AUSTRALIAN
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# It just doesnt add up!

## Govt cuts push public hospitals to the brink, p3


INSIDE



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# In this issue

# The sick will pay heavy price for Govt cuts

- Hospitals and staff at 'breaking point'
- Rumoured $6.7 billion funding injection 'inadequate'

Doctors have warned a major Sydney hospital is close to "breaking point" and exhausted nurses have threatened to close unfunded beds at a new regional hospital in signs of a system under strain even before huge Commonwealth funding cuts begin to bite.

As AMA President Professor Brian Owler declared patients would face ever-longer delays for emergency care and elective surgery as cuts due to come into effect from next year begin to bite, evidence that hospitals are already struggling to cope with demand is emerging.

Doctors at Sydney's Nepean Hospital have told the ABC that a critical shortage of beds has meant that they are often forced to treat patients in chairs and said it was not unusual for emergency department patients to wait for up to eight hours to see a doctor.

Dr Patrick Cregan, the recently retired chair of the Nepean Blue Mountains Local Health District, said that on occasion the hospital had a bed occupancy rate of 103 per cent and needed an additional 140 beds just to function and ensure patient safety.

Meanwhile, over-worked nurses at the new Wagga Wagga Referral Hospital have threatened to close 18 unfunded beds because of the strain caused by under-staffing.

The nurses said management had failed to honour a commitment to only open funded beds, putting staff under intolerable pressure and causing lengthy delays in emergency.

The problems have underlined warnings from Professor Owler that there would be a real human cost unless the Federal Government acts immediately to unwind massive Commonwealth public hospital spending cuts.

AMA analysis shows a huge $57 billion shortfall in Federal funding for hospitals will rapidly open up from mid-2017 as a lower indexation arrangement kicks in, creating a gap in resourcing that State and Territory governments are unlikely to be able to cover.

"The rubber starts to hit the road from next year," Professor Owler said. "From 2017 we're going to see the cuts that were announced back in 2014 really start to challenge services in our public hospital system.

"That is going to translate to less services for patients, it's going to mean patients languish on elective surgery waiting lists for long periods [and] people wait in emergency departments for unacceptable periods."

His warnings have come amid mounting speculation the Commonwealth will provide emergency funds to avert a pre-election crunch in public hospital finances – though it is expected to make little dent in the long-term shortfall.

Expectations are increasing that Prime Minister Malcolm Turnbull will use a rare joint meeting with the nation's premiers and treasurers scheduled for 1 April to clear the decks on a range of contentious issues in the lead-up to the Federal election, not least massive cuts to Commonwealth support for public hospitals unveiled in the Government's disastrous 2014-15 Budget.

But Professor Owler said a mooted injection of an extra $6.7 billion over four years for all State and Territory health and education services was "woefully inadequate" in face of the looming funding shortfall.

"I'm afraid that's just not going to cut the mustard," he said. "Cobbling together $6.7 billion over a four year period for states and territories to fund health and education is just not going to make it."

Professor Owler said that although such a short-term pre-election fix might appease some of the states, it would do nothing to ensure hospitals were supported by a reliable long-term source of funding that grew in step with the increase in demand for their services.

"It is clear there is a crisis in public hospital funding and an immediate commitment is required, but a quick fix will not solve the long-term capacity problems for public hospitals or ease the economic burden on State budgets," he said.

In the Budget, the Coalition announced it would renege on hospital funding guarantees to the states, saving $1.8 billion over four years, while a further $57 billion would be would be saved by 2024-25 by downgrading the indexation of Commonwealth hospital funding to inflation plus population growth.

Increasing the squeeze, the Independent Hospital Pricing Authority has set the National Efficient Price – which determines how much the Commonwealth pays for hospital services – at 1.8 per cent lower than the amount that was set last year, locking in hospital underfunding.

## States under pressure

The massive Commonwealth cuts have outraged the states, which have warned of a significant reduction in hospital services unless another stream of funding is found.

The savings appeared to be part of a broader Commonwealth strategy to dump most of the funding responsibility for health services onto the states and directly on to patients, and occurred in the context of a renewed debate about taxation and the structure of the Federation.

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# The sick will pay heavy price for Govt cuts ... from p3

Two premiers, Mr Baird and South Australia's Jay Weatherill, had championed changes to the GST and income tax arrangements to give states access to a more robust stream of revenue to fund hospitals and schools, but they were undercut when Mr Turnbull dismissed any talk of changing the consumption tax.

The resistance of Canberra to calls for more funds has been stiffened by the fact that all the states are currently in surplus, while the Commonwealth expects a deficit of $37.4 billion this financial year, and no return to surplus over the next four years.

But, while Treasurer Scott Morrison has continued to talk tough, telling the states to sort out their hospital funding problems themselves, behind the scenes Mr Turnbull has reportedly been approaching some premiers to discuss a possible deal.

Professor Owler discussed the looming crisis in a meeting with Mr Weatherill earlier this month, and the SA Premier echoed his concerns.

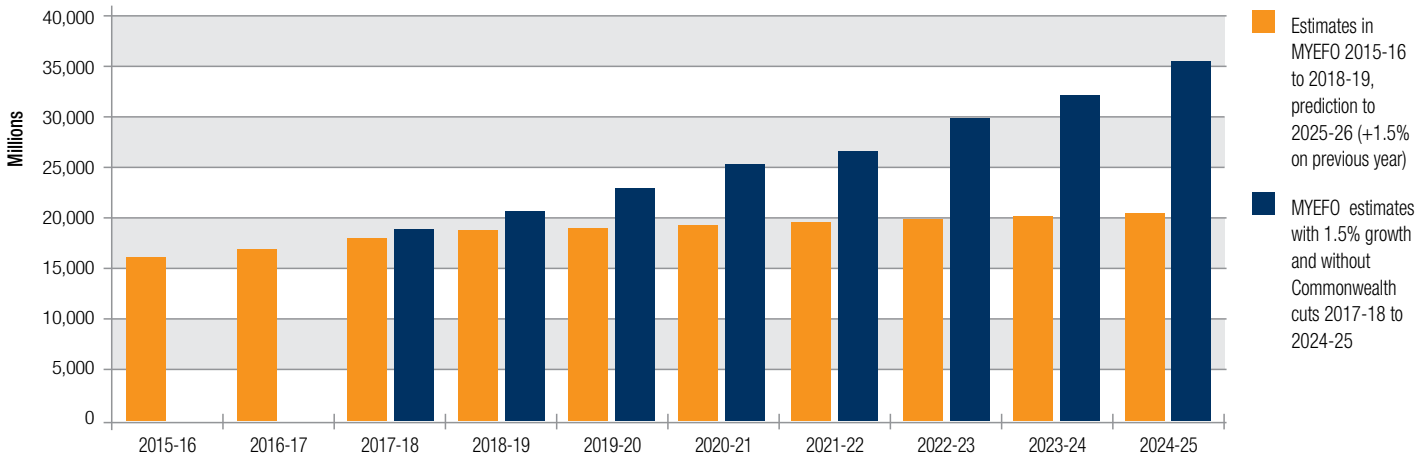
Any short-term deal offered by Mr Turnbull would only "kick the can down the road", he told ABC radio.

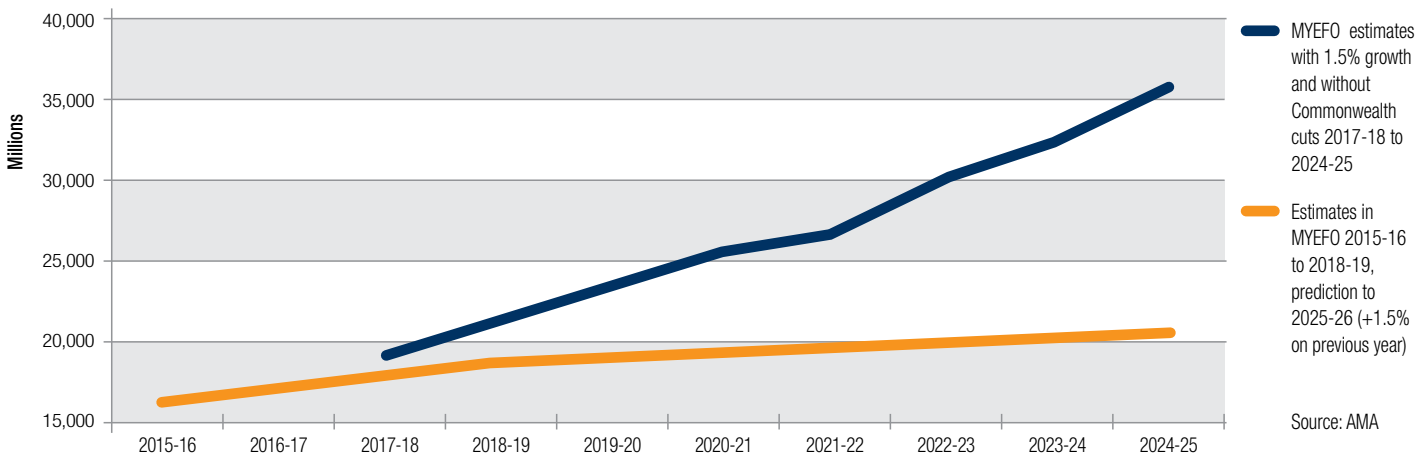
But he indicated the states were likely to accept any injection of funds offered.

