, former Labor politician Lindsay Tanner, released a statement that the club was "currently digesting the decision".

ADRIAN ROLLINS

Obituary

Professor Tess Cramond

Honoured: Professor Tess Cramond and her husband Humphry recognised by their peers

Medical pioneer and former AMA Queensland President Professor Tess Cramond, credited with saving thousands of lives, has died.

Professor Cramond, who helped blaze a trail for women in anaesthetics and medical politics, and whose lifetime of achievement included establishing and heading Royal Brisbane Hospital's Multidisciplinary Pain Clinic and becoming Dean of the Faculty of Anaesthetists of the Royal Australasian College of Surgeons, passed away on 26 December, aged 89.

She drew national and international accolades for her work advancing anaesthesia and pain medicine. Among her many awards, she received an Order of the British Empire, she was made an Officer of the Order of Australia, and she was presented with the AMA Women in Medicine Award, the Advance Australia Award and a Red Cross Long Service Award.

Hundreds gathered at Brisbane's Cathedral of St Stephen on 8 January for her funeral, where many paid tribute to her work as medical adviser to Surf Lifesaving Australia in introducing and promoting the teaching of CPR.

She was also recognised for helping pioneer the advancement of women in medicine.

Born in Maryborough, Queensland, in 1926 as one of four daughters, Professor Cramond entered medical school in the post-war years and graduated in 1955.

She told her friend Dr John Hains in an interview in 2012 that she was drawn to anaesthesia because, "I love the panorama of medicine that anaesthetics provided".

Professor Cramond was initially reluctant to get involved in medical politics, but eventually agreed to become State Secretary of the Australian Society of Anaesthetists.

Several years later, in 1978, AMA Queensland approached her to become State President – an offer she turned down at the time.

"I had just been appointed Professor of Anaesthetics, and I wanted to get the Anaesthetics Department established properly, so I knocked them back," Professor Cramond recalled.

But that was not an end to it. AMA Queensland approached her again to become President in 1982.

"When I was asked a second time I thought, 'If I knock them back again, they will never ask another woman', so I said yes."

But Professor Cramond made it clear that one of her proudest achievements was the establishment of the Multidisciplinary Pain Clinic.

The idea for such a clinic came to her during a visit to the United States, where she saw a similar establishment.

When she returned to Brisbane she got to work, and in 1967 the Clinic, which was to become the centrepoint of her career, was established at the Royal Brisbane. She was to serve as its Director for 42 years.

In her 2012 interview, Professor Cramond noted that one of the clinic's major contributions was to have trained 35 pain specialists since 2000, and was gratified that the Australian and New Zealand College of Anaesthetists had established a Faculty of Pain Medicine.

ADRIAN ROLLINS

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/ONLINE

Timing of Medicare cuts announcement criticised, *The Age*, 29 December 2015

Doctors have criticised the Turnbull government for using the Christmas-New Year holiday period to reveal the first tranche of items to be dropped from the government-subsidised Medicare Benefits Schedule. AMA President Professor Brian Owler said the proposed cuts would make the common tonsillectomy procedure marginally more expensive due to fewer individual parts of the operation being funded by Medicare.

Take care morning after the big night, *Adelaide Advertiser*, 1 January 2016

Health and safety experts are urging people to be careful embracing life the morning after a big night. AMA President Professor Brian Owler urged people to take it easy with water sports and even sunbaking over summer if they have consumed alcohol.

Anti-vax nuts try to cheat jab laws, *The Sunday Telegraph*, 3 January 2016

Anti-vaxers are trying to manipulate the new "no jab no pay" laws in a bid to gain taxpayer-funded rebates available only to those who vaccinate their children. AMA President Professor Brian Owler said the attempt is hurting only the child involved.

Threat to handouts prompts jab boosts, *The Sunday Telegraph*, 17 January 2016

Doctors have noticed a significant boost in the number of parents bringing their children in for vaccinations as the new "No Jab, No Play" laws start to bite. AMA President Professor Brian Owler said the laws were already having a beneficial effect on immunisation numbers.

Warning over autism doctor shopping, *The Australian*, 19 January 2016

GPs should be given stronger guidance about how to diagnose autism. AMA President Brian Owler said that having consistent guidelines would make things easier for doctors during diagnosis, but added that the emphasis should remain on assessing children early.

Doctors warn of busy emergency facilities, *Australian Financial Review*, 28 January 2016

The AMA Public Hospital Report Card found the performance of the public hospital system has stagnated, and even declined in some areas. AMA President Professor Brian Owler placed the blame for the declining public hospital performance firmly on the Federal Government's reduced rate of health funding which would lead to a funding "black hole" in 2017.

