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E-health reprieve

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INSIDE

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In this issue

GPs win an ePIP breather

Medical practices being pushed to the financial brink by the Medicare rebate freeze and other Government cuts have won a partial reprieve after Health Minister Sussan Ley pushed back the deadline on shared health summary uploads to early next year.

In a breakthrough following intense lobbying by the AMA, Ms Ley has advised GPs will be given until 31 January 2017 to comply with new rules that require practices to upload shared health summaries (SHS) for at least 0.5 per cent of patients every quarter to remain eligible for the Practice Incentive Program Digital Health Incentive.

AMA President Dr Michael Gannon, who has raised the issue at a several meetings with the Minister, said the decision was "very welcome".

"GPs are already under significant financial pressure from the Medicare rebate freeze and other funding cuts, and the last thing they needed was to also lose vital PIP incentive payments," he said.

The Government originally required practices to comply with the new eligibility criteria from May this year, but the AMA warned at the time that this would be unworkable for many practices and risked undermining the goodwill of GPs which was essential to making the My Health Record system a success.

In June, the AMA called for a moratorium on the new rules after a survey it conducted found that just 24 per cent of practices considered themselves able to comply, while almost 40 per cent said they would not be able to and 36 per cent were unsure.

Government figures show that in the first three months of operation, 1500 practices failed to meet their SHS upload target and 69 practices withdrew from the scheme altogether.

Dr Gannon said failure to comply had the potential to deliver a heavy financial blow to practices already under substantial financial pressure.

"If the Government had not relaxed its approach, close to a third of previously eligible general practices faced losing significant financial support," the AMA President said. "In many cases, practices would have been more than $20,000 worse off. With so many already close to breaking point, this could have been disastrous."

The Minister's decision follows a resolution passed by the AMA Federal Council in August calling for a moratorium on the new upload requirements and urging the Government to investigate the reasons why so many practices were struggling to comply.

The Federal Council said the Government should get the Practice Incentive Program Advisory Group (PIPAG) to conduct the review and provide recommendations on what could be done to improve practice compliance.

Dr Gannon said the episode highlighted the importance of the Government heeding the views and advice of general practitioners and their representatives.

The Government had pushed ahead with its SHS requirements against the advice of all the GP groups sitting on PIPAG, and the AMA President said in future it should ensure that any changes to the PIP Digital Health Incentive were based on the Advisory Group's advice.

Dr Gannon said the medical profession strongly supported the Government's My Health Record, and the Minister's decision to extend the SHS requirement deadline would help shore up the goodwill of GPs to support its successful implementation.

"It is pleasing that the Minister has recognised the concerns that have been consistently raised by the profession, and this decision provides some breathing space for practices," Dr Gannon said.

"With adequate time, education, and support, many of the affected 1500 general practices may well begin to genuinely engage with the My Health Record, and eventually champion it.

"But it is important that the Government continues to review the implementation of the PIP Digital Health Incentive in consultation with PIPAG.

"We need to know why practices failed to comply, and ensure that any of these issues are addressed before the end of January deadline. If a large number of practices still cannot comply by the new deadline, we may still need to revisit the policy."

ADRIAN ROLLINS

Conflicted pharmacists distracted by profit motive

Pharmacists under commercial pressure to sell unproven vitamins and other complementary medicines have a conflict of interest between their professional calling and retail imperatives, the AMA has said.

The AMA has told a Federal Government review of pharmacy regulation and remuneration that while pharmacists have a valuable contribution to make to improve the health of patients, this is being undermined by the focus in many pharmacies on retail sales.

"Pharmacist expertise and training are underutilised in a commercial pharmacy environment where they are distracted by retail imperatives, including the sale of complementary medicines that have no basis in evidence," the AMA said in a submission to the Pharmacy Regulation and Remuneration Review. "It would be difficult for anyone to argue that there is no inherent conflict of interest in this situation."

The Association's concerns have been echoed by a pharmacy insider who has warned that the industry is skewed toward pharmacists owning shares in multiple pharmacies who are primarily driven by profit.

"A significant number of these owners do not even work one day a year in a community pharmacy providing healthcare," the community pharmacist employee said in a submission to the Government's review. "These owners have a significant conflict of interest. Their primary goal is profit. The pressure is all for financial goals, never for patient outcomes."

The employee, who did not want to be identified, said there needed to be regulations in place to "stop pharmacists being distracted by retail issues."

"The practical operation of the ethical side to a community pharmacy should be completely separate to the retail side. Pharmacies should stop looking and operating like supermarkets."

The structure and regulation of the pharmacy sector is coming under scrutiny amid concerns that it is increasingly prioritising commercial interests and seeking to expand the services it offers while simultaneously trying to frustrate competition and innovation in the industry.

In service of what?

The $18.9 billion Community Pharmacy Agreement struck with the Federal Government last year includes $1.2 billion to support an expanded role for pharmacists in primary care.

The development was lauded by Health Minister Sussan Ley, who said at the time that: "We want to make sure that we give them a key role in the primary care teams of the future. That's an exciting new structural reform for the future".

But the AMA and other medical groups are alarmed by the Pharmacy Guild of Australia's push to boost pharmacy income by offering a range of services that they argue go well beyond pharmacist areas of expertise.

In addition to blood pressure tests, medication reviews, vaccinations and the writing of medical certificates, pharmacists want authority to prescribe Schedule 4 medicines, undertake early detection and diagnosis of mental illness, advise on nutrition, weight loss, pregnancy and baby care, and undertake chronic disease management.

In its submission, the AMA said this was wrong-headed and dangerous, and should not be funded under the CPA.

"These additional services represent an expansion of pharmacists' scope of practice beyond their core education and training," the AMA said.

"By lobbying for these types of services to be funded under the Community Pharmacy Agreement, the Pharmacy Guild of Australia, representing for-profit business owners, is trying to drive the scope of practice of a health profession.

"This is not an appropriate way to design a health care system to meet the future needs of the community."

Conflicted pharmacists distracted by profit motive

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It said any move to expand the pharmacist scope of practice must be underpinned by a process that ensures there is no increased risk for patients, that it is related to the qualifications and competencies of the profession, that it does not come at the cost of training opportunities for other health practitioners and that health system costs will be lower.

The Pharmacy Guild has argued that allowing pharmacists to provide a greater range of health services would meet unmet demand for care from people unable to see a doctor.

But the appropriateness of pharmacies as a venue to conduct health checks and other medical services has been challenged.

A community pharmacy employee told the Government review that the current practice of pharmacy assistants talking to customers about medications and other products was intrusive and of little benefit.

"I receive nil to pointless interaction with a pharmacy assistant when purchasing a medicine, and can count on [one] hand the times that a pharmacist was involved," the worker said in a submission. "What is the point? Exactly the same transaction can be offered in any retail store."

In addition, the employee said, "I am not the only patient in Australia that has no interest in discussing in public, with no privacy, my thrush problem, piles issue, worm problem etc. It is just not good enough. Pharmacy owners have been given enough chances to fix this."

The AMA said many of the services proposed by the Guild were beyond the competency of pharmacists, and giving them scope to provide them would only "duplicate effort and fragment care."

Pharmacist in the house

Instead, the AMA has proposed that the Government support general practices to make non-prescribing pharmacists an integral part of the primary health care team.

The Association said the Government would save money and improve patient care by establishing a Pharmacist in General Practice Incentive Program, which enable practices to employ non-prescribing pharmacists to support GP prescribing and assist with medication management and patient education.

An analysis prepared by Deloitte Access Economics found the program would save $1.56 for every dollar invested in it by cutting down on adverse drug reactions, reducing the number of PBS-subsidised prescriptions and lowering patient co-payments for consultations and medicines.

Deloitte estimated that if 3100 practices participated in the program, it would cost the Government $969.5 million over four years, but this would be more than offset by $2.1 billion in savings over the same period from lower hospital admissions, fewer prescriptions and reduced doctor visits.

ADRIAN ROLLINS

"What they said ...

Pharmacist[s]… are distracted by retail imperatives, including the sale of complementary medicines that have no basis in evidence. It would be difficult for anyone to argue that there is no inherent conflict of interest in this situation – AMA

[Pharmacy] owners have a significant conflict of interest. Their primary goal is profit. The pressure is all for financial goals, never for patient outcomes – community pharmacy employee

I am not the only patient in Australia that has no interest in discussing in public, with no privacy, my thrush problem, piles issue, worm problem etc. It is just not good enough - community pharmacy employee

The greatest barrier to my profession receiving the credit and remuneration it deserves is the impact of retail focused pharmacy chains and aggressive discounters. The emphasis on low prices and prescription volume is not a formula that delivers a great degree of pharmacist access and optimal delivery of services – pharmacy proprietor

Total health care solutions for consumers require the supply of prescription and non-prescription medicines. As a practising pharmacist, my pharmacy requires a sufficient OTC offer to adequately treat my patients. A dispensing-only pharmacy would provide a less than adequate service – community pharmacy owner

The location rules do, by nature, provide certainty for a pharmacist, which encourages them to invest - community pharmacy owner

I know of many young/new pharmacists who wish to own their own pharmacies, but cannot afford the prohibitive goodwill and prices charged for many current community pharmacies – young pharmacist

Putting the community in pharmacy

Outdated and anti-competitive industry rules are frustrating attempts to improve the service pharmacists provide to patients, critics including the AMA have warned.