"Mike Baird and I have been pushing for a much bigger solution – a 15-year solution – but we have to be realistic, we're on the shadows of an election, and it's an urgent problem," Mr Weatherill said.

ADRIAN ROLLINS

## Commonwealth hospital funding: before and after the Budget cuts




Source: AMA

# Flu season preparations begin

Free influenza vaccines are scheduled to be available from early April as the Federal Health Department ramps up preparations for the 2016 flu season.

The Commonwealth's Chief Medical Officer, Professor Chris Baggoley, has written to GPs and health services nationwide advising of plans to supply two age-specific quadrivalent influenza vaccines which will be available free of charge to eligible patients under the National Immunisation Program.

The advanced warning follows criticisms of delays in supplying flu vaccines last year.

The national immunisation program usually commences in March, but was held back until late April last year as manufacturers scrambled to produce sufficient stocks of the vaccines.

At the time, the Health Department blamed the delay on the decision to include vaccines for two new flu strains.

Last year was also the first time that single-dose quadrivalent vaccines were approved for use by the Therapeutic Goods Administration.

Professor Baggoley said this year the intention was to have the vaccines available from early April, "subject to...supply".

The two vaccines being supplied under the National Immunisation Program are Sanofi's *FluQuadri Junior*, for children younger than three years of age, and GlaxoSmithKline's *Fluarix Tetra*, for people aged three years and older.

Under the Program, the vaccines will be available free of charge for pregnant women; Indigenous children aged between six months and five years; Aboriginal and Torres Strait Islander people aged 15 years and older; people aged 65 years and older; and those six months or older with a predisposition to severe influenza.

Professor Baggoley said both the quadrivalent vaccines and trivalent vaccines will also be available for purchase on the private market.

The Australian Technical Advisory Group on Immunisation has urged the use of quadrivalent vaccines, but has advised that trivalent vaccines are acceptable alternative, particularly where quadrivalents are not available.

Professor Baggoley will provide an update on the National Immunisation Program in mid-March as well as resources including promotional posters. Fact sheets for both providers and consumers will be available for download from the Immunise Australia website (http://www.immunise.health.gov.au/) around the same time.

ADRIAN ROLLINS

# Govt ignores flaws in e-health push

The Federal Government is pushing ahead with mass trials of its My Health Record e-health system despite concerns that fundamental shortcomings are yet to be addressed.

Health Minister Sussan Ley has announced that the personal health information of more than one million people will be automatically uploaded to the internet from July as part of a large-scale test of My Health Record prior to a nationwide roll-out of the scheme.

Under the plan, 700,000 people living in North Queensland Primary Health Network (PHN) and 360,000 covered by the Nepean Blue Mountains PHN in western Sydney, will have until the end of June to opt-out or have a digital health record containing details of their health status, medicines and allergies automatically created and uploaded to the system.

The trial is the latest development in the Government's overhaul of Labor's failed Personally Controlled Electronic Health Record (PCEHR) system, which failed to attract much support from health practitioners or patients despite the expenditure of more than $1 billion.

Ms Ley said it was important that patients be able to safely and securely share their medical records with health workers no matter where they were in the country.

"I consider this a landmark turning point in improving our health system and bringing it into the 21st century," the Health Minister said. "Our new My Health Record means people will not have to remember the names of the medications prescribed, details of diagnosis and treatments, allergies, medical procedures and there will be no need to repeat the same information when they see another doctor or go to hospital."

The move follows a heavy-handed attempt by the Health Department to boost the adoption of My Health Record by threatening to withdraw incentive payments from practices that fail to upload shared health summaries to the system in May – action condemned by the AMA as grossly premature, particularly given the trial did not start until July.

The AMA warned that the design of the My Health Record system meant it was unlikely to realise the Minister's vision.

The clinical usefulness of the PCEHR was fatally compromised by the ability of patients to withhold or hide information, and the peak medical body said My Health Record was similarly flawed.

Patients can set controls on who has access to information in their My Health Record, and the AMA said that, whether or not such controls were used, doctors and other health providers had to be mindful of the possibility that the information that could view was incomplete.

"Unfortunately, My Health Record cannot be relied on as a trusted source of comprehensive information," the AMA said. "This means that My Health Record can be a potentially useful additional source of clinical information, but it is not a replacement for existing clinical records maintained by doctors."

Continued on p7 ...

# Govt ignores flaws in e-health push

... from p6

The system incorporates a "break-glass option" to allow access to vital information in case of a medical emergency, but the AMA said there were many situations short of such a crisis where access to core clinical information would be valuable.

Other aspects of the system highlighted by the Minister are also likely to discourage the use of My Health Records by doctors.

Ms Ley emphasised that in designing the system the Government had paid particular attention to protecting sensitive medical information, and deliberate breaches of privacy could incur fines of up to $500,000 or even jail terms.

But the AMA said such heavy penalties were unjustified and were likely to prove counter-productive.

It said medical practitioners and practice staff already dealt with confidential information on a daily basis, and there was "nothing inherently different or unique" about the data contained in My Health Records.

Instead, it warned the complexity of the compliance rules for using My Health Records and the scale of the penalties for breaches would likely deter many practitioners from adopting them.

"While extreme penalties may appeal to those with very strong sensitivities and concerns on information access, they are counterproductive for encouraging participation by health care providers," the AMA said. "They will be a very strong deterrent to participating in the My Health Record."

The adoption of My Health Records is also being hampered by a failure to engage with specialists.

The AMA said medical specialists were a key group for creating and using information in electronic health records, but the Government was yet to consult with them.

AMA President Professor Brian Owler said this neglect was compounded by the fact most medical practice software was designed for GPs, not specialists.

"Until we engage with people as to how it might work, and the software vendors are on board, it's never going to work," Professor Owler told *The Australian Financial Review*.

Currently, around 2.6 million people have a digital health record, and about 8000 health providers are registered to use the system.

ADRIAN ROLLINS

# Rural practice the prize for *Australian Medicine* reader survey winner


Logging on: *Australian Medicine* reader survey winner Jezreel Blanco receives her Apple iPad Pro from AMA President Professor Brian Owler

As she prepares to embark on a career as a rural GP, *Australian Medicine* reader survey winner Jezreel Blanco's one concern about winning the latest generation Apple iPad Pro is that it will out-match the speed of bush internet connections.

Adelaide-based Jezreel won the iPad after her name was randomly selected from more than 1500 readers who took part in the *Australian Medicine* survey, and was excited to receive the prize from AMA President Professor Brian Owler earlier this week.

The GP trainee is currently a resident at Flinders Medical Centre and is busily accruing the skills and experience she thinks will be vital to working as a general practitioner in a rural practice. She has already spent some time in obstetrics and paediatrics, and is currently working in an emergency department, where she hopes to gain experience in trauma care.

It is quite a shift in focus from Jezreel's initial career as a medical scientist. Following a four-year degree at Sydney University, she worked in a coordinating centre for neonatal research, which she found to be too removed from the frontline of care for her liking.

"We were doing research on neonatal illnesses, but I never got to meet the families who were effected," Jezreel said. "I was very interested in meeting with them and working them."

It was this realisation that spurred her to undertake a medical degree, and to soon become a rural GP – even if the internet access isn't great.

# Australia, the smoke-free country?

Anti-smoking campaigners have raised the prospect that Australia could one day be smoke-free following evidence that tens of thousands have quit smoking as a result of Australia's world-leading tobacco plain packaging laws.

A review of the effectiveness of the controversial measure has attributed about a quarter of the decline in smoking rates since late 2012 to plain packaging, in a finding hailed as a ringing vindication of the laws by public health groups.

A Post Implementation Review (PIR) undertaken by the Health Department found that forcing tobacco products to be sold in olive green packets plastered with graphic health warnings accounted for 0.55 percentage points of a total 2.2 percentage points fall in the prevalence of smoking in the past three years – equivalent to as many as 100,000 having kicked the habit.

The finding has come as the tobacco industry continues to lose ground in its fight to prevent the spread of plain packaging to other countries. Having lost A High Court challenge to the laws in Australia, the big tobacco companies have had to watch as a series of countries including Britain, Ireland and France have passed plain packaging laws, and dozens of others appear set to follow.

The success of the measure has been hotly contested by the tobacco industry, which claims it has little effect in discouraging smoking and has instead helped fuel trade in illicit tobacco.

One of the great difficulties has been to disaggregate the effects of plain packaging from other anti-tobacco measures like major hikes in the tobacco excise, smoke-free laws and quit smoking campaigns.

The Health Department review admitted that the sustained drop in smoking in Australia was only partly attributable to plain packaging.

But it cited research showing that the packaging changes had resulted in a statistically significant decline in the prevalence of smoking relative to what would have been the case without the new laws.

"In light of the evidence, the PIR concludes that tobacco plain packaging is achieving its aim of improving public health in Australia, and is expected to have substantial public health outcomes into the future," the review said.

Health campaigners said the fact that plain packaging was already having an effect was unexpected and gratifying.

Professor Mike Daube, who chaired the Government expert committee that recommended plain packaging, said it was

"especially rewarding" that the analysis had shown the measure was already working.