Hospitals faced with funding 'black hole', *Sydney Morning Herald*, 28 January 2016

The Federal Government is under pressure to reform taxes following a report card on public hospitals that shows the most urgent patients are waiting longer at emergency departments. AMA President Professor Brian Owler said hospitals would be insufficiently funded to meet the rising demands from 2017, when the states and territories were facing a "black hole".

State looks sick, *Herald Sun*, 29 January 2016

Victorian emergency patients are paying the price for a "funding crisis" in the nation's public hospitals, and doctors warn the worst is yet to come. The AMA warned that a further $57 billion of Commonwealth funding was expected to be lost from hospital coffers over seven years starting next year, by indexing funding growth to CPI and population expansion.

RADIO

Professor Brian Owler, 774 ABC Melbourne, 29 December 2015

AMA President Professor Brian Owler discussed recent cuts to the Medicare Benefits Schedule. Professor Owler said it was clearly a cost saving exercise by the Federal Government.

Professor Brian Owler, Radio National, 29 December 2015

AMA President Professor Brian Owler talked about new cuts to the MBS. Professor Owler said the AMA has supported the Medicare Benefits Schedule review from the outset, on the basis there were no cuts to access to patient services.

Dr Stephen Parnis, 4BC Brisbane, 7 January 2016

AMA Vice President Dr Stephen Parnis dismissed claims that pap smears would cost women $30. Dr Parnis said cuts to Medicare have resulted in reports of overpriced pap smears.

... continued on p22

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.

... from p21

Dr Stephen Parnis, Triple J Sydney, 25 January 2016

AMA Vice President Dr Stephen Parnis discussed the use of so-called "hangover clinics". Dr Parnis said the treatments they offered were a placebo, and he questioned whether their operations were ethical.

Professor Brian Owler, Radio National, 28 January 2016

AMA President Professor Brian Owler discussed the latest AMA Public Hospital Report Card which revealed a public hospital funding 'black hole' as Commonwealth funding cuts hit the States and Territories.

Professor Brian Owler, 2GB Sydney, 28 January 2016

AMA President Professor Brian Owler talked about a report from the AMA showing emergency department waiting times have worsened for the first time in seven years.

Professor Brian Owler, 774 ABC Melbourne, 28 January 2016

AMA President Professor Brian Owler talked about the AMA Public Hospital Report Card and said longer waits for elective surgery and emergency rooms often resulted in more health problems.

TELEVISION

Professor Brian Owler, ABC News 24, 28 December 2015

AMA President Professor Brian Owler talked about Health Minister Sussan Ley's proposed removal of 23 items from the Medicare Benefits Schedule.

Dr Stephen Parnis, ABC News 24, 1 January 2016

AMA Vice President Dr Stephen Parnis talked about how parents who refused to vaccinate their children would be stripped of childcare benefits by the Federal Government under new laws. Dr Parnis said public health was a major government responsibility, and vaccination rates were not as high as health experts would like them to be.

Professor Brian Owler, The Today Show, 14 January 2016

AMA President Professor Brian Owler discussed the importance of safe work environments for emergency workers after a police officer was allegedly shot by a patient with a history of ice addiction at a Sydney hospital.

Professor Brian Owler, Channel 7 Melbourne, 26 January 2016

Medibank says it is passing savings onto its members, but there are concerns more affordable premiums might mean cuts in benefits. AMA President Professor Brian Owler said doctors did not want to see people taking out cheaper premiums and policies and then realising that their private health insurance was not worth it.

Professor Brian Owler, The Today Show, 28 January 2016

The AMA Public Hospital Report Card 2016 showed that, against key measures, the performance of public hospitals is virtually stagnant, and even declining in key areas. AMA President Brian Owler said unless the Government looked at the way it funded public hospitals, people were likely to wait longer in emergency departments and for elective surgery.

Professor Brian Owler and Dr Stephen Parnis, Channel 9, 28 January 2016

The AMA released its new Public Hospital Report Card and the figures revealed that scores of patients were not being treated within recommended times. Doctors fear the situation is only going to get worse.

Professor Brian Owler, ABC News 24, 28 January 2016

The AMA has warned that public hospitals are facing a funding crisis. AMA President Professor Brian Owler said hospitals faced a crisis due to the funding fight between Federal and State governments.

ADRIAN ROLLINS

Health on the hill

POLITICAL NEWS FROM THE NATION'S CAPITAL

Patients could pay high price for lower premiums: AMA

Health Minister Sussan Ley has stepped up her pressure on the private health insurance industry, demanding all 35 funds reduce planned premium increases or justify higher charges.

Positioning herself as a strong advocate for consumers ahead of the federal election due later this year, Ms Ley has written to all insurers asking them to re-submit their applications for premiums increases due to come into effect from 1 April.