Controversial regulations that limit the ownership and location of pharmacies are being challenged by the AMA and other contributors to a Federal Government review of the pharmacy industry amid concerns that they are standing in the way of reforms to improve patient access and enhance collaboration between health professionals.

In its submission to the Pharmacy Regulation and Remuneration Review, the AMA said current rules prevented greater co-location of pharmacies in medical practices, to the detriment of patients.

Currently, pharmacies can only be co-located in medical practices where there are at least eight full-time prescribers, and cannot be opened within 500 metres of an existing pharmacy.

The AMA said the rule failed to take into account changes in the GP workforce, particularly an increase in the proportion of doctors who worked part-time.

"The current restrictions are inflexible and are difficult to justify in terms of public benefit," the Association's submission said. "Restricting co-location of pharmacies and medical practices also reduces the opportunities of increased collaboration and communication provided by close proximity of doctors and pharmacists."

The AMA said it had "no concerns" about the idea of locating pharmacies within or adjacent to supermarkets – an idea long championed by major retailers - as long as responsibility for dispensing medicines remained with a registered pharmacist.

ADRIAN ROLLINS

Funds behaving badly

Health funds are coming under increasing pressure to justify premium rises and value for money, following a string of scandals and a three-way battle between insurers, private hospitals, and prosthetics makers over who is to blame for rising costs.

With premiums rising by 35 per cent since 2010, far outstripping inflation, the funds are facing an exodus of members.

Government figures show the percentage of people with private health insurance dropped for the first time in 15 years in the June quarter this year, from 47.4 per cent to 47 per cent.

And a poll shows that almost 70 per cent of privately insured Australians have considered downgrading their cover or ditching it altogether over the past year.

Medibank Private alone lost 100,000 members in the past year, following an IT bungle that prevented customers from receiving tax statements on time, and a blowout in call centre wait times from three minutes to six minutes since January.

It is also fighting legal action brought against it by the Australian Competition and Consumer Commission (ACCC) after secretly changing policy conditions, leaving hospital patients hundreds of dollars out of pocket.

Medibank Private argues it was not required to expressly notify members that they were no longer covered for a range of common hospital tests, including blood tests, X-rays, and MRI scans.

"Information available to Medibank showed that, while consumer and member awareness of out-of-pocket expenses varied, the majority of Medibank members who had made claims in the past were aware of out-of-pocket expenses," Medibank argued in papers lodged with the Federal Court.

The insurer, which in August posted a $417 million profit, faces fines of more than $10 million as well as compensation payments and potential class actions if it loses the case.

The court case comes as fellow giant Bupa has admitted incorrectly assessing thousands of claims.

In early September, Bupa announced that an internal review had identified that, between 2011 and 2016, some customer claims involving pre-existing conditions had been rejected by assessors without review by a Bupa –appointed doctor.

"Bupa now has a new team of doctors looking at all 7740 rejected pre-existing condition customer claims from the relevant period and is writing to all potentially affected customers to advise that their cases are being reviewed," the fund said in a statement.

"Where cases have been incorrectly assessed, the customer will be appropriately reimbursed."

Managing director Dwayne Crombie said that overseas students, foreign workers, and tourists were most affected, along with people aged about 30 and those who had upgraded their cover.

But he said that of the first 700 claims to be re-examined, only 2 to 3 per cent had been overturned.

"Even though the process wasn't right, the assessors seem to have generally come to the right conclusion," Dr Crombie told *The Australian.*

Meanwhile, Bupa's own figures show that Australian families are paying up to $400 more a month for private health insurance than those in comparable countries.

A British family with two adults and two children would pay $170 a month for top cover, the same family in New Zealand would pay $290, but in Australia the same family would pay $588.

Bupa blamed the difference on the ageing Australian population, along with the price of prosthetics and devices in Australia.

In a priorities document provided to the Government and Opposition after the election, Bupa cited the example of a standard ceramic hip, which would cost the Prince of Wales public hospital in Sydney $4,900, but the private hospital next door would pay $11,000.

The health funds are lobbying Health Minister Sussan Ley to make major changes to the Prosthesis List, which determines what insurers pay for prosthetics, arguing it could save them $800 million a year.

But prosthetics manufacturers are fighting back, with peak body the Medical Technology Association of Australia (MTAA) commissioning a ReachTEL poll on people's views on their private health cover.

It found that 69.2 per cent of privately insured Australians had considered dropping or reducing their coverage, and that half blamed the insurance companies for rising premiums.

Asked if they trusted insurers to pass on savings from changes to the Prostheses List, 54 per cent of respondents said no.

MARIA HAWTHORNE

Govt delays pathology cut, abandons moratorium

The Federal Government has put off plans to axe bulk billing incentives for pathology services and abandoned its threat to impose a moratorium on the development of new collection centres.

In a climb-down for the Government, it has pulled back from its threat to scrap the incentive on 1 October and has advised that it will not be proceeding with the moratorium, which was announced during the Federal election in order to head off a protest campaign by the pathology industry against the axing of a bulk billing incentive.

Instead of a ban, the Government has directed that collection centre leases be put up for renewal every six months, down from the usual 12 months, until a new regulatory framework is put in place. Existing leases will be grandfathered for up to 12 months, after which the new rules will come into effect.

The bulk billing incentive cut, meanwhile, which was originally due to come into effect from 1 July and save $332 million, will now not be implemented until 1 January 2017.

"Bulk billing incentives for the pathology sector will continue until new regulatory arrangements are put in place and the Government will continue to consult with affected stakeholders," a spokesman for Health Minister Sussan Ley told the *Herald Sun.*

The changes are the latest developments in a complex deal hatched by the Government before the election to mollify the pathology sector, which had been angered by the bulk billing cut.

Facing the politically damaging threat by pathologists to stop bulk billing and begin charging patients, Mr Turnbull in May announced the Government would look to address industry complaints about collection centre rents by introducing changes linking them to local commercial rates. The Prime Minister said the new regime would be backed by "appropriate compliance mechanisms".

In response, Pathology Australia agreed to drop its national "Don't Kill Bulk Bill" campaign, saying that reduced rents would enable its members to absorb the bulk billing incentive cuts and sustain current rates of bulk billing.

At the time, the Government's announcement amounted to a backflip by Ms Ley who, in a 2015 review of Approved Pathology Collection centre arrangements, rejected pathology sector calls for a change in the definition of 'market value' and determined that existing regulations regarding prohibited practices and market rent were appropriate.

An investigation by the Health Department had found no evidence that medical practices were over-charging pathology operators to rent collection centre space in their clinics.

The Government has tried to put its decision to abandon the promised moratorium in a positive light by arguing that changes in the dynamics of the market since May made it no longer necessary.

But industry observers told *Australian Medicine* that the Government had been forced to abandon the moratorium pledge because it was unworkable. They said it contravened administrative law, which requires that the Health Department deal with a collection centre application when it is made.

The shift to six-month lease terms has been seen as a stop-gap measure as the Government hammers out the details of a new rents framework.

Shadow Health Minister Catherine King called on the Government to drop its cuts to the pathology bulk billing incentive "entirely".

"Malcolm Turnbull's pathology fix was only ever a stunt to get through the election," Ms King told the *Herald Sun.*

ADRIAN ROLLINS

Antivax film dumped following outcry

A controversial film that claims US health authorities are covering up evidence linking a vaccine to autism has been withdrawn from screening at a central Victorian film festival.

The Castlemaine Local and International Film Festival has decided to dump the controversial show *Vaxxed: From Cover-Up to Catastrophe* following widespread calls, including from AMA President Dr Michael Gannon, for it to be scrapped from the festival's line-up.

Late last month Dr Gannon called on organisers of the film festival to dump the program because it made claims about the safety of vaccines that had been thoroughly discredited, could undermine efforts to protect children against infectious diseases and might add to distress and hardship for parents of children with autism and.

The film is written and directed by Andrew Wakefield, a former doctor who was struck off after being found to have falsified the results of a notorious 1998 study claiming to have a correlation between the MMR vaccine and autism. It purports to document the experiences of a former US Centers for Disease Control and Prevention employee who claims the CDC covered up data showing a statistically significant association between the MMR vaccine and autism in African American children.

But actor Robert De Niro pulled it from screening at New York's Tribeca Film Festival amid widespread criticism, and the organisers of the Castlemaine Local and International Film Festival (CLIFF) have now followed suit.

The organisers, who had initially resisted calls to dump the film, said in a statement reported by the *Bendigo Advertiser* that they had decided to acquiesce to pressure because some had felt "personally and professionally threatened".

"This is unacceptable. It is with the utmost regret, therefore, the CLIFF is compelled, for clear reasons of personal and public safety, to withdraw the screening from the CLIFF 2016 programme," the organisers said in a statement.

The decision came amid strong criticism by Victorian Health Minister Jill Hennessy, Dr Gannon and other health experts of the claims made in the film.

Dr Gannon said assertions made in *Vaxxed* of a link between vaccines and autism had been held up to close public examination over a long period of time and proven to be false.

He said the makers of *Vaxxed* should not be given a platform to peddle their discredited claims.