"Plain packaging was always about the long term, and especially focussed on children," Professor Daube said. "Evidence that it has reduced smoking in adults in the short-term is a huge bonus."

Although Australia has some of the lowest smoking rates in the world – 14.7 per cent of adults light up on a regular basis – it remains a major killer. Around 15,000 a year die from smoking-related illnesses, and it is estimated the drug costs the country $31.5 billion a year.

President of the Australian Council on Smoking and Health, Maurice Swanson, said the early success of plain packaging laws foreshadowed huge promise for tobacco control measures.

"The legislation was always designed for long-term impact, and if these results are merely the start of the journey, a smoke-free Australia could one day be a reality," Mr Swanson said.

But tobacco industry is not giving up.

British American Tobacco Australasia claimed the Department's review did not provide conclusive evidence of the success of plain packaging.

Spokesperson Scott McIntyre claimed the proportion of daily smokers has been in long-term decline, and plain packaging had had negligible impact on the pace of that.

Mr McIntyre added that industry figures showed tobacco sales increased by 0.3 per cent in the year following the introduction of plain packaging.

This increase, however, is slower than the rate of population increase, and is consistent with other evidence that the proportion taking up or persisting with the habit is shrinking.

ADRIAN ROLLINS

# Premium hike could drive cover downgrade

There are fears a surge in private health insurance premiums will drive more patients into downgrading or dumping their policies, leaving many with inadequate cover and increasing the pressure on stretched public hospitals.

The Federal Government has approved an average 5.59 per cent increase in premiums from 1 April – more than double the rate of inflation.

Health Minster Sussan Ley has claimed a victory of sorts after convincing 20 of the nation's 33 private health funds to resubmit lower increases than originally planned, a move she said had saved consumers $125 million.

But the latest round of premium hikes, which range from 3.76 per cent to 8.95 per cent, are likely to feed mounting consumer dissatisfaction with the value of private health insurance, leading to more downgrading or dumping their insurance.

The AMA has raised the alarm on these and other developments in the private health insurance market that undermine the quality of cover and could disturb the important balance between private and public health systems.

AMA President Professor Brian Owler said in the past six years the proportion of people with policies that had exclusions had jumped from 10 to 35 per cent, often with serious consequences.

The AMA's criticisms were echoed in an Australian Competition and Consumer Commission report highly critical of the quality and accuracy of information provided by the health funds, which the watchdog said served to confuse consumers about what they were covered for and hampered their ability to make informed choices.

Ms Ley has launched a review into the private health insurance industry to examine regulation of the sector, including the setting of premiums, as well as other issues including the industry's push into primary health care; a possible relaxation of community rating principles; and a proposal to replace health insurance rebates with Medicare-style payments for hospital care.

The Health Minister said the review had received more than 40,000 submissions from the public, and flagged there would be "broader structural overhauls" made to current industry regulation.

Part of the Government's focus is on the cost of medical devices in the private health sector, and the Minister has launched a separate review of the Prostheses List.

Ms Ley said the process for approving premium increases also need to change.

But whereas the Health Minister has put the focus on industry regulation as much of the cause of the problem, Professor Owler put much of the blame on the hunger for profit.

Since the privatisation of Medibank Private, the market share of for-profit insurers has surged to 63 per cent, something AMA Medical Practice Committee Chair Professor Robyn Langham said had been a "game-changer".

"We now have an industry dominated by the interests of for-profit health insurers rather than not-for-profits, with a subsequent shift of focus from providing patient benefits to increasing profits for shareholders," Professor Langham said.

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

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

Professor Langham said the AMA was planning to produce an annual report card to given consumers clear and simple information regarding the health insurance policies on offer.

She said consumers would be able to check differences in benefits paid for a sample of common procedures, and identify exclusions and restrictions (including junk 'public hospital-only' insurance policies).

The AMA's submission to the Government private health insurance review can be viewed at: https://ama.com.au/submission/ama-submission-private-health-insurance-consultations-2015-16

## The only way is up

A selection of health fund premium increases to take effect from 1 April

| Insurer | Average increase |
|---|---|
| Medibank Private | 5.64 |
| NIB | 5.55 |
| HBF | 4.94 |
| BUPA | 5.69 |
| Doctor's Health Fund | 3.76 |
| CUA Health Fund | 8.95 |
| Industry weighted avg | 5.59 |

ADRIAN ROLLINS

# What ails us

Heart disease remains the nation's biggest killer, but the number of deaths attributed to dementia is increasing rapidly as the population ages, overtaking stroke to become the second most common cause of death.

In an encouraging sign that public health campaigns around smoking, drinking, exercise and diet are making a difference, Australian Bureau of Statistics figures show the number of people dying from heart attacks is shrinking, down more than 14 per cent in the past decade to 20,173 in 2014, continuing a two-decade-long decline.

Instead, people are increasingly succumbing to causes of death more commonly associated with ageing, most particularly dementia.

According to the ABS, 11,965 died from causes associated with dementia and Alzheimer's disease in 2014 – a stunning 157 per cent increase in just 10 years (though it is partly explained by classification changes in the collection of data).

As lives have lengthened, the number of cancer deaths has edged higher, and seven of the top 20 causes of death are varieties of the disease. In all, 44,734 people died from cancer in 2014 – almost a third of all deaths.

The most common form of cancer is of the lung or trachea, which accounted for 5.4 per cent of all deaths in 2014, followed by cancers of the blood and lymphatic systems (2.8 per cent) and of the colon and associated organs (2.7 per cent). Prostate cancer (3102 deaths) was a bigger killer than breast cancer (2844).

In more evidence of the changing profile of mortality as the population ages, the number of people who have died from injuries suffered in accidental falls has surged 43 per cent in the past decade – a rate of increase that appears to owe more than to accident-prone tradies alone.

The ABS figures showed the effectiveness of the national immunisation program, public health measures and effective medical treatment in preventing and treating infectious diseases. Just 2730 people died from various forms of infections and parasitic diseases in 2014 – a standardised death rate of 9.7 people per 100,000 (by comparison, cancer killed almost 164 per 100,000).

Though, unsurprisingly, older people die more, the ABS has also analysed deaths according to years of potential life lost.

By this measure, heart disease slips to second in the ranking of causes of death, and dementia plummets to 17.

Instead, suicide becomes the most significant cause of death (reflecting its disturbing prevalence among the young – see accompanying story). The number of lives cut short through self-harm in 2014 were equivalent to 97,066 years of life lost, according to ABS calculations.

Only heart disease (77,584 years lost) comes anywhere near close, followed by lung cancer (57,660 years) and colon cancer (30,065 years).

The consequences of differences in access to health care were shown in an analysis of potentially avoidable deaths.

In 2014, capital cities had an age-standardised avoidable death rate 1.4 times less than that of regional and rural areas, and the age-standardised avoidable death rate in Greater Darwin was 150.7 per 100,000, compared with 91 per 100,000 in Sydney and Melbourne, and just 83 per 100,000 in Canberra.

### The deadly top 10, 2014

| |
|---|
| Ischaemic heart diseases |
| Dementia, incl Alzheimer's disease |
| Stroke |
| Lung cancer |
| Chronic lung diseases |
| Diabetes |
| Leukaemia and lymphatic cancer |
| Colon cancer |
| Heart failure |
| Urinary system diseases |

Source: Australian Bureau of Statistics

ADRIAN ROLLINS

# Tragic death highlights heavy suicide toll

The suicide of a 10-year-old girl in outback Western Australia has highlighted a remorseless rise in the number of young people taking their own lives.

Official figures show that the death of the girl in a small community in the Kimberley region of far north WA, while shocking, is far from unheard of.

According to the Australian Bureau of Statistics, 88 children aged between five and 14 years died as a result of intentional self-harm between 2010 and 2014.

Though child suicide is rare, it is nonetheless the leading cause of death in the five to 17 years age group, accounting for one in every five fatalities.

Suicide is the most common cause of premature death nationwide, and its incidence is increasing. The ABS has reported that in 2014, the rate of death from intentional self-harm reached 12 per 100,000 – higher than at any other point in the past decade.

While the causes of suicide are complex, official figures show a clear upward trend in its incidence. Between 2005 and 2014 the number of deaths from self-harm climbed from 2102 to 2864 – a 36.2 per cent increase, and more than double the rate of population growth over the same period.