"Consumers have strong concerns about the affordability of their premiums; hardly surprising given premiums have increased at a rate of around 6 per cent per year for the past five years," the Health Minister said. "It is important I am armed with the full picture before approving any premium increase, particularly as consumers are telling me they are finding it increasingly difficult to simply shop around for a better deal."

Under current arrangements, health insurers receive around $6 billion a year from the Federal Government each year and, in return, have to get proposed premium increases approved by the Health Minister.

For the last two years, premiums have increased by an average 6.2 per cent, even as a proliferation of policies with multiple exclusions and large excess has undermined the value of cover on offer.

Ms Ley said health funds would need to lower their planned premium increases or provide evidence as to why they cannot do it.

But there are suggestions that the Minister is grandstanding on the issue for short-term political gain rather than trying to achieve sustained reform.

The funds lodged their proposed premium increases with the Health Department late last year, but Ms Ley made her announcement just a week before the Government traditionally notifies insurers of its decision.

Peak industry body Private Healthcare Australia told *The Australian* health funds undertook months of research and taking actuarial advice in coming up with their premium proposals, and for the Minister to make her request so late in the process was "quite challenging for the funds to comply with".

Leading industry figures including PHA Chief Executive Dr Rachel David and NIB Managing Director Mark Fitzgibbon said premiums were being driven up systemic pressures including the rising cost of prostheses and hospital care.

Dr David told *The Australian* a "one-off discount on pricing is unlikely to address the fundamental problems".

Jumping the gun

But the nation's largest insurer, Medibank Private, pre-empted Ms Ley's move by a week when it announced it was re-submitting its proposed premium increases for 2016.

While Medibank has not disclosed what size of premium increase it is proposing, a financial update from the fund suggests it is likely to be below the industry-wide average rise of 6.2 per cent approved last year.

In the financial update, which coincided with the premium announcement, Medibank reported that it had revised its premium revenue growth projections down from "above 5.5 per cent" to between 4.5 and 5 per cent.

... continued on p24

Health on the hill

POLITICAL NEWS FROM THE NATION'S CAPITAL

... from p23

Managing Director George Savvides said the recently-privatised fund was passing the benefits of cost-cutting measures on to its customers through lower premiums.

"Medibank has been working hard to address private health insurance affordability issues at their source by working in partnership with hospitals and other providers to reduce waste and inefficiency in the healthcare system," Mr Savvides said. "Medibank members will directly benefit from the savings achieved as we invest in delivering more value to our members through more competitive pricing and enhanced product benefits."

Medibank announced its move after releasing preliminary figures showing an operating profit in the first half of the financial year of $270 million and a $100 million boost to its full-year profit outlook from above $370 million to in excess of $470 million.

The improved financial performance has been underpinned by a crackdown on benefit payouts and a series of tough deals struck with private hospitals involving shifting the financial burden of medical complications away from the insurer onto providers.

Medibank's decision to resubmit its proposed premiums for 2016 was hailed by Ms Ley, who said any move to cut costs was welcome.

The price of war

But AMA President Professor Brian Owler warned patients could be the losers in any price war that breaks out between the major health funds.

Professor Owler told Channel Seven he was concerned that people lured into taking out a health insurance policy by cut-price premiums might later find it does not provide the cover they expected, leaving them out-of-pocket for important medical care.

Without accompanying regulatory measures to buttress the quality of health insurance cover, the AMA is concerned any premium price war could result in even more policies riddled with multiple exclusions and hefty excess charges.

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

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

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

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

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

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

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

ADRIAN ROLLINS

Government plays Nauru card as High Court deliberates

The Federal Government has incurred widespread condemnation over its plan to transfer 72 asylum seeker children from the Australian mainland to Nauru "within weeks".

In a move seen as pre-empting a High Court judgement on the legality of offshore detention in Nauru, expected later this month, Immigration Minister Peter Dutton on 13 January

Continued on p25 ...

Health on the hill

POLITICAL NEWS FROM THE NATION'S CAPITAL

... from p24

announced that 72 children "off boats" who were being detained were due to return to Nauru.

The announcement has been condemned by lawyers and child advocates, and appears at odds with AMA calls for all children to be immediately removed from detention.

Just before Christmas, AMA President Professor Brian Owler released a statement in which he reiterated the AMA's long-held view that all asylum seeker children should be moved out of immigration detention.

The AMA President acknowledged that the number of children being detained had fallen significantly under the Coalition Government, but added that "it is time for all the detained children to be moved to safer places".

"Some of the children have spent half their lives in detention, which is inhumane and totally unacceptable," he said. "These children are suffering extreme physical and mental health issues, including severe anxiety and depression."

Government figures indicate 68 children are currently being held in detention on Nauru, and a further 79 are on the mainland.

Australian Human Rights Commission President, Professor Gillian Triggs, told ABC Radio the mooted transfer of 72 children to Nauru was a "considerable disappointment".