"The director of the film's an ex-colleague of mine called Dr Andrew Wakefield, who's obviously decided that running a wellness clinic in exile in Cuba's no longer floating his boat, and he's going to make anti-vaccination films, having potentially damaged thousands of children in England and Wales with his false MMR scare campaign. He's entirely discredited. Anyone he hangs around with is discredited," the AMA President said.

Challenged over the right to present these claims in a film, Dr Gannon replied: "Not when it's made by a charlatan, not when it's made by someone who's been entirely discredited by the scientific world, the medical world, someone who was struck off the medical register for having harmed people and been seen as being a danger to the community.

"That's not the kind of person I'd be getting my scientific information from. And that's not the kind of person who I would trust to fairly vet the claims of one person within a bureaucracy of tens of thousands of people.

"I would say censor and ban this rubbish."

Ms Hennessy said it was important to challenge the myths peddled by anti-vaccination campaigners.

"We've got to keep challenging the anti-science myth pedalling that goes on around vaccination and a film that goes out there to say 'vaccinations aren't safe' is really, really unhelpful, particularly in communities where the vaccination rates are in many circumstances lower than what the state average is," Ms Hennessy said.

Antivax film dumped following outcry

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"Sadly, what you'll see when you screen a film like this, you'll see confirmation bias," the AMA President said on ABC radio. "You'll see people who want to believe that there's something wrong here, and that will just get in their head. There are people who - for some strange reason - like believing in conspiracy theories."

The AMA President lambasted the makers of the film for the "potential carnage" caused if it resulted in lower vaccination rates, and the harm it might inflict on families.

"Those families around Australia that struggle with the hardship of dealing with children afflicted by autism spectrum disorder, blaming them, setting them up, saying that they did something to injure their child's brain development. I think that is so unfair," he said.

Dr Gannon said the safety and efficacy of each vaccine was subject to rigorous examination, and it was vital that people remained confident in the safety and effectiveness of the National Immunisation Program.

"Every individual vaccine is subject to the closest level of scrutiny as to its effectiveness, both for individuals and a population level, and it's safe," he said. "I can assure your listeners that the health authorities do take this stuff extremely seriously [and] even small pockets of people who choose not to vaccinate their children, there is a cost to be had there.

"One, two, three per cent reductions in vaccination rates harm children. They put them in intensive care, they kill them. This is not scare-mongering. It is so important to maintain vaccination rates well above 90 per cent. It's irresponsible to do anything that might threaten the public's health."

ADRIAN ROLLINS

Drug approvals to be put on the fast-track

Waiting times for new medicines will be cut by between 18 weeks and two years under new rules designed to allow fast-tracked approvals of drugs already accepted in other jurisdictions.

The changes will allow the Therapeutic Goods Association (TGA) to make greater use of assessments made by the US Food and Drug Agency (FDA) and the European Medicines Agency (EMA), and to enter "worksharing" arrangements with overseas regulators to assess new drugs.

Health Minister Sussan Ley said the changes would bring Australia into line with other international regulators.

"Bringing medicines onto the Australian market quicker will be achieved in part by greater use of assessment of medicines by comparable overseas regulators like the US Food and Drug Administration (FDA) and the European Medicines Agency (EMA)," Ms Ley said.

"Provisional approvals will also be available that could result in certain life-saving medicines, such as new cancer drugs, coming to market two years sooner."

The changes are part of the Government's response to a review of medicines and medical devices, which was submitted to the Government more than a year ago by independent expert, Emeritus Professor Lloyd Sansom.

Professor Sansom's initial report found that Australian patients had to wait, on average, five months longer than patients in the US or Europe for anti-cancer medicines, seven months longer for cardiovascular medicines and up to 15 months longer for nervous system medicines.

"It's a common complaint that certain high profile medicines are not brought to Australia, and it is expected that implementing expedited pathways for registration of new medicines will result in many new medicines coming onto the Australian market," Ms Ley said.

"Greater use of assessment of medicines by comparable, trustworthy, overseas regulators is estimated to bring medicines from companies that use this assessment pathway to market four-and-a-half months earlier than under the current regime."

The changes will allow drug sponsors to submit FDA or EMA evaluation reports to the TGA for consideration when applying for registration in Australia.

Ms Ley said the TGA would also be able to manage more efficiently an estimated 60,000 notifications and approvals each year for patient-specific access to unapproved products.

Seriously ill patients would get faster access to essential, but not yet approved, medicines under reforms to the Special Access Scheme (SAS), including a new online application process and an increase in the number of medicines subject to streamlined approval.

The reforms will be rolled out over the next 18 to 24 months.

MARIA HAWTHORNE

Rebate freeze eroding quality GP care

The nation's GP leaders have warned the Federal Government's Medicare rebate freeze is undermining the quality of care and will have "serious repercussions" for patients.

The nation's peak general practice representative group United General Practice Australia (UGPA), which includes the AMA, the Royal Australian College of General Practitioners, the Rural Doctors' Association of Australia and several other doctor organisations, has told the Government that financial pressure caused by the Medicare rebate freeze was threatening the kind of services general practices could provide.

"Modern general practice relies on sophisticated infrastructure to support quality care. The Government's policies are eroding this infrastructure," UGPA said in a statement. "It is challenging for practices to even maintain the status quo as the impact of the Medicare freeze compounds year on year."

The peak group said GPs were being caught in a financial squeeze between increasing patient demands and rising running costs on one side, and stagnant income from Medicare on the other.

"Like all small businesses, general practices must cover many costs, including for staff, equipment, technology, building, insurance, and medical indemnity,". "Many general practices are reviewing their practice costs and business operations in order to remain viable. The ongoing freeze is eroding the ability of practices to continue to meet demand and maintain the highest possible levels of primary care."

The warning follows the release of data showing that patient out-of-pocket costs have surged as struggling practices have moved to offset the relative loss of income caused by the rebate freeze.

Medicare figures show that GP patient fees jumped 6.5 per cent last financial year, the biggest rise in four years, to reach an average $34.25, underlining AMA warnings that Government policies were pushing many general practices to the financial breaking point, with serious consequences for patients and access to quality care.

"GPs are caught in a diabolical squeeze," AMA President Dr Michael Gannon said recently. "They are caring for increasingly sick patients while the Government tightens the financial screws in the name of budget repair. GPs are now at breaking point. Many patients who are currently bulk billed will face out-of-pocket costs well over $20."

Health Minister Sussan Ley has claimed the record high bulk billing rate of 85.1 per cent showed that patients continued to get ready access to care.

But UGPA said this ignored the enormous pressure being placed on GPs and the increased costs imposed on patients.

"With an ageing population and a dramatic increase in the number of patients with complex and chronic conditions, the demand on quality health care from GPs is growing significantly and quickly," the peak general practice coalition said. "The Medicare rebate freeze is squeezing general practice. It will have serious repercussions for our patients, especially the most vulnerable, and the health of the economy.

The group has added its voice to AMA calls for the Government to immediately scrap the rebate freeze.

ADRIAN ROLLINS

Public-private work split good for care

Governments should consider providing incentives for specialists and surgeons to devote more of their time to work in the public sector, according to a health system researcher.

Professor Gary Freed of the University of Melbourne said his investigation into the way doctors allocated their time between the public and private health systems showed the majority did the bulk of their clinical work in better-remunerated private settings.

In his study, Professor Freed tracked the time allocation across eight groups of specialists who worked in both the public and private systems.

Of these, eye surgeons were the most likely to concentrate on private sector work, spending 87 per cent of their time with private patients, while orthopaedic surgeons, ear, nose and throat specialists and rheumatologists all spent more than 70 per cent of their week in private care.

Further down the scale, cardiologists and gastroenterologists devoted more than 60 per cent of their time to private patients, while kidney specialists split their time broadly 50:50 between the two systems.

Professor Freed told *The Age* the way specialists split their time between the two systems was inefficient and could be contributing to delays in treatment for public patients.

But AMA President Dr Michael Gannon disputed this and argued that by working across the two systems doctors were a conduit on sharing ideas for improvement.

"There are things that the public system does better in Australia and there are things that the private system does a whole lot better," Dr Gannon told *The Age*.

Rather than criticising doctors for the way they split their time, Dr Gannon took aim at what he said were "quite burdensome" bureaucratic demands imposed on doctors working in the public system that were acting as a deterrent to greater engagement.