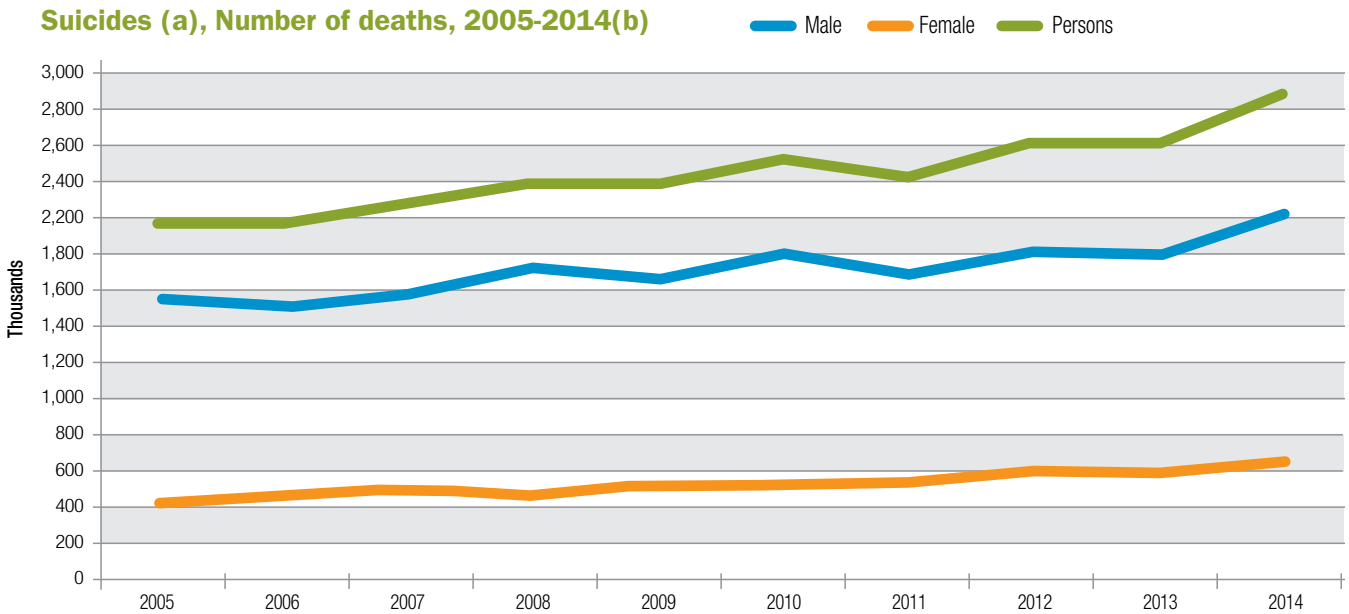
This is particularly disturbing because, although the age-specific suicide rate is highest among men aged 85 years or older (37.6 per 100,000), it is the most common cause of death not only in children, but also young and middle-aged adults. Among men in their early 40s, the suicide rate is almost 30 per 100,000, and around 25 per 100,000 for men in their 30s.

Self-harm is a particular problem in Indigenous communities – the suicide rate among Aboriginal and Torres Strait Islander people is double that of the rest of the population.

The National Mental Health Commission has announced the establishment of a National Expert Advisory Group for Suicide Prevention, including representative from Government, the Indigenous community, medical experts and support groups to "re-focus efforts" on suicide prevention.

ADRIAN ROLLINS

**Suicides (a), Number of deaths, 2005-2014(b)**




Source: Australian Bureau of Statistcs

# A refined way to complain

BY AMA VICE PRESIDENT DR STEPHEN PARNIS

Working on a better way (L to R): AHPRA CEO Martin Fletcher, AMA VP Dr Stephen Parnis, Medical Board Chair Dr Joanna Flynn, surgeon Dr Susan Neuhaus, respiratory physician Dr Jonathon Burdon, anaesthetist Dr Rod McRae, MBA Vic Chair Peter Dohrmann

Last month, a working group of senior AMA members and I met with the President of the Medical Board of Australia, the CEO of AHPRA and their senior officials to continue a process begun in 2015 to improve notification processes, particularly for doctors who are the subject of a complaint.

A common problem in recent years has been that investigations have taken far too long. To better assist timely and sensible vetting of notifications and complaints, we discussed the decision matrix AHPRA has developed for use by the Health Care Complaints entities and the Medical Board. This process steers complaints and notifications to the right pathway, significantly reducing the time taken for a preliminary assessment, and reducing unnecessary angst for doctors.

It was obvious from the discussion, and from the data presented to us by AHPRA, that the benchmark times for preliminary assessment of notifications are contributing to improved performance by AHPRA, in all states except Queensland, where a new regulatory regime has been established.

With that notable exception, I expect that this is leading to a more timely and transparent process for practitioners, and it would appear to be reflected in the number of representations practitioners have been making to the AMA in recent times.

However, these benchmark timeframes are more difficult to set for formal investigations. For example, some investigations have to be put on hold until other statutory processes, such as police investigations or coronial investigations are completed. That said, the Medical Board and AHPRA, following representations from the AMA, has recognised the necessity of better communicating the process to practitioners. I expect that here, too, improvements are being felt.

Ageing cases are now automatically escalated, so that more urgent and senior people are involved. Doctors are being advised about the reasons for delay. These matters are now reviewed at specific intervals by senior staff members, and in some cases by Medical Board members at an earlier stage, to ensure that all but unavoidable delays are eliminated, and to accelerate progress if at all possible.

Obtaining feedback from doctors about their experience is essential, and the Medical Board and AHPRA now accept that gaining a better understanding of a medical practitioner's experience is essential to refine processes. I expect further work and progress in this area over the next year.

I and my AMA colleagues have raised serious concerns about the Medical Board's practice of seeking out the expectations of complainants about the outcome of their complaint. We are particularly concerned that this may give rise inappropriate expectations, and deny due process.

According to the Board, understanding a notifier's expectations assists AHPRA to determine the pathway for the compliant i.e. the local Health Complaints Commissioner, or the Medical Board/AHPRA. The practitioner will be provided with this information, but only as it relates to what the Board has decided to investigate. This will allow the practitioner to focus only on the issues under investigation when responding to the Board, and may expedite more timely resolution of a complaint. We will continue to monitor this issue closely.

We concluded our most recent meeting with an important discussion about how the experience of the scheme can better inform the profession to deal with poor performance earlier.

The Medical Board and AHPRA have established a unit to look at how MBS data can be used to identify risks sooner, such as by providing examples of specific types of practice or certain scenarios which regularly become cases of concern to the medical profession and the wider community.

Clearly, early detection and prevention would protect the public and further enhance the standing of the medical profession.

Prevention is always better than cure and, if used appropriately, could be used as an opportunity for effective education by our medical schools, the learned colleges, and the medical indemnifiers.

Our next task is to ensure that the data collected by this unit is sufficiently robust.

The Working Group will continue to work through this important process, and the AMA regularly engages with the Medical Board and AHPRA through frequent meetings of the AMA President and Vice President with the MBA President and AHPRA CEO.

I wish to thank the members of the working group for their tremendous expertise and commitment – Dr Susan Neuhaus, Dr Roderick McRae, Dr Antonio Di Dio and Dr Jonathan Burdon.

In closing, I also wish to acknowledge the positive and strong relationship between the AMA and the Medical Board of Australia and AHPRA. It fosters a robust and effective exchange, and will continue to improve the regulatory environment for medicine in Australia.

# Claims of sub-standard chronic care 'blatantly wrong'

The AMA has hit back at "blatantly wrong" claims that GPs are failing to adequately care for patients with chronic illnesses.

AMA Council of General Practice Chair Dr Brian Morton said that although there was "no doubt" management of chronic disease could be improved, a Grattan Institute study accusing GPs of serial shortcomings in their care of patients with chronic illnesses including diabetes, asthma, heart disease and mental illness, was flawed.

Using data drawn from 162 medical practices using the Medical Director patient management system, the report, *Chronic failure in primary care*, claims that just 15 per cent of diabetic patients had their blood glucose, weight and blood pressure checked every year, less than 30 per cent with high blood pressure had it adequately managed and two-thirds of patients with a mental illness missed out on care.

But Dr Morton strongly disputed the findings, which he said did not stand up to scrutiny.

For instance, he said, the proportion of Australians admitted to hospital with uncontrolled diabetes was 7.5 per 100,000 – one of the lowest rates among rich countries and well below the United Kingdom (23.9 per 100,000).

The Grattan Institute report itself admitted the paucity of data available to assess the effectiveness of the primary health system in managing complex and chronic disease, which Dr Morton said meant its analysis and conclusions must be treated with caution.

The report's author, Professor Hal Swerrison, used the findings of the report to argue that the Government was getting a poor return on the $1 billion a year it provided to GPs to prepare chronic disease plans and conduct health assessments.

To rectify this, Professor Swerrison recommended that Medicare rebates be frozen at current levels and funds currently provided through the Practice Incentive Program, Service Incentive Payments and other sources to support chronic disease management be instead combined into an annual $40,000 payment to practices based on achieving performance targets and health outcomes.

A similar model was considered in the Primary Health Care Advisory Group report presented to Health Minister Sussan Ley late last year, as well as a blended model of fee-for-service and so-called capitation payments. The Minister is yet to formally respond to the report.

In its submission to the Primary Health Care Advisory Group, the AMA expressed support for a blended payment model and reform of Medicare chronic disease items to strengthen the role of a patient's GP, cut red tape, streamline access to allied health care and reward longitudinal care.

Dr Morton said any changes to the model of care needed to be carefully considered and tested before being introduced, and a much more urgent priority was to lift the freeze on Medicare rebates.

"The burden of complex and chronic disease in this country continues to grow, and the Government needs to take a long-term view if it is to tackle this problem effectively," he said. "The Government needs to invest significantly in general practice, [including] immediately lifting the current freeze on the indexation of Medicare rebates."

He said the Grattan Institute report also highlighted the need for much better primary health care data: "There is very little data as to what actually works in Australia in the primary care space. Yes, we need data, and we need to collect it."