"The children have been transferred from Nauru to Australia for medical reasons and they are, frankly, in despair at the prospect of returning to the conditions and circumstances of their detention in Nauru," Professor Triggs said.

Lawyer Daniel Webb, who is a director with the Human Rights Law Centre that has mounted the High Court action, told ABC Radio the fate of these children – including 33 babies born in Australia – depended in part on the High Court judgement.

"It would be fundamentally wrong for the Minister to send them back to a tiny island, to conditions that we know would cause them a great deal of harm," Mr Webb said.

The AMA has issued an updated Position Statement in which it has reiterated its call for an independent statutory body of clinical experts to be appointed to investigate and advise on the health and welfare of asylum seekers and refugees, and report their findings to the Parliament.

The *AMA Position Statement on the Health Care of Asylum Seekers and Refugees* can be viewed at: https://ama.com.au/position-statement/health-care-asylum-seekers-and-refugees-2011-revised-2015

ADRIAN ROLLINS

Psychiatric bed block 'a national disgrace'

Mental health experts have condemned a shortage of acute hospital beds for the mentally ill as "a national disgrace".

The National Association of Practising Psychiatrists said Australia ranks poorly among developed nations in providing hospital beds for patients with mental illness, and has urged a significant investment in the area.

The Association cited Organisation for Economic Co-operation and Development figures showing that in 2013 Australia had 39 psychiatric beds for every 100,000 mental health patients, putting it toward the bottom among the 34 OECD member countries. The OECD average was 68 beds per 100,000.

The recent National Mental Health Commission review of the mental health system recommended diverting $1 billion from public acute hospitals in the next five years to expand the number of sub-acute beds – advice the Government has so far ignored.

But NAPP Vice President Dr Gil Anaf said that, rather than axing acute hospital beds to increase the number of sub-acute places, the truth was that "we need both".

"The dis-investment in public psychiatric beds has led to increased stigmatisation of people with mental illness," Dr Anaf said. "People wandering the streets in distressed circumstances without treatment simply reinforces negative stereotypes of people with mental illness."

The Association praised comments by Flinders University researcher Dr Stephen Allison, who objected to the view that investment in acute hospital beds was "payment for failure".

"Sleeping on streets and living on hand-outs is not 'living in the community'," Dr Anaf said. "This leads to increased financial and social costs, and revolving door admissions."

ADRIAN ROLLINS

Australian Medical Association Limited • ABN 37 008 426 793

Invitation for nominations for election to Federal Council

AREA NOMINEES

Invitation for nominations for election to Federal Council as Area Nominees

The Constitution of Australian Medical Association Limited (AMA) provides for the election, every two years, to the Federal Council of one Ordinary Member as a Nominee of each of the following Areas:

1. New South Wales and Australian Capital Territory Area • 2. Queensland Area • 3. South Australia and Northern Territory Area
4. Tasmania Area • 5. Victoria Area • 6. Western Australia Area

The current term of Area Nominee Councillors expires at the end of the AMA National Conference in May 2016.

Nominations are now invited for election as the Nominee for each of the Areas listed above.

1. Nominees elected to these positions will hold office until the conclusion of the May 2018 AMA National Conference. • **2.** The nominee must be an Ordinary Member of the AMA and a member in the relevant Area for which the nomination is made. • **3.** The nomination must include the name and address of the nominee and the date of nomination. It may also include details of academic qualifications, the nominee's career and details of membership of other relevant organisations. • **4.** Each nomination must be signed by the Ordinary Member nominated AND must be signed by two other Ordinary Members of the AMA resident in the Area for which the nomination is made. • **5.** Nominations must be **emailed** to the Secretary General (atrimmer@ama.com.au). To be valid nominations must be received no later than **1.00pm (AEDT) Friday 4 March 2016.** • **6.** A nomination may be accompanied by a statement by the nominee of not more than 250 words to be circulated to voters. • **7.** The ballot will by undertaken by electronic ballot.

The nomination form can be downloaded from: ama.com.au/system/files/AreaNomineeForm.pdf.

For enquiries please contact Lauren McDougall, Office of the Secretary General and President (email: lmcdougall@ama.com.au).

SPECIALTY GROUP NOMINEES

Invitation for nominations for election to Federal Council as Specialty Group Nominees

The Constitution of Australian Medical Association Limited (AMA) provides for the election, every two years, to the Federal Council of one Ordinary Member as a Nominee of each of the following Specialty Groups:

1. Anaesthetists • 2. Dermatologists • 3. Emergency Physicians • 4. General Practitioners • 5. Obstetricians and Gynaecologists
6. Ophthalmologists • 7. Orthopaedic Surgeons • 8. Paediatricians • 9. Pathologists
10. Physicians • 11. Psychiatrists • 12. Radiologists • 13. Surgeons

The current term of Specialty Group Councillors expires at the end of the AMA National Conference in May 2016.