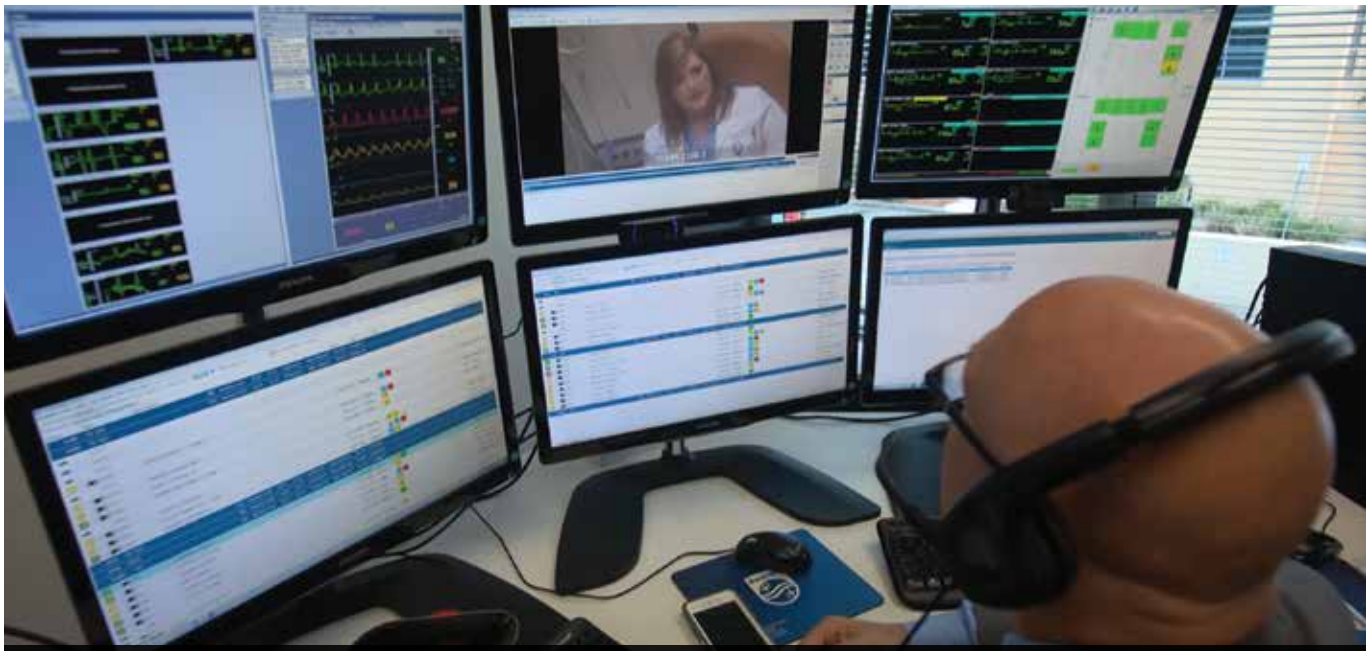
"For example, every year in the public system, even as someone who works there part time, I have to pass education modules on dealing with violent patients, hand washing modules, cultural competence modules," the AMA President said. "High levels of managerialism have reduced morale in the public hospital system."

Dr Gannon said that although many doctors liked working in the public system because of opportunities to teach, undertake research and care for the vulnerable and less well off, the bureaucratic demands and financial constraints acted as a deterrent.

The issue has arisen as the AMA and the Australian Salaried Medical Officers Federation prepare to release a guide on rights of private practice in public hospitals.

ADRIAN ROLLINS

Hospital trial turns night into day for US doctors, patients



Dr Timothy Buchman talks to a colleague in Atlanta from the 'Turning Night Into Day' centre at Macquarie University

Night has become day for a group of US doctors and critical care nurses, who are using new technology to remotely monitor their intensive care patients in hospitals in Atlanta from a Sydney health campus.

The intensivists and nurses from US health provider Emory Healthcare are part of a clinical trial to assess the health benefits for both patients and doctors of having highly experienced clinicians available to provide senior support around the clock.

Taking advantage of remote intensive care unit (eICU) technology and the 14-hour time difference, the medical teams are essentially working the Atlanta night shift during the day in Sydney.

"We're in Australia because we are trying to look at a different model of care," Cheryl Hiddleson, the director of Emory's eICU Centre, told *Australian Medicine*.

"We were having our clinicians up all night while they were trying to do other things during the day – that's just what happens. We know that working the night shift is tough.

"This study is to look at our staff and see how the difference in the times that they are working makes to their performance and their health."

Under the trial, senior intensivists and critical care nurses from Emory are based in Sydney for six to eight week rotations.

They work at MQ Health at Macquarie University, using eICU technology developed by health technology maker Royal Philips, to provide continuous night-time critical care oversight to high-risk patients in Emory's six hospitals across the state of Georgia.

"We intensive care folk have one mission, and that's to deliver the right care for the right patients at the right time," Dr Timothy Buchman, the chief of Emory's Critical Care Services, said.

"Almost everything we do has to be done with both speed and care. That's easy in a big hospital at 10am on a Monday, but that task becomes a lot harder in a remote or rural hospital at unsocial hours – on weekends, holiday, or especially at night.

"There are fewer people, and less experienced people, and patients can become sicker around the clock. Patients and their families deserve the best care, and this is about bringing that senior support to the bedside."

The day before Dr Buchman spoke to *Australian Medicine*, he helped treat a patient who had been airlifted to one of Emory's Atlanta hospitals at 2am US time – 4pm in Sydney.

Hospital trial turns night into day for US doctors, patients

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The patient was suffering severe pancreatitis and respiratory failure, and was being treated by a relatively junior doctor.

"I had a complete echo of the bedside monitor, and was able to guide the doctor through the treatment," Dr Buchman said.

"The attending physician would have been at home, probably asleep. But I was able to go in as if I was there and help implement care plans."

Two hours later, another patient came in from a smaller hospital, suffering post-operative haemorrhaging.

"She was deeply anaemic, but she was also a Jehovah's Witness and so was refusing blood products," Dr Buchman said.

"The other hospital said we needed experimental therapies, so we accepted her admission. I was able to evaluate her remotely and provide the level of care she needed. When I came in to work this morning, I was able to check on her condition again."

The previous night, just before 1am, the family of a terminally ill cancer patient, who had been intubated earlier in the day, requested a meeting to evaluate his care.

"I was able to talk to them – they could see me, I could see them – and they decided to shift from aggressive care to comfort," Dr Buchman said.

"The patient was able to die. His family were able to be there and it was able to occur in a timely fashion. The family had come to a decision and acceptance, and they could have that meeting when they needed it, instead of having to wait for hours."

Emory already uses the eICU to provide senior support to smaller and remote hospitals throughout Georgia. The time difference trial is intended to see if the technology can help keep senior clinicians in the workforce.

"People do function a lot better when they can do night work in day time," Dr Buchman said.

"This technology is important, but it is only an enabler. The people - the staff, the patients – are what is important, and this technology gives us the ability to use this accumulated wisdom during daylight for patients on the other side of the world who would not normally have access to this level of expertise."

.MARIA HAWTHORNE

Terms set for GP registrars

The AMA has helped broker an agreement on the terms and conditions for employing GP registrars for 2017-18.

The agreement, between General Practice Registrars Australia (GPRA) and General Practice Supervisors Australia (GPSA), replaces the 2015-16 agreement, which was set in December 2014.

The National Terms and Conditions for the Employment of Registrars (NCTER) 2017-18 has been reached three months earlier than in the past, giving registrars and practices more time to negotiate their employment arrangements for 2017.

It covers GP registrars undertaking Australian GP Training in all general practice terms of training, although those employed in community controlled health workplaces, the Australian Defence Force, or in remediation may be bound by other contractual arrangements.

GPSA Chair, Dr Bruce Willett, said his negotiating team relied heavily on supervisor and training practice feedback to set the terms.

There has been no increase to the base rates nor percentages, due to the existing Medicare freeze, rising costs, and the freeze on training practice subsidies.

GPRA Chair, Dr Jomini Cheong, said that the new agreement provided greater clarity around issues that had previously been open to interpretation.

Both organisations agreed that the NCTER 2017-18 represented the fairest possible outcome for both training practices and registrars, given the current political and economic environment.

The NCTER again requires that registrars be engaged as employees, and allows for percentage payments to be made on a billings or receipts basis not less than every three months.

The NCTER is a goodwill document that applies because of the agreements in place between the Australian Government and the Regional Training Organisations (RTOs), which require training practices to observe it.

Dr Willett and Dr Cheong thanks the Australian Government, the RTOs, and the AMA for their ongoing support and promotion of the NCTER.

MARIA HAWTHORNE

No PBS listing for Truvada

HIV advocates have urged the Pharmaceutical Benefits Advisory Committee (PBAC) to reconsider its decision to recommend against taxpayer subsidies for the HIV prevention drug Truvada.

The once-daily antiretroviral pill was approved for use in Australia for pre-exposure prophylaxis (PrEP) in May.

> "It costs about $1200 a month to buy in Australia, but reportedly can be bought online and imported for less than $100 a month"

It costs about $1200 a month to buy in Australia, but reportedly can be bought online and imported for less than $100 a month.

AIDS groups claim the drug has the potential to halve the number of HIV transmissions in Australia within a year.

But PBAC rejected drug sponsor Gilead Science's application on cost grounds, saying that the estimated $105,000 to $200,000 per quality adjusted life year (QALY) was "unacceptably high and uncertain".

PBAC said that while the evidence showed PrEP could reduce the risk of acquiring HIV when used in conjunction with safer sex practices and regular testing, it was not always effective in preventing infection.

Gilead had proposed limiting access to the subsidy to those with a predicted annual risk of infection of 3 per cent or higher, based on the individual's likelihood of engaging in unsafe sex.

"The PBAC noted that the efficacy of Truvada was highly dependent on adherence, and that it is not clear if subjects at high risk of contracting HIV due to self-reported low adherence to safer sex practices would also have lower adherence to medication," PBAC said.

"The PBAC considered it may be more appropriate for a broader group of individuals to have access to Truvada as PrEP, for example all individuals for whom clinician and consumer judge the potential benefit to outweigh the risk.