The AMA has proposed a PIP incentive payment to support quality improvement, "informed by better data collection".

Last month, pharmacists outlined the scope of their ambitions for involvement in the provision of health services, particularly chronic care.

Pharmacy Guild of Australia Executive Director David Quilty told a parliamentary inquiry into chronic disease prevention and management that pharmacies could play an "enhanced role" in a number of areas including: transitional care, continued dispensing and prescription renewal, treatment of minor ailments, vaccination, medicine adherence, point of care testing, risk assessments, early intervention, broader diabetes management, treatment of patients through biologics, asthma support, improved after-hours access to primary health care, illicit drug use and the use of pharmacies as rural health hubs, with a strong focus on triage services.

While the AMA has highlighted the risk to patients of allowing pharmacists to administer vaccines, conduct health tests and provide other services outside their scope of expertise, it has proposed the introduction of non-dispensing pharmacist in general practices as a way to help improve medication management, particularly for the chronically ill.

ADRIAN ROLLINS

# The heat is on

Killer heat: AMA Vice President Dr Stephen Parnis says heatwaves kill more than any other natural disaster

Heatwaves kill more Australians than any other natural disaster and much of the nation is ill-prepared for a likely increase in the number and intensity of extreme heat weather events linked to climate change, AMA Vice President Dr Stephen Parnis has warned.

Dr Parnis told the Australian Summit on Extreme Heat and Health and Health that a three-day heatwave that gripped Victoria in 2009 killed at least 374 people, and during a similar period of extreme heat five years later, the number of cardiac arrests rose seven-fold.

By comparison, the Black Saturday bushfires that tore through much of the State a week after the 2009 heatwave resulted in 174 deaths and 100 serious injuries – considerably fewer than the number who had succumbed to the deadly effects of extreme heat.

Dr Parnis, who works in emergency medicine, said his own clinical experience had shown that once people overheat, they can quickly deteriorate, suffering multiple organ failure that can rapidly turn fatal without urgent care.

“Heatwaves are one of the more insidious manifestations of climate change, but one of the most deadly,” he said.

His warnings were backed by former Australian of the Year Professor Fiona Stanley, leading biologist Professor Lesley Hughes and climate health researcher Dr Elizabeth Hanna, who declared that heatwaves posed “an immediate and pressing risk to the health of Australians”.

The AMA Vice President recalled that in the mid-2000s he resuscitated a young, healthy cyclist who suffered heatstroke in the course of a long ride in temperatures in the high 30s.

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# The heat is on

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"He suffered rhabdomyolysis, an unstable heart rhythm, an acute confusional state, hypovolaemic shock, and acute renal failure," Dr Parnis said. "In plain English, he could have very easily died."

Warnings that the nation is likely to face more frequent, more intense and longer-lasting heatwaves have been underlined by the Bureau of Meteorology, which reported that for seven days in mid-December much of south-east Australia baked in extremely hot weather conditions, including widespread record high night time temperatures. This was followed by above-average temperatures in January and February and warnings that the nation is set for an unseasonably warm autumn.

Dr Parnis said sustained hot spells not only directly threatened lives, particularly the elderly, the very young and the chronically ill, they put critical services and systems like health care, electricity, communications and transport under huge pressure.

He said when the 2009 heatwave struck Victoria, ambulance services were overwhelmed, hospitals and their emergency departments quickly became overcrowded, elective procedures had to be cancelled and building cooling systems, including in some hospitals, broke down.

"It is easy to forget that essential infrastructure can be rendered unreliable, or even useless, during climate emergencies," Dr Parnis said. "Mobile phone network collapses and electricity blackouts are particular hazards."

The AMA recently revised its Position Statement on Climate Change and Health, in which it called for the development of a National Strategy for Health and Change that would include comprehensive action to tackle the effects of extreme heat.

Dr Parnis said some states already had detailed plans in place, but there needed to be a national strategy that not only encompassed all three tiers of government, but public institutions and private companies as well.

"The AMA believes that responding to extreme heat events is everyone's responsibility," he said. "State government, local government, community and private organisations all have an important role to play, as do we all as individuals."

He said experience in Victoria had shown the importance of a multipronged response, including health warnings, public messages about cutting down on outdoor work and watching out for elderly neighbours, and opening up swimming pools, public libraries and shopping centres as havens from the heat.

"We have excellent bushfire preparedness systems in some States – surely the same should apply for other disasters like heatwaves," Dr Parnis said. "We must do more to build our resilience to heatwaves. If we don't, then the consequences will be predictable, and severe."

In a joint statement at the conclusion of the Australian Summit on Extreme Heat and Health, Professor Stanley, Professor Hughes, Dr Hanna and other participants said there needed to be:

- acknowledgement that heatwaves were a health hazard;
- work to mitigate the effects of extreme heat and improve resilience, such as by changes to urban design;
- the development of a scaled response to heatwaves, similar to that provided for bushfires; and
- effective heatwave warnings.

ADRIAN ROLLINS

# Hepatitis C cure could come at a cost

The Federal Government has begun to draw down putative savings from cuts to pathology and diagnostic imaging bulk billing incentives to subsidise access to advanced hepatitis C treatments.

In a step Health Minister Sussan Ley said could lead to the eradication of hepatitis C in Australia, around 233,000 Australians diagnosed with the disease will now pay as little as $6.20 a prescription after four medicines – some previously costing as much as $110,000 for a course of treatment – were listed in the Pharmaceutical Benefits Schedule.

"With this announcement there is great hope we can not only halt the spread of this deadly infectious virus, but eliminate it altogether in time," Ms Ley said.

The initiative has won praise from advocates who have campaigned for years for subsidised to the medicines, which they say will save many lives.

Hepatitis C, an infectious blood-borne virus that attacks the liver and can cause cirrhosis and cancer, kills around 700 a year and leaves thousands more seriously ill.

The Government's decision to list the drugs sofosbuvir (Sovaldi), sofosbuvir with ledipasvir (Harvoni), daclatsavir (Daklinza) and ribavirin (Ibavyr) came eight months after the Pharmaceutical Benefits Advisory Committee (PBAC) recommended that sofosbuvir be listed on the PBS because of "high clinical need".

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# Hepatitis C cure could come at a cost

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This overturned advice from the PBAC a year earlier, in which it recommended against listing the drug because it was likely to have "a high financial impact on the health budget".

In recommending the drug's listing, the PBAC warned it was likely to cost taxpayers $3 billion over five years to put 62,000 chronic hepatitis C patients through a course of treatment – three times the Government's current budgeting.

Though sofosbuvir has been hailed as a "game-changing" medicine that can cure hepatitis C in as little as 12 weeks, its prohibitive price – a course of treatment can cost more than $110,000 – has meant that until now it has been out of the financial reach of most sufferers.

Listing on the PBS means a prescription will cost as little as $38.30 for general patients and $6.20 for concession card holders.

But the Health Minister has politicised the announcement by explicitly linking the decision with the highly controversial move to axe bulk billing incentives for pathology services and cut them for diagnostic imaging.

The Minister has argued the incentives had done little to lift bulk billing rates and had instead gone to boost the bottom line of big pathology and radiology operators.

The Government expects that axing the incentives will save $650 million over four years, and Ms Ley said the decision was part of the Coalition's drive to remove waste and inefficiency from health spending, freeing up funds for better uses.

"Every dollar spent on inefficiency in the health system is a dollar we cannot invest in new breakthrough cures like this one," the Health Minister said.

But the savings measure is yet to be approved by Parliament, and the Government may have a fight on its hands.

The pathology sector has vowed to oppose the measure, and plans to use thousands of pathology collection centres and imaging clinics around Australia to promote messages criticising the move.

Providers warn that the change will mean that many patients will be charged a co-payment for having a pathology or diagnostic imaging test, potentially causing some to delay or avoid screening, open up the risk of undiagnosed cancers and other serious illnesses.

ADRIAN ROLLINS

# How to ensure easy patient access to new hep C medicines

From 1 March, four new antiviral Hepatitis C medicines on the PBS are available on the PBS, making them affordable for all patients and available from community pharmacies.

These medicines (daclatasvir, ledipasvir with sofosbuvir, sofosbuvir and ribavirin) can be prescribed with an authority under the general PBS schedule (where most medicines are listed) or under the Highly Specialised Drug (HSD) schedule.

To ensure your patient can have their prescription dispensed at their local community pharmacy, it is important that the new hepatitis C medicines are prescribed using the PBS general schedule. (The authority number will not have a PTE or PUB prefix if prescribed using the general schedule.) This will also mean the community pharmacy can recoup the appropriate fees from the government, reflecting the cost of delivery.

The HSD listing will generally only be used to prescribe and supply the new hepatitis C medicines to patients in prisons, and to non-admitted public patients in NSW and ACT public hospitals (because these hospitals are not participating in certain electronic prescribing systems).

Because of their high cost, some pharmacies may only order these medicines on demand, rather than keep them in stock. You should consider advising your patient to renew their prescription with you and lodge prescriptions with their community pharmacy well before their current prescription runs out. This will ensure that there is no risk of a break in treatment because of dispensing delays.

The Government has developed a fact sheet for prescribers about how the new hepatitis C medicines can be prescribed under the PBS, and in what circumstances.