Nominations are now invited for election as the Nominee for each of the Specialty Groups listed above.

1. Nominees elected to these positions will hold office until the conclusion of the May 2018 AMA National Conference. • **2.** The nominee must be an Ordinary Member of the AMA and a member of the relevant Specialty Group for which the nomination is made. • **3.** The nomination must include the name and address of the nominee and the date of nomination. It may also include details of academic qualifications, the nominee's career and details of membership of other relevant organisations. • **4.** Each nomination must be signed by the Ordinary Member nominated AND must be signed by two other Ordinary Members of the AMA Specialty Group for which the nomination is made. • **5.** Nominations must be **emailed** to the Secretary General (atrimmer@ama.com.au). To be valid nominations must be received no later than **1.00pm (AEDT) Friday 4 March 2016.** • **6.** A nomination may be accompanied by a statement by the nominee of not more than 250 words to be circulated to voters. • **7.** The ballot will by undertaken by electronic ballot.

The nomination form can be downloaded from: ama.com.au/system/files/SpecialtyGroupForm.pdf.

For enquiries please contact Lauren McDougall, Office of the Secretary General and President (email: lmcdougall@ama.com.au).

SPECIAL INTEREST GROUP NOMINEES

Invitation for nominations for election to Federal Council as Special Interest Group Nominees

The Constitution of Australian Medical Association Limited (AMA) provides for the election, every two years, to the Federal Council of one Ordinary Member as a Nominee of each of the following Special Interest Groups:

1. Public Hospital Practice (previously called Salaried Doctors)
2. Rural Doctors
3. Doctors in Training
4. Private Specialist Practice.

The term of Councillors expires at the end of the AMA National Conference in May 2016.

Nominations are now invited for election as the Nominee for each of the Special Interest Groups listed above.

1. Nominees elected to these positions will hold office until the conclusion of the May 2018 AMA National Conference. • **2.** The nominee must be an Ordinary Member of the AMA and a member of the relevant Special Interest Group for which the nomination is made. • **3.** The nomination must include the name and address of the nominee and the date of nomination. It may also include details of academic qualifications, the nominee's career and details of membership of other relevant organisations. • **4.** Each nomination must be signed by the Ordinary Member nominated AND must be signed by two other Ordinary Members of the AMA Special Interest Group for which the nomination is made. • **5.** Nominations must be **emailed** to the Secretary General (atrimmer@ama.com.au). To be valid nominations must be received no later than **1.00pm (AEDT) Friday 4 March 2016.** • **6.** A nomination may be accompanied by a statement by the nominee of not more than 250 words to be circulated to voters. • **7.** The ballot will by undertaken by electronic ballot.

The nomination form can be downloaded from: ama.com.au/system/files/SIGForm.pdf.

For enquiries please contact Lauren McDougall, Office of the Secretary General and President (email: lmcdougall@ama.com.au).

UK doctors suspend strike action as talks progress

The British Medical Association has put the Cameron Government on notice that there will need to be "significant, concrete progress" in negotiations on contracts for junior doctors if a massive walkout on 10 February is to be averted.

After staging a 24-hour strike early last month, British public hospital doctors called off follow-up action due on 26 January in order to allow for the resumption of talks with the UK Government.

But the BMA warned that unless the dispute was resolved, plans for an all-in strike in early February would go ahead.

Around 45,000 junior doctors were estimated to have gone on strike across England on 12 January to protest against proposed changes to employment contracts they believe will lead to unsafe work hours that will compromise patient safety.

Striking doctors established picket lines outside more than 100 National Health Service hospitals and clinics, according to the British Medical Association, in the first such industrial action in more than 40 years.

The NHS reported that 1279 inpatient operations and 2175 outpatient services were cancelled as a result of the strike, while thousands of junior doctors honoured a commitment to attend work to ensure that accident and emergency departments were not affected by the protest.

Chair of the BMA's Junior Doctors Committee, Dr Johann Malawana, said the decision had been made to suspend strike action planned for 26 January while negotiations with the Government and the NHS proceed.

"The BMA's aim has always been to deliver a safe, fair junior doctor contract through negotiated agreement," Dr Malawana said. "Following junior doctors' clear message to the Government during [the 12 January] action, our focus is now on building on early progress made in the current set of talks."

The doctors are protesting over a plan by the Government to force them on to contracts which would increase requirements to work long shifts, including on weekends and out-of-hours. They claim there are inadequate safeguards against unsafe working hours, potentially compromising patient care and safety, while the BMA declared an in-principle objection to the Government's aim of removing the distinction between weekend and after-hours work and the rest of the working week.

British Health Minister Jeremy Hunt said numerous studies had shown that people received lesser care on weekends than they did during the week, and "I can't, in all conscience as Health Secretary, sit and ignore those studies".