"The PBAC noted that in order to make Truvada available for PrEP to the whole 'at-risk' population, a substantial reduction in price would be needed to achieve cost effectiveness."

In response, Gilead said it was "committed to working with the PBAC towards the future listing of Truvada for PrEP".

The Australian Federation of AIDS Organisations (AFAO) chief executive officer Darryl O'Donnell said the decision would limit access to an effective prevention tool.

"People are needlessly getting HIV while we wait for access to this prevention pill," Mr O'Donnell said.

"The Australian Government has made a world-leading commitment to virtually end HIV transmission in Australia by 2020. We can do this together if we have access to the best prevention tools, of which PrEP is pivotal. We won't reach the Australian Government's goal without PrEP being subsidised through the Pharmaceutical Benefits Scheme."

Mr O'Donnell said AFAO would work with Gilead to understand what went wrong.

"This is a proven technology," Mr O'Donnell said.

"Given the negative decision, the Pharmaceutical Benefits Advisory Committee either didn't get the information they needed, or the price put forward by the company was too high.

"We are calling on Gilead to urgently submit a new application for Truvada and do whatever it takes to ensure the next submission is successful."

Greens Leader, Senator Richard Di Natale, called on the Government to make personal importation of Truvada more affordable in the wake of the PBAC decision.

"We simply cannot leave Australians at unnecessary risk when this drug gives us the chance to end HIV transmission in Australia," Senator Di Natale said.

"An investment of $34 million over four years would see the Commonwealth Government able to work with the States, Territories, and community organisations to supply this drug to high-risk Australians who aren't in clinical trials, and provide a safety net for those whose clinical trials will soon end."

MARIA HAWTHORNE

Building the Indigenous medical workforce

There are too few Aboriginal and Torres Strait Islander doctors and medical students. According to the Australian Medical Students' Association, only about 2.5 per cent of students in the first year of medical school are Indigenous, and this percentage is decreasing. The total enrolment of Indigenous students in medicine is put at just 1.6 per cent, while the proportion who graduate is only 0.5 per cent.

Increasing the number of Indigenous medical practitioners and health care workers is a goal not just for the AMA, but for all involved in closing the gap and improving the health and wellbeing of Australia's first peoples.

The number of Aboriginal and Torres Strait Islander medical students is too low, with about 265 Indigenous medical students (as at 2015) enrolled at medical schools in Australia. To boost the number of Indigenous students, each year the AMA offers an Indigenous Peoples' Medical Scholarship to provide financial assistance to Aboriginal and/or Torres Strait Islander people who are studying for a medical degree at an Australian university. The value of the Scholarship is currently $10,000 a year, and is applicable for the full duration of a medical degree.

The AMA is not the only organisation supporting Aboriginal and Torres Strait Islander medical students to graduate. The Shalom Gamarda Indigenous Scholarship Program offers residence at Shalom College in Sydney to Aboriginal and Torres Strait Islander students studying at the University of New South Wales.

Shalom Gamarada assists Indigenous students by providing financial support, reducing the time they travel to and from university, and by creating an atmosphere that enhances their university life, with tutoring and counselling support.

Originally concentrating on medical and health science students, in 2011 the program expanded to include students studying other disciplines. Since the program's inception in 2005 it has assisted 67 students. There are currently 28 Indigenous students at Shalom College and, to date, 13 students have graduated from Shalom Gamarada, including 10 doctors, an optometrist, a social worker and one architect.

The AMA was honoured at attend a ceremony at the NSW Parliament on 24 August to acknowledge and celebrate Shalom Gamarada's philanthropy and support for Aboriginal and Torres Strait Islander medical students.

Hilton Immerman, CEO of Shalom College, is the driving force behind the Shalom Gamarada Scholarship Program. This truly inspiring and generous program has increased the numbers of Indigenous medical practitioners in Australia.

At the Shalom Gamarada function, we heard that in just over a decade, the program has gone from supporting one Aboriginal student of medicine at the University of NSW with a scholarship to the current situation, where 64 students have received assistance.

In 2016, there are 26 Indigenous students receiving a Shalom Gamarada scholarship, most of whom are studying Medicine at UNSW. Most impressive is the completion rate; Shalom Gamarada students have, in recent years, achieved pass rates of 90 per cent. As Shalom Gamarada says, "this is a remarkable success - higher than that for non-Indigenous Australian students studying difficult, 'long-haul' courses like Medicine and Law."

Another incredible achievement is that 25 Indigenous scholarship holders completed the 2013 end of year examinations, with 23 passing (often with credits and distinctions) and recording a pass rate of 92 per cent. Thanks to the efforts of Hilton Immerman and the Board and staff of Shalom College, UNSW now has one of the highest retention rates of Aboriginal and Torres Strait Islander students in Australia.

The 2016 AMA Indigenous Peoples' Medical Scholarship was awarded to Darren Hartnett at this years' AMA National Conference. Mr Hartnett is currently a third-year medical student at the University of Newcastle.

Applications for the 2017 Indigenous Peoples' Medical Scholarship open in November 2016, and close on 31 January 2017. To ensure that the Scholarship scheme is sustainable, the AMA is currently working to make the necessary arrangements for the Indigenous Peoples' Medical Scholarship Trust Fund to be eligible for Deductible Gift Recipient (DGR) status. It is the AMA's hope that having DGR status will encourage greater philanthropic donations towards the Scholarship scheme. A prospectus has been developed by the AMA to outline the levels of sponsorship.

SIMON TATZ

What ails us

Dementia is on track to become the nation's biggest killer within the next five years, eclipsing deaths caused by heart disease and stroke.

But a worrying jump in suicides means it remains the leading cause of premature mortality, with more than 3000 people taking their own lives last year – a 5.7 per cent increase in just 12 months.

In its latest snapshot of the causes of death, the Australian Bureau of Statistics has reported that dementia's rise up the rankings has been remorseless.

A decade ago, the condition was the fourth most common cause of mortality, accounting for 6550 deaths. By last year, the death toll from dementia had virtually doubled to 12,625 people – the second most common cause of death but still well short of the 19,777 lives claimed by ischaemic heart disease.

But the ABS predicts that, and on current trends, dementia will overhaul heart disease to become the most common cause of death around 2021 – a function of the aging population, declining death rates for heart disease and stroke, and the lack of treatments to prevent or cure it.

This has been captured in changes in the standardised death rates of the three diseases. While the death rate from dementia has grown in the past decade from 28.6 to 40.1 deaths per 100,000, for heart disease it has declined over the same period from 103.5 to 66.1, and for stroke it has dropped from 51 to 35.7.

While dementia, heart disease and stroke are primarily killers of the elderly, the ABS has documented the rise of suicide to be the biggest killer of young and middle-aged adults.

The nation's overall suicide rate has been climbing steadily in the past decade, from 10.2 per 100,000 in 2006 to 12.6 per 100,000 last year.

It has become the leading cause of death for people aged 15 to 44 years, and the second biggest killer for those aged 45 to 54 years. Reflecting this, the median age at death for suicide last year was just 44.5 years, compared with a median age of 81.9 years for all deaths.

The heaviest toll was among men – three quarters of all suicide deaths were males, and the death rate was 19.4 per 100,000, compared with 6.2 per 100,000 among women.

The highest suicide rate was among men in the 40 to 54 year age group, where the incidence was 30.9 per 100,000. Among women, the highest rate was 10.4 per 100,000 in the 45 to 49 years age group.

Consistent with the gap in other areas of health, suicide rates among Indigenous people are far in excess of those in the broader population.

According to the ABS, the Indigenous suicide death rate was 25.5 per 100,000 last year – more than double the 12.5 per 100,000 rate among non-Indigenous Australians.

After heart disease, dementia and stroke, the next biggest killer was lung cancer (8466 deaths), chronic lower respiratory diseases (7991), diabetes (4662), colon cancer (4433), blood and lymph cancer (4412) and heart failure (3541).

The top 10 killers - 2015

Disease	Number
Ischaemic heart disease	19777
Dementia	12625
Stroke	10869
Lung cancer	8466
Chronic respiratory disease	7991
Diabetes	4662
Colon cancer	4433
Blood, lymph cancer	4412
Heart failure	3541
Urinary system diseases	3433

ADRIAN ROLLINS

Some improvements made in closing Indigenous health gap

Indigenous Australians appear to be living longer with disease, with a decrease in the number of years lost through premature death, a new report has found.

But two in three Indigenous Australians still die before the age of 65, compared with just one in five non-Indigenous Australians, the Australian Institute of Health and Welfare (AIHW) study has found.

> "... Indigenous Australians were 2.3 times as likely to die early or live in poor health than non-Indigenous Australians, losing a total of 284 years of healthy life for every 1000 people in 2011"

The *Australian Burden of Disease Study: Impact and causes of illness and death in Aboriginal and Torres Strait Islander people 2011*, analyses the impact of diseases and injuries in terms of the number of years of healthy life lost through living with an illness or injury (the non-fatal burden) and the number of years of life lost through dying prematurely from an illness or injury (the fatal burden).

It found that Indigenous Australians were 2.3 times as likely to die early or live in poor health than non-Indigenous Australians, losing a total of 284 years of healthy life for every 1000 people in 2011.