Consensus advice on the management of hepatitis C has been developed by the Gastroenterological Society of Australia, the Australasian Society for Infectious Diseases, the Australasian Society for HIV, Viral Hepatitis and Sexual Health Medicine, the Australasian Hepatology Association, Hepatitis Australia and the RACGP.

GEORGIA MORRIS

# A vision for GPs


The training that aspiring GPs receive should be responsive to local health care needs and include greater prevocational rotation opportunities in areas such as paediatrics, obstetrics and anaesthetics, the AMA has said.

Setting out its vision for GP training, the peak medical organisation said that although the current system was world-class, it needed to evolve and improve to make sure it produced practitioners well placed to meet future health care needs.

The AMA said the training system needed to develop a workforce that met individual and community needs, served the most disadvantaged, and achieved health equity.

To do this, GP registrars needed to be trained to the point where they could safely undertake independent practice and viewed professional development and lifelong learning as essential to high quality practice.

AMA President Professor Brian Owler said general practice was the cornerstone of the health system, and the Vision Statement set out what the AMA considered to be core values and priorities of high quality GP training.

"GPs are the first port of call when Australians feel unwell or want health advice, and directly manage 90 per cent of the medical problems they are presented with," Professor Owler said.

Evidence indicates that most people have a usual general practice or practitioner, and Professor Owler said GPs were a very cost effective part of the health system, accounting for just 7 per cent of total health spending.

The AMA has developed the *Vision Statement for General Practice Training 2016* to guide its advocacy on improvements to GP training, and as a way to promote general practice as a career.

There are currently around 4500 registrars undertaking GP training, and there are concerns that not enough medical graduates are opting for a career in general practice.

Professor Owler said that, by highlighting the professional and personal rewards of general practice, the Vision Statement would encourage more to consider it as a career.

The GP workforce is ageing, and is unevenly distributed around the country, providing uneven access to care.

While the big cities have a relatively high concentration of GPs, there is often a shortage in rural areas, and bonded programs and other Government attempts to redress this have met with only limited success.

The AMA has proposed that there be much greater investment in GP training opportunities in regional and rural areas.

The AMA Vision Statement for General Practice Training 2016 is at https://ama.com.au/ama-vision-statement-general-practice-training-2016

ADRIAN ROLLINS

INFORMATION FOR MEMBERS

## Essential GP tools at the click of a button

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

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

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

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

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

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

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

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

INFORMATION FOR MEMBERS

# 2016 AMA MEDIA AWARDS

## MOST INNOVATIVE USE OF WEBSITE OR NEW MEDIA

State and Territory AMAs are invited to submit an entry for the "Most Innovative Use Of Website Or New Media" Award.

With new forms of media - Facebook, YouTube, Twitter, email campaigns - complementing websites, we want to recognise and award innovative approaches to getting the AMA message to members and the public. It could be clever use of the existing website or it could be smart use of the new media tools.

**Judging Criteria:**

- clarity of message,
- range of information,
- timeliness of information,
- audience reach,
- impact with membership,
- impact in the news media.

## BEST STATE PUBLICATION

State and Territory AMAs are invited to submit an entry for the "Best State Publication" Award.

To assist in the judging process, States and Territories are asked to submit three successive editions of their magazine/ newsletter.

**Judging Criteria:**

- quality and consistency,
- range of information,
- relevance & appeal, and
- feature stories.

State and Territory AMAs are also invited to provide information on:

- readership,
- production and design, and
- budget.

## BEST LOBBY CAMPAIGN

State and Territory AMAs are invited to submit an entry for the "Best Lobby Campaign" Award.

The lobbying campaign should be one that has been directed at any level of government (local, State or Federal).

This is not to be confused with a public health campaign, although the lobby project might be supported by a public health campaign.

**Judging Criteria:**

- objectives,
- strategy,
- materials,
- tactics, and
- results.

## BEST PUBLIC HEALTH CAMPAIGN

State and Territory AMAs are invited to submit an entry for the "Best Public Health Campaign" Award for either a public health or a preventative health campaign.

A separate submission is required for each campaign nominated.

Please include campaign proposals, press articles, media releases, posters, and other relevant material.

**Judging Criteria:**

- relevance of campaign,
- quality & clarity of message,
- range & quality of campaign material,
- coverage of campaign, and
- effectiveness of campaign.

## NATIONAL ADVOCACY AWARD

State and Territory AMAs are invited to submit an entry for the "National Advocacy" Award for the best example of cooperation between the Federal AMA and the State/Territory AMAs on a major issue.

**Judging Criteria:**

- quality & clarity of message,
- strategy and tactics,
- coverage of campaign, and
- effectiveness of campaign.

## Further information

Should you require any further information regarding the 2016 AMA State Awards, please contact:

Kirsty Waterford
Ph: 02 6270 5464
E: kwaterford@ama.com.au

# AMA Federal Council elections

Several vacancies on the AMA Federal Council will be put to the vote following the receipt of rival nominations.

The Returning Officer, Anne Trimmer, has announced that electronic ballots will be held for each of five contested positions on the Council, which is the AMA's peak policy making body.

A ballot of members in relevant Federal Voting Groups or Areas will be held for the following positions next month:

## CONTESTED POSITIONS

### Area Representatives

**VICTORIA:**

- Dr Anthony Bartone
- Dr Umberto Boffa

**QUEENSLAND:**

- Dr Wayne Herdy
- Dr Richard Kidd

### Specialty Groups

**GENERAL PRACTITIONERS**:

- Dr Anthony Bartone
- Dr Richard Kidd

**PAEDIATRICIANS:**

- Dr Paul Bauert
- Dr Kathryn Browning Carmo

**PSYCHIATRISTS:**

- Dr Steve Kisely
- A/Professor Robert Parker

Fifteen other positions on the Council have been filled without contest, and Ms Trimmer has declared the following members elected:

## FILLED VACANCIES

### Area Representatives

**NSW/ACT:** A/Professor Saxon Smith
**SA/NT:** Dr Christopher Moy
**TAS:** Dr Helen McArdle
**WA:** Dr Michael Gannon

### Specialty Groups

**ANAESTHETISTS:** Dr Andrew Mulcahy

**DERMATOLOGIST:** Dr Andrew Miller

**EMERGENCY PHYSICIANS:** Dr David Mountain

**OBSTETRICIANS AND GYNAECOLOGISTS:** Dr Gino Pecoraro

**ORTHOPAEDIC SURGEONS:** Dr Omar Khorshid

**PATHOLOGISTS:** Dr Beverley Rowbotham

**PHYSICIANS:** A/Professor Robyn Langham

**RADIOLOGISTS:** Professor Makhan (Mark) Khangure

**SURGEONS:** A/Professor Susan Neuhaus

### Special Interest Groups

**DOCTORS IN TRAINING:** Dr John Zorbas

**PUBLIC HOSPITAL PRACTICE:** Dr Roderick McRae

## OPEN VACANCIES

Nominations were not received for three positions, and Ms Trimmer has called for expressions of interest from members. The positions are:

- Private Specialist Practice
- Rural Doctors
- Ophthalmology

Members interested in filling these vacancies are asked to contact Ms Trimmer at: atrimmer@ama.com.au

# AMA in the news

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

## PRINT/ONLINE

### Focus on health wins, *Northern Territory News*, 20 February 2015

AMA President Professor Brian Owler visited health facilities in Alice Springs, as well as the Indigenous communities of Utopia, Ampilatwatja, and Kintore. Professor Owler said Indigenous health gains might be slow, but it is important successes are not lost in a sea of depressing statistics.

### Angry medicos urge action over plight of detainees, *Sydney Morning Herald*, 22 February 2016

AMA President Professor Brian Owler has savaged the Department of Immigration and Border Protection for what he says has been its intimidation of doctors who speak out about the plight of asylum seekers.

### Row stymies e-health rollout, *AFR Weekend*, 27 February 2016

Pharmacists and doctors are feuding over the Federal Government's struggling electronic My Health Record system. AMA President Professor Brian Owler said the organisation backed e-health records as a way of controlling health costs, but the Government had failed to ask medical specialists what they needed to make My Health Record work.

### Hangover cure no miracle as clinic closes, *Sun Herald*, 28 February 2016

NSW health authorities have launched an investigation into a national chain of hydration clinics after a Sydney woman was hospitalised following an intravenous vitamin infusion sold as a miracle hangover cure. AMA Vice President Dr Stephen Parnis has accused those behind the IV infusion trend of bringing the medical profession into disrepute.

### Patients to feel pain as cuts bite, *Adelaide Advertiser,* 11 March 2016

Across Australia, public hospitals will lose more than a $1 billion in federal funding next year. AMA President Professor Brian Owler said as hospital capacity shrinks, doctors won't be able to get their patients into hospital or keep them there to receive the critical care they require.

### AMA warns of hospital funding crisis as cuts bite, *Sydney Morning Herald*, 11 March 2016

Hospitals are limiting surgery hours and forcing patients to wait longer for elective procedures as an economic disaster looms. AMA president Brian Owler said patients with life-threatening conditions such as cancer would wait longer for surgery, while emergency departments would struggle to treat half their sickest patients within 30 minutes.