"We have to do something about this. People get ill every day of the week," the Minister said, and criticised the strike as "wholly unnecessary".

But the BMA was unrepentant about the action, and warned that further industrial action would go ahead as planned without further progress to meet doctor concerns.

"It is important to be clear…that differences still exist between the BMA and the Government on key areas, including the protection of patient safety and doctors' working lives and recognition of unsocial hours," Dr Malawana said. "Significant, concrete progress will need to be made if future action, currently planned for 10 February, is to be averted."

A Department of Health spokesman said the decision to suspend the 26 January strike had been "extremely welcome news".

"In the end, the Government and junior doctors want to do the same thing by improving patient care at weekends – and we look forward to further constructive discussions," the spokesman said.

The World Medical Association had thrown its support behind the junior doctors.

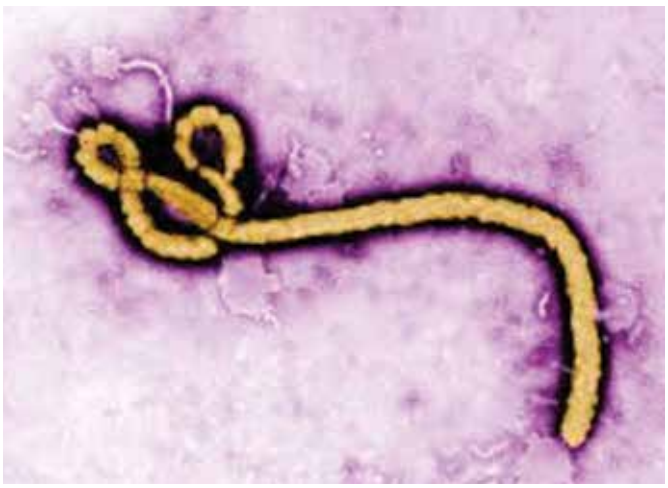
WMA President Sir Michael Marmot said the peak international medical organisation recognised the right of doctors to take action to improve working conditions that may also affect patient care.

"In this case, it is clear that patient care would suffer in the long term if the Government's proposals to change the working hours of junior doctors goes ahead," Sir Michael said, adding that the doctors had received widespread support from the public and NHS colleagues.

He urged the Government to "establish a new working relationship with junior doctors. It is essential that trust is restored on both sides, for the sake of patient care".

ADRIAN ROLLINS

Ebola re-appears just as outbreak is declared over



More than 100 people in Sierra Leone have been placed into quarantine following confirmation of the death of a woman from Ebola.

Just hours after the World Health Organisation declared "all known chains of transmission [of Ebola] have been stopped in West Africa", laboratory tests confirmed that a 22-year-old woman who died near the Sierra Leone capital Freetown on 12 January had contracted the deadly disease.

The discovery is a blow to hopes that the world's deadliest outbreak of the disease, in which more than 11,300 people died, was finally over.

Sierra Leone health authorities are still trying to identify the source of the transmission, though the news agency Reuters reported that in late December she had travelled to an area near the border with Guinea which had been one of the last remaining hot spots in the country before it was declared Ebola-free on 7 November.

Reuters reported a joint statement of the Sierra Leone Ministry of Health and the Office of National Security said in which they announced 109 people had been quarantined, including 28 considered to be at high risk.

Efforts to trace 43 missing people who may have had contact with the dead woman were on-going late last month – only seven had been identified and quarantined by 26 January.

Authorities are concerned that relatives of the dead woman washed her body before burial, a cultural practice that had been blamed for helping the rapid transmission of the deadly disease during the outbreak.

In its announcement just before the latest case was confirmed, the WHO had declared an end to the outbreak in Liberia, but warned that the battle to eradicate the disease was not yet complete.

"The job is not over. More flare ups are expected and...strong surveillance and response systems will be critical in the months to come," the Organisation said.

Liberia was first declared free of Ebola transmission in May last year, but there have been two flare-ups since – the most recent in November.

The WHO made its declaration on 14 January, 42 days after the last Liberian patient confirmed to have Ebola twice tested negative for the disease. The period allowed for two incubation cycles of the virus.

It said the date marked the first time since the epidemic began two years ago that all three of the hardest-hit countries – Guinea, Liberia and Sierra Leone – had not had a single case in 42 days.

But the WHO urged the need for continued vigilance and swift action when cases were identified.

It said the three West African countries remained at "high risk" of small outbreaks, most likely caused by the virus persisting in survivors even after recovery.

"We are now at a critical period in the Ebola epidemic as we move from managing cases and patients to managing the residual risk of new infections," the WHO's Special Representative for the Ebola Response, Dr Bruce Aylward, said.