"While Indigenous Australians face a substantially higher disease burden than non-Indigenous Australians, improvements have been seen, with more possible," AIHW spokesperson Dr Fadwa Al-Yaman said.

"Between 2003 and 2011, total burden of disease in the Indigenous population fell by 5 per cent, with an 11 per cent reduction in the fatal burden.

"However, over the same period, there was a 4 per cent increase in the non-fatal burden. This suggests a shift from dying prematurely to living longer with disease."

Over the same period, the fatal burden dropped by 16 per cent and the non-fatal burden by 4 per cent in the non-Indigenous population.

Chronic diseases accounted for almost two-thirds (64 per cent) of the overall burden among Indigenous Australians, with mental health and substance use disorders causing 19 per cent of the burden.

Suicide (15 per cent), cardiovascular diseases (12 per cent), cancer (9 per cent), and respiratory diseases (8 per cent) were the other leading causes.

Much of the disease burden is preventable, with smoking, drinking, obesity, and poor diet the main culprits.

"By reducing risk factors such as tobacco and alcohol use, high body mass, physical inactivity, and poor diet, over one-third of the overall burden for Indigenous Australians could be avoided," Dr Al-Yaman said.

There were some positive findings, with large declines in the rates of burden attributable to high cholesterol (37 per cent), high blood pressure (23 per cent) and physical inactivity (22 per cent), and a decline in premature death from cardiovascular disease.

But the burden caused by domestic violence increased by almost one-quarter (23 per cent).

The Heart Foundation said the report showed the need for an increased focus on cardiovascular disease prevention and care for Indigenous Australians, with one in four Aboriginal and Torres Strait Islander people having problems accessing health services.

"For historical, geographical, and cultural reasons, health care services remain under-utilised by Aboriginal and Torres Strait Islander peoples," Heart Foundation spokesman Simon Dixon said.

"As a result, poorer health and lower quality of life become the norm until a critical event like a heart attack happens, which, unfortunately, is too late for many.

"It has been estimated that if Aboriginal and Torres Strait Islander peoples achieved the same level of cardiovascular health as non-Indigenous Australians, this mortality gap could be closed by 6.5 years.

"Disturbingly, less than 5 per cent of eligible Aboriginal and Torres Strait Islander peoples attend cardiac rehabilitation programs and subsequently have twice the risk of admission or death within the first two years of a heart attack."

MARIA HAWTHORNE

Your AMA Federal Council at work

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

Name	Position on council	Committee meeting name	Date
Dr Tony Bartone	Vice President	Launch of the Revalidation Model	16/8/16
		MBS Review After Hours Working Group	13/9/16
Professor Geoffrey Dobb	AMA Board Member	Health Star Rating Advisory Committee	9/8/16
Dr Richard Kidd	AMACGP Chair	Health Care Home - Payment Mechanism Working Group	8/9/16
		TGA codeine upscheduling regulation impact analysis meeting	18/8/16
		Health Sector Group (HSG)	13/9/16
Dr Kean-Seng Lim	Member AMA Council of General Practice	Health Care Home - Patient Identification Working Group	19/8/16
Dr Brian Morton (Proxy for Richard Kidd)	AMA Member and Former AMACGP Chair	PIP Advisory Group (PIPAG)	14/9/16
Dr Gino Pecoraro	Obstetricians and Gynaecologist specialist	Launch of the Revalidation Model	16/8/16
Dr Anne Wilson	Member AMA Council of General Practice	National Immunisation Committee	22/9/16

INFORMATION FOR MEMBERS

Essential GP tools at the click of a button

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

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

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

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

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

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

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

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

Health on the hill

POLITICAL NEWS FROM THE NATION'S CAPITAL

Govt adviser calls for public hospitals to be 'contestable'

Mortality rates and treatment outcomes for individual hospitals and medical practitioners could be made publicly available and patients given a choice of hospital and specialist under Productivity Commission proposals to improve the quality and accessibility of health services.

In the preliminary findings of a review initiated by Treasurer Scott Morrison into options for increased competition and consumer choice in the $300 billion human services sector, the Commission has proposed increased information disclosure by hospitals and practitioners and greater contestability between services.

"Greater competition, contestability and informed user choice could improve outcomes in many human services," the PC said. "Well-designed reform, underpinned by strong government stewardship, could improve the quality of services, increase access…and help people have a greater say over the services they use and who provides them."

Mr Morrison said he had ordered the review to improve the efficiency and cost effectiveness of human services.

But Opposition leader Bill Shorten, reprising Labor's scare campaign during the Federal election on the privatisation of Medicare, said he feared it would be used to justify the wholesale handover of human services to the private sector.

"We've all seen this move before," Mr Shorten said. "When Malcolm Turnbull and the Liberal Party start talking about changing human services it means that poor people get it in the neck."

The Commission said that not all human services were amenable to increased competition, contestability and choice, but identified public hospitals and palliative care services among six priority areas targeted for reform.

While Australian public hospitals performed well by international standards, "there is scope to improve", the PC said, including by matching domestic best practice and publicly disclosing more information.

"Public patients are often given little or no choice over who treats them or where. Overseas experience indicates that, when hospital patients are able to plan services in advance and access useful information to compare providers (doctors and hospitals), user choice can lead to improved service quality and efficiency," the PC said.

It said that any reforms to boost user choice would have to be supported by "user-oriented information", and suggested the English model in which increased choice is offered at the point where GPs refer patients to a specialist.

The Commission said experience in England had shown that patients given a choice of hospital and consultant-led team sought out better performing providers, and hospitals in locations where competition was most intense recorded the biggest improvements in service quality.

In order to exercise their choice, patients had access to web-based information enabling them to compare providers according to waiting times and mortality rates, and could use an online booking service.

The enormous variety of Australia's public hospitals, including big differences in the populations they serve, workforce arrangements and characteristics and the complexity of their links to the rest of the health system, militate against like-for-like competition – something the Commission admitted.

If such issues or political considerations made fostering direct competition unfeasible, the Commission instead suggested exerting pressure for improved performance by making the position of senior hospital managers more precarious.

Health on the hill

POLITICAL NEWS FROM THE NATION'S CAPITAL

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"There have been difficulties in the past commissioning non-government providers, and lessons from these attempts should not be forgotten," it said. "As a result, it may be more feasible to implement contestability as a more transparent mechanism to replace an underperforming public hospital's management team (or board of the local health network) rather than switch to a non-government provider."

The Commission said State and Territory governments could also take a more contestable approach to commissioning services when renegotiating service agreements with local health networks.

On palliative care, the PC lamented that a dearth of comprehensive, publicly available national data hampered accountability and helped drive big differences in the quality and range of services available.

It said there was little evidence that low quality providers were being held to account.

The PC acknowledged that the "emotionally taxing and psychologically distressing" environment in which a person was approaching the end of their life militated against making choices about palliative care.

"Taboos about discussing death can prevent this from happening," the Commission said. "Patients often rely on medical professionals to initiate conversations about palliative care, many of whom are inadequately trained about, and intimidated by, holding such conversations."

Notwithstanding such challenges, the PC argued that introducing greater competition, contestability and user choice in palliative care would improve outcomes and reduce current substantial variation in the quality of, and access to, services in different areas of the country.

To achieve this, though, "would require careful design to ensure that the interests of patients and their families are well served. Special measures for consumer protection may be needed".

Indeed, even where reform ushered in greater competition and contestability, the PC said the unique nature of human services meant the Government would need to maintain strong oversight.

"Government stewardship is critical," the agency said. "This includes ensuring human services meet standards of quality, suitability and accessibility, giving people the support they need to make choices, ensuring the appropriate consumer safeguards are in place, and encouraging and adopting ongoing improvements to service provision."

Other priority areas of human services nominated by the Commission for increased competition and contestability included public dental services, social housing, services in remote Indigenous communities and grant-based family and community services.

Among those areas assessed for reform but not identified as a priority by the PC at this stage were general practice, primary health networks (PHNs), mental health services, community health services and child and family health services.

The preliminary report is open for submissions until 27 October, and the Commission is due to deliver its final report by October 2017.

ADRIAN ROLLINS

Device reforms may be too late to prevent premium pain

The Federal Government is coming under pressure to speed up its review of prosthetic prices if consumers are to avoid another painful hike in private health insurance premiums.

Health funds have warned that unless the cost of medical devices on the Prostheses List falls into line with the much lower prices paid by public hospital in the next few weeks, policyholders will continue to pay an extra $150 to $300 on their premiums.

The warning is the latest shot in a tussle underway between insurers, medical device manufacturers and private hospitals other over the cost of prostheses, as documented in a series of articles in *The Australian* newspaper.

The health funds, increasingly worried about the backlash from consumers over rapidly rising premiums and complex and confusing insurance products, have set their sights on prostheses prices as a key way to contain costs.

They claim that existing pricing arrangements are woefully out of date and force insurers to pay grossly inflated prices for medical devices compared with public hospitals. According to insurers, they are being charged up to $3450 for a

Health on the hill

POLITICAL NEWS FROM THE NATION'S CAPITAL

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coronary stent that costs $1200 in the public system, while a defibrillator costing them $52,000 costs a WA public hospital just $22,555.

Altogether, the funds estimate they could save $800 million by bringing public and private prostheses prices into line, savings they say would be passed on in cheaper premiums for consumers.