### Porn turning kids into predators, *The Australian*, 29 February 2016

Online pornography is turning children into copycat sexual predators, doctors and child abuse experts warned. AMA Vice President Dr Stephen Parnis said the internet was exposing children to sexually explicit content that taught sex was about use and abuse.

## RADIO

### Professor Brian Owler, Radio National, 22 February 2016

AMA President Professor Brian Owler discussed calling for the immediate removal of infants and children from immigration detention centres, and for all asylum seekers to have access to quality health care.

### Dr Stephen Parnis, 2HD Newcastle, 22 February 2016

AMA Vice President Dr Stephen Parnis discussed Turnbull Government plans for asylum seeker Baby Asha and her family to be returned to Nauru once medical and legal process are complete. Dr Parnis said doctors were in an untenable situation in treating patients with serious physical and mental health issues, particularly the children, who were under threat of return to conditions that will only exacerbate their health problems.

### Dr Stephen Parnis, 5AA Adelaide, 28 February 2016

AMA Vice President Dr Stephen Parnis talked about hangover clinics. He said clinics which claim to cure hangovers through intravenous infusions have no benefit and could put lives at risk.

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# AMA in the news

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

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### Professor Brian Owler, 2UE Sydney, 11 March 2015

AMA President Professor Brian Owler talked about public hospital funding. Professor Owler said Australia has one of the best health care systems in the world, but it relies on having adequate funding.

## TELEVISION

### Professor Brian Owler, ABC Melbourne, 21 February 2016

Federal Immigration Minister, Peter Dutton, says that asylum seeker baby Asha and her family will moved to community detention, and not immediately sent to Nauru. The AMA reiterated its call for all children to be immediately released from detention

### Dr Stephen Parnis, ABC Melbourne, 2 February 2016

A new report warns that Australia isn't properly prepared for health problems triggered by an increase in heat waves over the next 40 years. AMA Vice President Dr Stephen Parnis said hundreds of people could die every year if nothing is done to tackle climate change.

### Dr Stephen Parnis, Channel 10, 8 March 2015

An official submission to the Government proposes increasing the tax on alcohol. AMA Vice President Dr Stephen Parnis is supportive of increasing the price.

### Professor Brian Owler, Prime 7, 10 March 2016

AMA President Professor Brian Owler warns regional communities they will be worst hit when the Federal Government's hospital cuts take effect from next year. AMA urges the Government to prioritise health when it lays down the budget in May.

### Professor Brian Owler, Sky News, 10 March 2016

AMA President Professor Brian Owler talks about the No Jab, No Pay laws coming into force on March 18, when parents who don't ensure their child's immunisation is up-to-date stand to lose childcare benefits.

ADRIAN ROLLINS

# Health on the hill

POLITICAL NEWS FROM THE NATION'S CAPITAL

## Medicinal cannabis hits jack-pot

Medicinal cannabis will be bracketed with morphine and other restricted medicines under changes to the Poisons Schedule being made following the passage of legislation legalising and regulating its cultivation and supply.

Health Minister Sussan Ley said the Health Department and the Therapeutic Goods Administration were "well advanced" in changing the categorisation of medicinal cannabis to a Schedule 8 substance.

Ms Ley said the change would simplify arrangements regarding the legal possession of medicinal cannabis products, "placing them in the same category as restricted medicines such as morphine, rather than an illicit drug".

The TGA is due to make an interim decision on the change in March, which will then be subject to further consultation.

The change is part of a suite of measures being undertaken after Parliament approved amendments to the Narcotic Drugs Act making it legal to cultivate and manufacture medicinal cannabis.

The legislation was passed in rapid order and without amendment, aided by support from the major political parties and across the political spectrum.

"This is an historic day for Australia and the many advocates who have fought long and hard to challenge the stigma around medicinal cannabis products so genuine patients are no longer treated as criminals," Ms Ley said. "This is the missing piece in a patient's treatment journey, and will now see seamless access to locally-produced medicinal cannabis products from farm to pharmacy."

Medicinal cannabis is currently imported by individuals from overseas to treat a range of conditions including severe epilepsy and nausea and loss of appetite associated with chemotherapy.

AMA President Professor Brian Owler has said medicinal cannabis should be subject to the same sort of scrutiny and testing as any other medicine.

The Government's legislation provides for the creation of a single, national body to regulate the cultivation and supply of medicinal cannabis.

Those wanting to cultivate cannabis for medical or research purposes will have to show that they are a "fit and proper person", do not have ties to criminal activity, and be able to demonstrate they have the capacity to ensure the physical security of the crop before being granted a licence.

The quantities and strains of cannabis produced will be tightly controlled, and a system of permits will be used to ensure that amounts to be manufactured are planned in advance, and are in proportion to demand.

Ms Ley said the Government, through the national regulator, would closely track the development of medicinal cannabis products "from cultivation to supply, and curtail any attempts by criminals to get involved".

Initially, the focus of the scheme will be production for domestic consumption, with any provision for exports "to be addressed at a later date".

ADRIAN ROLLINS

## Our drivers deserve the best: Owler

AMA President Professor Brian Owler has called for tougher vehicle safety standards, improved road user education and the development of a national road trauma database as part of efforts to reduce death and injury on the country's roads.

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# Health on the hill

POLITICAL NEWS FROM THE NATION'S CAPITAL

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AMA President Professor Brian Owler after giving evidence to a Senate enquiry into road safety

Professor Owler told a Senate inquiry into road safety that there was much that can and should be done to reduce traffic trauma, including the adoption of world-leading design rules and technologies, such as autonomous emergency braking.

"I do not see why an Australian life should be worth any less than the life of a European or US or Japanese citizen," he said. "I think our vehicles should be rated to the highest standards. It makes good sense."

Cars equipped with autonomous emergency braking can detect the threat of an imminent collision and apply the brakes, either avoiding an accident or significantly reducing its severity.

Professor Owler said it was not just about preventing fatalities. He said people involved in simple accidents like rear-end collisions can suffer injuries such as whiplash that can have serious lifelong consequences.

He told the committee he had seen "many young people" who had lost their job and their partner after suffering whiplash and subsequently developing a dependence on opioids while trying to manage the pain.

Often, calls to tighten design and safety standards are resisted on the grounds that will add to production costs.

But Professor Owler said the marginal increase to the cost of a vehicle was more than offset by the huge savings to be made from preventing deaths and injuries that, over a lifetime, might cost millions of dollars in care.

One of the biggest blank spots in efforts to cut down the road toll was the lack of a national road trauma database, he said.

Though road deaths were recorded and shared across state borders, this did not extend to traffic accident injuries, hampering efforts to come to grips with the scale of the issue and how it could best be tackled.

"The number of deaths is only a fraction of the number of injuries that occur," Professor Owler said. "While some of those injuries might heal...there are many injuries that are very devastating or at least result in significant time off work, loss of income, disruption to families. Being able to record that information is a very basic step that we need to take in order to be able to assess how we are going to make roads and cars safer."

"It would provide a platform for being able to assess any investment [in road safety] that is made. But it will also allow us to determine where the problems are occurring".

Professor Owler said while this was important, the most significant action governments should take would be to improve driver behaviour through education – particularly aimed at young people learning how to drive.

He said there was "a lot of positive feedback" regarding programs that aimed to educate those about to get their driver's licences about speed, driving conditions, distractions and the role of passengers.

"People will make mistakes, and that is why education is so important, particularly for young drivers," the AMA President said.

ADRIAN ROLLINS

# Health on the hill

POLITICAL NEWS FROM THE NATION'S CAPITAL

## Dying with dignity

Laws legalising euthanasia in the ACT and the Northern Territory would be reinstated under a Bill introduced to the Senate with the support of a group of MPs drawn from across the major parties.

In a rare display of cross-party action, Labor MPs including Alannah Mactiernan, Katy Gallagher and Nova Peris have joined with Liberal MP Sharman Stone and Australian Greens leader Richard Di Natale in backing legislation which would restore to the ACT and the NT the right to legislate around euthanasia.

The new laws would roll back a Private Member's Bill, introduced by Liberal MP Kevin Andrews in 1996, that nullified NT euthanasia legislation and stripped the ACT of the power to legislate for euthanasia.

The issue is politically divisive, and the Labor caucus last month decided to allow ALP MPs a conscience vote on the matter.

The push to allow for euthanasia has gathered momentum in recent months and has the backing of several high-profile advocates including broadcaster Andrew Denton.

But even if the legislation is passed by the Senate, there are doubts it will attract sufficient support in the Lower House to become law.

## Indecent disclosure

Health care providers are set to come under scrutiny over the adequacy of their information disclosure as the consumer watchdog vows to crack down on confusing and misleading conduct.

Australian Competition and Consumer Commission Chair Rod Sims said the agency had "important investigations underway" into the disclosure practices of health care providers amid concerns some were in breach of Australian Consumer Law.

Flushed with success after forcing Canberra's Calvary Private Hospital to provide patients with more information about potential out-of-pocket costs, Mr Sims said the ACCC would focus on shortcomings in disclosure to consumers.

He said the Commission's scathing report on the behaviour of the private health insurance industry, released last year, would provide a springboard for greater scrutiny regarding the provision of incomplete information that was not only confusing but potentially misleading.

## Research boost

Research to develop an AIDS vaccine and reduce the incidence of over-diagnosis are among 96 projects sharing $130 million of funding in the latest round of grants from the nation's peak medical research organisation.