Dr Aylward said the risk was diminishing as the virus gradually disappeared from the population of survivors, "but we still anticipate more flare-ups, and must be prepared for them".

Health authorities are concerned that the latest case in Sierra Leone did not present as a typical Ebola infection, causing delays in its diagnosis, and that there may have involved a breakdown in procedures around the safe handling of a patient infected with the disease.

ADRIAN ROLLINS

Kidnapping leaves big hole in care

AMA President Professor Brian Owler has voiced concerns for the safety of an Australian couple kidnapped from a health clinic in Burkina Faso, and raised fears the incident will not only disadvantage the local community but could deter others from undertaking humanitarian work.

Dr Ken Elliot and his wife Jocelyn, who have worked as medical missionaries in the impoverished West African country for more than 40 years, were snatched by suspected Al Qaida-linked militants from their home in Baraboule, near Djibo, about 200 kilometres north of the capital Ouagadougou.

Reports suggest the couple, who are both in their 80s, were taken in the early hours of 16 January, and may have been taken hostage for ransom as part of a fierce struggle between rival militant factions.

They were very well known in the area, where they run a 120-bed hospital. Dr Elliot is the only surgeon, and the clinic they established in 1972 serves a population of two million.

In a video published recently for the Friends of Burkino Faso Medical Clinic by Global Business Solutions Institute, Dr Elliot talked of the "enormous need" for care in the area.

In the video, Dr Elliot said there was a great shortage of surgical care in the region, and their hospital treats everything from hernias and bladder stones to tumours.

"You name it, we do it, because there is nowhere else to do it," he said. "When you look around and see the need, the need is enormous, [but] the rewards are enormous."

President Owler told ABC Radio the Elliots were among hundreds of Australian doctors around the world performing humanitarian work, often in isolated areas.

"We sometimes hear their stories, but most of the time the stories are not told and they're really unsung heroes," the AMA President said. "We should be very proud of the sort of work that these people are doing. They do, clearly, put themselves in danger."

Professor Owler said that, in addition to fears for the welfare of the Elliots, he was also concerned about what effect their abduction would have on the local community.

"Clearly, he and his wife have been doing humanitarian work

in Africa for most of their lives, devoted their lives to heling the local people and, of course, when this sort of thing happens, it takes away a vital resource from these local people," he said.

In the wake of the kidnapping, Djibo locals have mobilised to demand the release of the Elliots, amid concern that without them local health services will deteriorate.

A local family friend, Seydou Dicko, told the BBC that "he is not only Australian but he is someone from Burkina Faso, someone from our community, because what he did for our community even the Government itself couldn't do more than that".

Professor Owler said the incident could also deter others from following in the path of the Elliots and other Australian doctors providing health services for disadvantaged communities in some of the world's poorest countries.

"I think it probably deters other people from taking up similar work in the future," he said.

The Department of Foreign Affairs has said it is working with local authorities to try and locate the couple.

ADRIAN ROLLINS

Drug tests put on trial following tragedy

Safety protocols for human drug trials are coming under renewed scrutiny after one man died and three may have suffered permanent brain damage in a French test that went badly wrong.

In one of the most serious reported incidents in years, six men taking part in the Phase 1 clinical trial of an experimental molecule developed by the Portuguese pharmaceutical firm Bial were rushed to hospital in Rennes, north-west France after suffering severe adverse reactions to the drug.

One man who was declared brain dead has subsequently died, and University Hospital of Rennes Chief Neuroscientist Dr Pierre-Giles Edan said MRIs conducted on three other volunteers, who were all healthy males aged between 28 and 40 years, showed deep cerebral haemorrhage and necrosis. Dr Edan warned the damage "might be irreversible".

A fifth man was suffering neurological problems and a sixth was being monitored but was in a stable condition.

A subsequent update reported that one volunteer with no symptoms had been discharged from hospital, two others had been transferred to hospitals closer to home, while the two still being treated at the University Hospital of Rennes "present a positive scenario".

French Health Minister Marisol Touraine described the situation as "an accident of exceptional gravity", and pledged to "get to the bottom" of it.

Three separate investigations, including one by the French prosecutor, have been launched to determine whether the tragedy was caused by the drug itself or by an error in the way the trial, being conducted by the private Rennes-based firm Biotrial for Bial, was conducted.

The trial was the first time the Bial compound BIA 10-2474 had been used on humans following a series of tests involving laboratory animals.

It had begun in July, and the company said 108 people had taken the drug without experiencing any "moderate or serious" adverse reaction before the six men received an oral dose on 7 January. Phase 1 trials are to test for the safety of novel treatments, and typically involve taking escalating doses. Experts suspect the men received a higher dose than previous recipients.

One of the issues likely to be the focus of investigation is why the six men received the dose at the same time, rather than staggered over time.