But the Medical Technology Association of Australia, which represents medical device manufacturers, has defended the sector against what it considers to be false and misleading claims.

MTAA co-lead Andrea Kunca said the industry rejected accusations of inflated pricing and fully supported the work of a Government working group brought together earlier this year to work through "meaningful solutions" for reform of the Prostheses List.

The Australian has published claims that the MTAA, in concert with private hospital operators, has so far been successful in frustrating attempts by Health Minster Sussan Ley to reform the Prostheses List, and any changes are unlikely to come in time to head off another sharp increase in the health fund premiums next year.

According to *The Australian*, fierce lobbying by well-connected outfit CapitalHill Advisory on behalf of the MTAA derailed an early attempt by Ms Ley to cut implant prices.

Influential Senator Nick Xenophon has announced he will push for a Senate inquiry into private health insurance and the pricing of medical devices on the Prostheses List, a move welcomed by the MTAA.

"There have been a number of misleading and false claims put in the public arena in regards to the medical device industry," Ms Kunca said. "A Senate inquiry will allow these false claims to be answered once and for all. From the MTAA's perspective we look forward to presenting the facts rather than anecdotal misinformation put forward by some."

Premium crunch time

The health funds have to submit proposals for their 2017 premiums, which have to be approved by the Health Minister and are announced in April, by early November.

Doctors, insurers and the Government fret that another 6.5 per cent premium increase could accelerate the shift among policyholders toward cheaper policies with multiple exclusions and less coverage, or even convince many to ditch private health cover altogether – the insurance industry has cited research that at least 20 per cent of current members would find premiums unaffordable in the next six years.

Ms Ley recently overhauled the membership of the Prostheses Listing Advisory Committee, appointing University of New South Wales Professor of Medicine Terry Campbell as Chair. Professor Campbell's appointment was a belated replacement of long-serving Chair Professor John Horvath, who left last December to become a strategic adviser at Ramsay Health Care.

The stoush comes against the backdrop of rising dissatisfaction among doctors and consumers with the quality and value for money of private health insurance.

The AMA has been a vocal critic of the proliferation of complex and confusing policies, many with multiple exclusions that leave unsuspecting patients with inadequate cover.

AMA President Dr Michael Gannon has declared the medical profession's support for Government reforms to improve the value of private health insurance by banning junk public hospital-only policies, standardising terms, mandating minimum levels of cover and preserving community rating.

Dr Gannon said doctors were doing the right thing, with 86 per cent of privately insured medical services charged on a no gap basis, and a further 6.4 per cent involving a known gap.

"This means that less than 8 per cent of privately insured patients are charged fees that exceed that paid by their private health insurance," the AMA President told the National Press Club in August. "Put simply, the majority of doctors and hospitals understand the impact of gaps on patients and are doing the right thing by them."

He said that because of these, doctors were deeply unimpressed with the behaviour of some insurers, "particularly the biggest and most profitable ones", in putting profits ahead of the interests of patients.

Dr Gannon said that if such actions, including aggressive negotiations with private hospitals and attacks on the professionalism of doctors, continued unchecked "we will inevitably see US-style managed care arrangements in place in Australia".

ADRIAN ROLLINS

Health on the hill

POLITICAL NEWS FROM THE NATION'S CAPITAL

Medicare claims shopped around

Fears that patients will face increased delays in receiving reimbursements from Medicare under plans to close shopfronts and consolidate processing centres have been dismissed by the Federal Government.

Department of Human Services staff told the *Sunday Herald Sun* that the Government planned to shut Medicare shopfront services, with all claims to be processed in one of 17 centres operating nationwide.

They warned this was likely to cause a blow-out in the time taken to reimburse patients.

But Human Services Minister Alan Tudge told Fairfax Media rejected the claim and said most patients would not detect any change, adding that the vast majority of claims were undertaken online.

"There has been a huge reduction in demand for face-to-face claiming so we are consolidating back-of-house processing work to ensure we provide high quality, consistent services," the Minister said. "Some 96 per cent of all Medicare claims are lodged electronically."

Mr Tudge said that even with the consolidation of shopfront services undertaken in recent years, most people would be able to find one within a few kilometres of where they lived.

But Labor seized on the *Sunday Herald Sun* report, claiming the changes would make it harder for patients to make a claim, and force them to wait longer for their rebate.

Shadow Health Minister Catherine King said the changes would not only make it harder for patients, particularly the elderly, but paved the way for the potential privatisation of Medicare – an suggestion vehemently rejected by Mr Tudge.

"Every single aspect of Medicare which is currently operated by Government will continue to be operated by Government, including the processing of the Medicare rebate," he said.

ADRIAN ROLLINS

Phelps on track to be Sydney mayor

Former AMA President Dr Kerryn Phelps has been tipped as a future Sydney Lord Mayor after being elected to the position of deputy mayor.

Dr Phelps won the deputy mayor role with a seven-to-two vote at a Sydney council meeting late last month, after successfully standing for election on a ticket led by incumbent Lord Mayor Clover Moore. Ms Moore won the mayoralty for a record fourth time.

Dr Phelps is being positioned to succeed Ms Moore, and told the *Daily Telegraph* she was planning a "very exciting and energetic and busy year ahead".

ADRIAN ROLLINS

Cancer registry privacy fears

The AMA has raised concerns sensitive patient information will be in the hands of a for-profit operator following the Federal Government's decision to award a $220 million contract to Telstra to build and operate a national cancer screening register.

The AMA has told a Senate Committee inquiring into the decision that although it did not have any in-principle objection to outsourcing clinical registries, it was worried by Telstra Health's lack of experience in the field, and the implications of giving a profit-making enterprise access to commercially valuable and highly sensitive personal information.

"Telstra Health does not have direct previous experience in operating registries of this kind," the AMA said in a submission to the Senate Standing Committee on Community Affairs.

Under the Government's plan, data from nine separate cancer screening registers will be consolidated into a single National Cancer Screening Register containing the bowel and cervical cancer screening records of all participating Australians. Information on the register will be used to support the expansion of bowel cancer screening to cover almost 10 million people, and cervical screening for 1.4 million women.

The AMA said it would be "more comfortable" if the registry, which will contain sensitive information about a person's cancer risk, medical procedures and health status, was in commercially disinterested hands.

"Given the potential commercial value of the data contained in the register, the AMA would be more comfortable with it being operated by Government, a tertiary institution, or not-for-profit entity that has little interest in how the data in the register might otherwise be used," it said. "This would go a long way to allaying concerns about the secondary use of data for commercial reasons."

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The AMA's concerns were echoed by health policy expert Professor Lesley Russell, of the Menzies Centre for Health Policy.

"Telstra Health will have the ability to access data from the Australian Immunisation Register, from the Australian Institute of Health and Welfare, and from Medicare claims, and the registers will be integrated with GPs, specialists and pathology laboratories," Professor Russell said in a submission t the Senate Committee.

"Will the Australian population be comfortable with the fact that a for-profit business knows whether they have had a full or partial hysterectomy, if they are at risk of bowel cancer... and when they last had a colonoscopy?

"Will GPs, specialists and diagnostic labs be happy that Telstra Health can, at least potentially, scrutinise their diagnoses and treatment?"

Privacy Commission Timothy Pilgrim said the centralisation of such sensitive information in a database that can be accessed from many points posed "a number of security and privacy risks", and suggested the operation of the register be subject to additional requirements under the Privacy Act.

But Telstra Health said it was "uniquely placed" to provide the register, with the size, scale and expertise to ensure its secure and successful operation.

It said Telstra already manages "extremely sensitive" data for hospitals, financial institutions and Government, and all information contained in the register would be hosted in Australia and controlled by the Government.

"Telstra will build and operate the Register in accordance with strict data security requirements determined by the Australian Government. These are the same requirements that would apply to any Australian Government or not-for-profit agency."

Concerns have also been raised about how Telstra Health was awarded the job, and what might happen to the register and the data it contains when the five-year contract expires.

Telstra said it won the contract following an open tender, but the AMA is among those complaining the process has been opaque.

"There has been a lack of transparency around the process for awarding this contract," it said. "The awarding of such a contract to an entity that has hitherto had no direct role in establishing or operating a register of this kind sets a challenging and potentially troublesome precedent."

Professor Russell said the basis on which Telstra won the contract over other applicants had not been disclosed, and the Government had not explained why other entities such as the Department of Human Services, the AIHW and Cancer Australia had not been considered for the work.

"What happens when the Telstra Health contract expires in five years' time – will it automatically be renewed, will it be up for competitive bids? How will this contestability affect the continuity, ongoing resources and work needed for the registers?" she asked.

Shadow Health Minister Catherine King said "clearly there are questions that need to be answered about handing these records to a for-profit company with no experience in this area".

"This is sensitive, personal information about people's health – we need to get it right," she said.

ADRIAN ROLLINS

Medicare data breach prompts law change

The Federal Government has moved to tighten privacy laws after doctor provider numbers were disclosed in a breach of security around Medicare and Pharmaceutical Benefit Scheme data.

Attorney-General George Brandis has announced plans to amend the Privacy Act to make it a criminal offence to re-identify de-identified Government data following a discovery that encrypted MBS and PBS data published by the Health Department had been compromised.