Health Minister Sussan Ley said the money was part of $850 million that will be disbursed by the National Health and Medical Research Council to fund a wide range of projects.

There has been criticism that scientists starting their research career have often been unfairly overlooked in the race for funding, but NHMRC Chief Executive Officer Professor Anne Kelso said grants were awarded to a mix of both "outstanding new talent and experienced and internationally recognised researchers".

## TPP

Drug companies may effectively hold at least an eight-year monopoly on the supply of expensive biologic medicines under the terms of the controversial Trans Pacific Partnership trade deal, activists have warned.

Trade watchers have seized on remarks made by Australia's Special Trade Envoy, Andrew Robb, during a visit to Washington DC late last month to claim the Government was looking at using administrative delays and other bureaucratic processes to effectively extend monopoly protection for biologic medicine manufacturers to eight years – three years longer than stipulated under the treaty.

The Washing-based *Politico* news service reported assurances from Mr Robb, who was visiting the US capital to help rally US Congress support for the TPP, that the trade agreement would effectively provide at least eight years market protection for biologic makers, as possibly as long as 17 years.

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# Health on the hill

POLITICAL NEWS FROM THE NATION'S CAPITAL

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During negotiations for the TPP, Australia and other countries resisted US demands for at least 12 years of data protection for biologic manufacturers, and there was eventual agreement on a "five-plus" approach guaranteeing makers a minimum of five years' monopoly on supply.

Though Mr Robb told *Politico* Australia would not be "a party to anything that would imply that we've changed our position", he emphasised the importance of providing drug companies similar protection to that they received in the US: "We've got a very burgeoning biologics sector in Australia, [and] if they weren't getting the protection that they could get in the United States, they wouldn't be setting up in Australia".

Health advocates warn this would effectively mean at least eight years before cheaper generic versions of expensive biologic medicines - gene and cellular-based therapies that are being developed to treat diseases long-considered intractable, such as cancer, HIV/AIDS, rheumatoid arthritis, diabetes, hepatitis B and multiple sclerosis – would become available.

## Get moving

Teenage girls are being urged to 'make your move' following findings that they are, on average, only half as physically active as their male counterparts.

Health Minister Sussan Ley has launched the #girlsmakeyourmove campaign to encourage young women to play sport and engage in other activities amid concerns many are heading for a life of poor health.

Ms Ley said research showed almost 60 per cent of girls aged between 15 and 17 years undertook little or no exercise, compared with a third of boys in the same age group.

The Minister said such sedentary habits, particularly during the formative teenage years, could lead to a lifetime of chronic disease.

"[This campaign] aims to tackle this sliding door moment in a young woman's life when they actually are laying down the foundation for the rest of their lives," Ms Ley said. "Physical activity in the teenage years lays down the muscle and bone you need for the rest of your life."

Many girls get put off playing sport or engaging in physical activity because of a lack of confidence, fear of being judged or a bad experience, and the campaign uses television ads and social media to feature girls enjoying playing sport and being active.

ADRIAN ROLLINS

INFORMATION FOR MEMBERS

## Essential GP tools at the click of a button

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

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

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

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

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

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

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

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

# Research

## Postcode perils

Is your neighbourhood making you fat? That is the question a group of Europe-based researchers set out to answer in a unique study aimed at finding out what it is about where people live that has an impact on their diet and exercise habits.

Analysing data from more than 6000 people living in Paris, London, Ghent, Rotterdam, Amsterdam and Budapest, they found that levels of physical activity, self-rated health and happiness were associated with how people perceived and used their neighbourhood.

In a result that has big implications for urban planning and design, the study found that residents of lower socio-economic areas perceived their environment as less conducive to healthy behaviour than those in more affluent areas. Surveys found that neighbourhood perception was not only associated with objective features such as traffic safety and aesthetics, but also with social cohesion.

Higher levels of social networking and cohesion were associated with better self-rated health, lower odds of obesity and higher fruit consumption.

The four-year SPOTLIGHT study was supported by Google Street View, which assisted in measuring factors such as green spaces, street layout and food outlets in different areas. Features such as the presence of food outlets, outdoor recreation facilities, and green spaces varied significantly between the cities included in the study.

Lead researcher Jeroen Lakerveld from the VU University Medical Centre in Amsterdam said in future, neighbourhoods should be designed on the basis of how their structures will affect the physical health of inhabitants.

"Urban planners and policy makers have a responsibility to ensure the neighbourhoods they design, and the facilities and businesses that the neighbourhoods contain, will promote health behaviour, and is protective against unhealthy behaviours," Dr Lakerveld said.

"It could save millions in health care costs if health promotion focuses on upstream determinants of healthy behaviours, including healthy food purchases and greater physical activity.

"The best neighbourhoods are those which facilities to support good health and also encourage social networking and community support."

Co-editor Dr Harry Rutter, from the London School of Hygiene and Tropical Medicine, said the collection of papers provides a robust evidence based for policy makers.

"We have known for some years that where a person lives will affect their health, and now we can see more clearly exactly how that happens and, in practice, what we need to do about it," Dr Rutter said.

The SPOTLIGHT project is funded by the European Commission, and the study was published in *Obesity Reviews*.

KIRSTY WATERFORD

## A nation in pain

Australians are world champion pill poppers, quadrupling their use of common opioid-based painkillers such as codeine, morphine, and oxycodone quadrupling in the last decade, an international study has found.

Researchers from the independent body responsible for implementing the United Nations international drug control conventions, the International Narcotics Control Board, found that the use of opioid painkillers in Australia rose from 22 million doses annually in 2001 to 106 million doses annually in 2013.

Though there has been a worldwide trend toward greater reliance on painkillers, Australia is one of a handful of regions that accounted for the vast bulk of increase in their use.

The INCB study, which examined the consumption of the painkillers, and the prevalence of disorders that needed them, in 214 countries, found that overall opioid painkiller use had doubled since 2001. But Australia, North America, Western and Central Europe and New Zealand accounting for more than 95 per cent of global opioid use.

While researchers speculated the higher usage in developed countries could be due to increased pain management for cancer in aging populations and other chronic illnesses, low-income and developing countries, which have higher rates of the diseases for which opioid medications are needed, had little access to the drugs, and there was no significant increase in their use.

Co-author of the study, Professor Richard Mattick, from the University of New South Wales' National Drug and Alcohol Research Centre, said that there were a number of factors that made it difficult for patients in in developing countries to get painkillers, particularly cost, but also including a lack of training among medical professionals and fear of dependence.

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# Research

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Professor Mattick told The Guardian that because there was no recognised level of appropriate prescribing and dosage for opioids, it was hard to tell if their use in Australia was excessive or inappropriate.

"You can't have benefits without some harms; it's just nonsense to think otherwise," Professor Mattick said.

"So, while it's correct to bring attention to harms, I think we have some work to do to understand this situation accurately, and to get a comprehensive national picture of what is driving this use."

The study was published in the *Lancet*.

KIRSTY WATERFORD

INFORMATION FOR MEMBERS

## NPS MedicineWise – CALL FOR NOMINATIONS

The NPS MedicineWise Board is calling for nominations for one Board Director position currently held by Dr Winston Liauw, whose term concludes 18 June 2016. Dr Liauw is eligible for re-nomination.

As with all Non-Executive Director vacancies the Board are seeking multiple nominations for this position so we strongly encourage you to put forward individuals that meet the criteria and whom you feel can make a valuable and strategic contribution to NPS MedicineWise.

### NOMINATIONS

Nominations must clearly demonstrate that candidates meet all of the criteria for this position. The specific criteria for this position is as follows:

1. A person who is currently working as a medical specialist in Australia with a demonstrable understanding of the strategies and interventions that facilitate Quality Use of Medicines and medical technologies in specialist and hospital settings.
2. A demonstrated understanding of roles and responsibilities of specialists, hospitals and state health departments to support organisational outcomes.
3. A demonstrable understanding of Australia's health policy environment and health reform agenda, particularly as it relates to the acute and hospital sectors, and the ability to identify opportunities to progress the strategic vision of NPS MedicineWise.

In addition, all nominations should address the core criteria for directorship (see Application Form).

All nominations must be received by **5pm EST on Wednesday 6 April 2016** in order to be considered. The preferred candidates will be invited to attend a formal interview with the Board Governance and Nomination Committee, and this is currently scheduled to take place on 4 May 2016.

Nominations must include:

- A completed application form which clearly addresses all the criteria. (A copy of the application form is enclosed).
- A copy of the candidate's curriculum vitae.
- A letter of support from the nominating organisation(s).
- A letter from the nominated candidate accepting the nomination.

### GUIDANCE FOR CANDIDATES

Our Guide for Director Applicants, Constitution and Board Charter are enclosed to provide candidates with information on the role and application process. I would be grateful if you could forward this information, together with the Application Form, to your nominee(s).

If you have any questions regarding this process, please do not hesitate to contact our CEO, Lynn Weekes (ceo@nps.org.au) or Governance Officer, Nicola Ryan (nryan@nps.org.au) by email or by telephone on 02 8217 8671.

# 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**

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

Learning.doctorportal.com.au

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


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

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

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

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

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

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

**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.

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