Bial designed the drug to provide relief from pain and anxiety by acting on cannabinoid receptors in the brain.

The six volunteers each received 1900 euros ($A3000) to take part in the trial.

In a statement, Bial said that as soon as the five volunteers showed severe symptoms, "they were immediately transferred [to hospital]".

"Our main concerns at this time are with the monitoring of the trial participants, in particular the five hospitalised volunteers," the company said.

The company subsequently expressed "deep regret" over the death of the volunteer, and said it was "continually and closely following the health state conditions of the other five volunteers".

Bial said the trial had been approved by French regulatory authorities, and had been conducted "since the beginning in accordance with all the good international practices [sic] guidelines".

It said results, including the completion of toxicology tests in the pre-trial phase, had "permitted the start of the clinical trials in humans".

The company said it was committed to ensuring the well-being of participants and to determine "thoroughly and exhaustively the causes which are at the origin of this situation".

The Daily Mail has reported that French authorities have registered only 10 drug trial incidents since 2000, all with consequences far less serious than those in Rennes.

The incident has drawn parallels with a drug trial in Britain in 2006, in which six volunteers developed serious health problems and two were left in a critical condition. One, Ryan Wilson, spent 147 days in hospital after suffering multiple organ failure, and had to have all his toes and several fingers amputated. The German company that made the drug collapsed.

The accident reinforced calls for doses to be staggered over time, so that an adverse reaction in one subject could be detected before exposing others to the same risk.

ADRIAN ROLLINS

Blocking organ donation to get harder

Families who want to override the decision of a loved one to donate their organs may have to provide their reasons in writing under changes being considered in the United Kingdom to respect donor wishes.

NHS Blood and Transplant (NHSBT) has announced it is considering a range of measures to reduce the number of occasions in which families veto the decision of organ donors amid evidence the practice has cost hundreds of lives in the last five years.

The organisation has released figures showing that since 1 April 2010, 547 families in the UK have overridden the request of their loved one that their organs be donated, resulting in around 1200 people missing out on a potentially life-saving transplant.

Across the UK almost 6580 people are estimated to be currently waiting for a donated organ, and around 1000 people in need of a transplant die while waiting each year.

Families are overriding patient wishes despite evidence that the majority thinks this is wrong. A survey conducted by the NHSBT found 73 per cent thought it unacceptable that next of kin could veto a donation decision, while just 11 per cent supported it.

"While most families approached about donation support their relative's decision to donate as recorded on the Organ Donor Register, a number of families each year override a previously made donation decision," NHSBT Director of Organ Donation and Transplantation, Sally Johnson, said.

In response, the organisation is looking at options to curb the practice, including no longer formally asking families for consent, making it clear that their consent is not legally necessary, and asking them to provide a written explanation of their objection – something that is already required in Scotland.

"We think our proposed changes would make the existing legal situation clearer to families and, hopefully, help them to support their relative's decision," Ms Johnson said.

While there is no suggestion yet that Australian authorities might take similar action, there is great concern about the country's persistently low organ donation rate.

There has been only a modest lift in the rate of deceased organ donors in the last seven years, from 12.1 per million to just 16.1 per million, despite a $250 million Government campaign.

Former Assistant Health Minister Fiona Nash sparked controversy last year when she announced a review of the Organ and Tissue Authority, with its then-head, television presenter David Koch, resigning in protest.

Mr Koch said the Authority had raised Australia's world ranking in organ donation from 32 to 19 since it was launched in 2009, and accused Senator Nash into caving into the demands of the ShareLife advocacy group, which he claimed wanted to "take control of the money".

The AMA has supported efforts to boost organ donor rates.

Late last month, AMA President Professor Brian Owler reiterated his call for people to consider becoming an organ donor, and to discuss the issue with their family.

"Becoming an organ donor can, quite literally, be a lifesaving decision," Professor Owler said. "Just one donor can transform the lives of 10 other people."

But he said that because organ and tissue donation would not proceed against the wishes of the family, it was vitally important that those who wanted to be donors "share your decision…with others, especially family members," Professor Owler said.

The AMA's Position Statement on Organ and Tissue Donation and Transplantation, last updated in 2012, can be viewed at: https://ama.com.au/position-statement/organ-and-tissue-donation-and-transplantation-2012

ADRIAN ROLLINS

AMA Member Benefits

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

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

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

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

Careers Advisory Service: Your one-stop shop for information and resources to help you navigate through your medical career.

CPD Tracker: Record your continuing professional development (CPD) online with the AMA's CPD Tracker, a free service for members.

Amex: American Express is a major partner of the AMA and offers members special discounts and extra rewards on a range of credit cards, merchant services and offers for existing AMA cardholders.

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

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

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

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

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

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

Not a member?

Join now to discover the representation, services, resources and benefits available to members:

www.join.ama.com.au/join