The Department was alerted to the worrying security lapse by Melbourne University Department of Computing and Information researcher Dr Vanessa Teague, who found she was able to decrypt some service provider ID numbers in a dataset being used by her and several of her colleagues. She immediately alerted the Department.

In a statement, the Department said no patient information had been compromised in the incident.

"The dataset does not include names and addresses of service providers, and no patient information was identified," the Department said. "However, as a result of the potential to extract some doctor and other service provider ID numbers, the Department of Health immediately removed the dataset from the website to ensure the security and integrity of the data is maintained."

The security breach has come as a Senate inquiry hears concerns about data security surrounding the decision to

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award Telstra Health $220 million contract to design and operate the National Cancer Screening Registry, and follows the collapse of Australian Bureau of Statistics systems on census night.

The AMA said that although the data security breach was concerning, it should not result in governments withholding data.

The Association said that although it was paramount that personal information be properly secured and protected, it was important that de-identified and encrypted data be made available by Government to help inform research and the analysis of health information.

Senator Brandis reassured that the Government remained committed to making valuable data publicly available.

"The publication of major datasets is an important part of twenty-first century government providing a great benefit to the community," the Attorney-General said. "It enables... policymakers, researchers and other interested persons to take full advantage of the opportunities that new technology creates to improve research and policy outcomes."

But Senator Brandis said that advances in technology had meant that methods used in the past to de-identify data "may become susceptible to re-identification in the future".

Under his proposed changes to the Privacy Act, it would be a criminal offence to re-identify de-identified Government data, encourage someone else to do it, or to publish or communicate such data.

The Health Department said it was conducting a "full, independent audit" of the process followed in compiling, reviewing and publishing the data, and promised that "this dataset will only be restored when concerns about its potential vulnerabilities are resolved".

The Office of the Australian Information Commission is undertaking a separate investigation.

ADRIAN ROLLINS

Superbugs could be 'worse than global financial crisis': World Bank

The rise of drug-resistant superbugs could cost more than US$1 trillion a year in extra health costs, plunge millions into extreme poverty and inflict greater economic damage than the global financial crisis if left unchecked, the World Bank has warned.

As world leaders prepare to discuss the threat of antimicrobial resistance (AMR) at the UN General Assembly in New York, the World Bank has released projections showing that the current widespread and often indiscriminate use of antibiotics will have severe health and economic consequences unless urgent action is taken.

"The scale and nature of this economic threat could wipe out hard-fought development gains and take us away from our goals of ending extreme poverty and boosting shared prosperity," World Bank Group President Jim Yong Kim said.

Modelling by the global development agency indicates that without more careful use of antibiotics, AMR will have an increasing effect. Growing numbers of people, particularly in poorer countries, will succumb to infectious diseases; people will get sick more often; health costs will soar; livestock production will tumble and global trade will shrink.

Even in the best case scenario, the World Bank warns that without urgent action to curb AMR, by 2050 global economic growth would be 1.1 per cent lower, health costs will be up by US$300 million a year, global trade would be down by 1.1 per cent and an extra eight million people would be thrown into extreme poverty.

But the consequences could be much worse.

In its more pessimistic high-AMR scenario, the agency estimates that by 2050 global growth could be cut by 3.8 per cent, the number in extreme poverty would soar by an extra 28.3 million and countries would have to spend an extra US$1.3 trillion a year on health care.

"Drug-resistant infections, in both humans and animals, are on the rise globally," the World Bank said.

"If AMR spreads unchecked, many infectious diseases will again be untreatable. Without AMR containment, humanity may face a reversal of the massive public health gains of the past century, and the economic growth, development, and poverty reduction that they enabled.

"The annual costs could be as large as those of the global financial crisis that started in 2008."

The World Bank said these "immiserating" effects would fall hardest on low-income countries and would derail current progress toward the goal of eliminating extreme poverty by 2030.

The AMA has been at the forefront of efforts to curb the use of antibiotics, supporting campaigns such as the Choosing Wisely initiative to educate doctors and, more importantly, patients, about the appropriate application of such medications.

One of the biggest targets of these campaigns has been to educate patients, particularly parents, about the inappropriateness of prescribing antibiotics for the treatment of colds and other viral infections.

Sydney GP and former Chair of the AMA Council of General Practice Dr Brian Morton advised in 2014 that, "prudent use of antibiotics…includes not using them when their benefit is minimal. Patients…need to understand that the symptoms they are experiencing is their own immune system working to resolve the infection. They also need to understand that using antibiotics in such cases may actually do more harm than good. Not only can it contribute to the development and transfer of resistant bacteria but patients risk possible side effects, such as upsetting the balance of gut bacteria and rashes".

The World Bank has urged a holistic approach to tackling AMR, warning it cannot be treated as a discrete health problem.

"Drug-resistant diseases are very much like infectious diseases with pandemic potential: because there is "no cure," their spread can be hard to control. The surveillance, diagnostic, and control capacity to deal with the first group of diseases is the same capacity that is required to control of diseases in the second group," it said.

The World Bank said investing in core human and veterinary public health systems in low- and middle-income countries was fundamental to establishing the surveillance needed to identify and control AMR.

"Increased global cooperation is essential as AMR containment is a global public good. It will require coordinated efforts to monitor, regulate, and reduce the use of antibiotics and other antimicrobials," the agency said.

ADRIAN ROLLINS

WMA condemns denial of medical care to prisoners

The World Medical Association has condemned Iran for withholding medical care from political prisoners as a form of punishment.

In a letter to Iran's leader, the Ayatollah Sayed 'Ali Khamenei, WMA President Sir Michael Marmot said the WMA was deeply concerned by issues raised in an Amnesty International report giving details of medical care being denied to political prisoners, including prisoners of conscience, as a form of additional punishment, coercion or to elicit confessions.

Sir Michael said the provision of adequate medical care is a key human right, which under international law must not be adversely affected by imprisonment. United Nations Rules for the Treatment of Prisoners provides that, "prisoners should enjoy the same standards of health care that are available in the community, and should have access to necessary healthcare services free of charge without discrimination on the grounds of their legal status".

Sir Michael called on the Iranian authorities to stop withholding medical care as a punishment, and to ensure that security officials and prison staff, including medical staff, suspected of deliberately denying medical care were investigated and, where there was evidence, prosecuted.

"We appeal to your humanity and sense of justice and trust that you will take promptly all the necessary steps related to our demands," Sir Michael wrote.

KIRSTY WATERFORD

INFORMATION FOR MEMBERS

1 NOVEMBER 2016 – AMA LIST OF MEDICAL SERVICES AND FEES

The 1 November 2016 edition of the AMA Fees List will soon be available in hard copy and electronic formats.

The hard copy book is for AMA members in private practice or with rights of private practice, and salaried members who have requested a book. Dispatch of the book will commence on 14th October 2016.

The AMA Fees List is available in the following electronic formats:

- **PDF** of the hard copy book
- **CSV** file for importing into practice software
- **Online database** where members can search for individual or groups of items and download the latest updates and electronic files.

PDF and CSV versions of the AMA Fees List will be available to all members via the Members Only area of the AMA website http://www.ama.com.au/resources/fees-list from 21st October 2016. The Fees List Online Database will be updated on 1st November 2016.

Access the Fees List via the AMA website

To access the AMA Fees List online, simply go to the AMA homepage and logon by clicking on the symbol icon the right corner of the blue task bar and entering your AMA username and password. Once logged in, on the right hand side of the page, click on 'Access the AMA Fees List'. From here you will find all electronic formats of the Fees List.

Access the AMA Fees List Online Database

The AMA Fees List Online Database is an easy-to-use online version of the AMA Fees List. To access the database follow the steps above or go to: https://ama.com.au/article/ama-fees-list-online

AMA Fees Indexation Calculator

Also available to members is the AMA Fees Indexation Calculator, this allows you to calculate your own fee increase based on your individual cost profile. To access the AMA Fees Indexation Calculator, follow these steps:

1) From the home page hover over **Resources** at the top of the page. A drop down box will appear. Under this, select **Fees List**.
2) Select AMA Fees Indexation Calculator (Members Only).

Members who do not currently have a username and password should email their name, address and AMA member services number to **memberservices@ama.com.au** requesting a username and password.

Financial members with rights to private practice will automatically receive the book. If you are a salaried member and would like a copy, please contact the AMA on 02 6270 5400 or email feeslist@ama.com.au.

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**

Jobs Board: Whether you're seeking a new position, looking to expand your professional career, or looking to recruit staff to your practice, doctorportal Jobs can help you. Discounts apply for AMA members. jobs.doctorportal.com.au

MJA Events: AMA members are entitled to discounts on the registration cost for MJA CPD Events!

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

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

Learning.doctorportal.com.au

MJA Journal: The Medical Journal of Australia is Australia's leading peer-reviewed general medical journal and is a FREE benefit for AMA members.

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.

Career Advice Service and Resource Hub: This should be your "go-to" for expert advice, support and guidance to help you navigate through your medical career. Get professional tips on interview skills, CV building, reviews and more - all designed to give you the competitive edge to reach your career goals.

www.ama.com.au/careers

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

Mentone Educational: AMA members receive a 10% discount on all Mentone Educational products, including high quality anatomical charts, models and training equipment.

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

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

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

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

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

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

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