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Why are we waiting?

Delays in care set to blow out as huge funding gap looms, p6

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Budget must fix public hospital funding

BY AMA PRESIDENT PROFESSOR BRIAN OWLER

Just weeks before I became Federal AMA President, I teamed with former AMA Vice President, Professor Geoffrey Dobb, to respond on behalf of the AMA to the health decisions in the 2014-15 Federal Budget.

As it turned out, it was quite an introduction to the Federal medico-political scene as we witnessed one of the worst health budgets for many years – it was the Budget of the GP co-payment and the big cuts to public hospital funding.

The AMA was not happy on the night. We are still not happy today. We may have successfully seen off the co-payments, but the pain of the public hospital funding cuts remains, and will hit hardest over the next 12 months.

Australia's public hospitals, doctors, other health workers, and patients are under increasing pressure as a result of reduced capacity – and things will only get worse without a massive injection of long-term funding from the Federal Government in the May Budget.

Our public hospitals face a catastrophic funding crisis from 2017 when the full impact of the Federal Government's 2014 Budget decision to strip $57 billion (from 2017-18 to 2024-25) of hospital funding from the States and Territories takes effect.

The AMA has highlighted the crisis facing public hospitals and patients for almost two years, but the Federal Government has done nothing.

State and Territory Governments are facing an economic disaster unless the Federal Government urgently restores promised public hospital funding.

Worse, patients face longer waits for vital health care, and some may miss out altogether.

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.

Currently, 32 per cent of people presenting to an Emergency Department (ED) who are classified as 'Urgent' do not get seen within the recommended time of 30 minutes.

As funding cuts hit harder, hospitals will struggle to keep this below 50 per cent, despite their best endeavours.

Doctors will always do the best they can by their patients, but these cuts mean the system as a whole simply won't be able to meet the demand.

There is a very real human element to these cuts – patients will suffer.

For a patient requiring urgent attention for abdominal pain, this could mean they are seen one to two hours after they present to the ED.

Their symptoms could be consistent with indigestion, or could be a perforated bowel.

The quicker a doctor can see them and make a diagnosis, then the quicker they can receive relief from their pain, and their condition can be prevented from deteriorating, potentially to a very serious situation.

It is patients like this who will not be seen in a timely manner because of the Federal Government's cuts.

Indigenous people will be some of the worst affected by these cuts. They have a life expectancy that is 10 years less than that for non-Indigenous people.

If the Government is truly committed to closing the gap, then it needs to properly fund public hospitals."

The AMA is calling on the Prime Minister to use the May Budget to offer the States and Territories a genuine long-term public hospital funding commitment, not a short-term fix.

It has been reported that the Prime Minister has been making approaches to some States about a possible short-term pre-election funding fix to the problem.

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.

Through the National Health Reform Agreement, the States and Territories were beginning to make improvements to the transparency and performance of their hospitals, reducing waiting times for patients, and increasing their capacity.

Because of the Commonwealth's unilateral decision to cut $57 billion in funding, this progress will go backwards.

The Government found money to fund Defence for the next decade. It must now do the same for Health, especially for public hospitals.

Unless there is a public hospital bailout in the May Budget – and it must be bog and for the long-term – this fundi9ng issue will be at the forefront of AMA advocacy ahead of this year's election.

More reviews than an outpatient clinic

BY AMA VICE PRESIDENT DR STEPHEN PARNIS

Health policy reviews can be an important tool in keeping our health system efficient and effective.

At the moment, however, there seem to be more reviews taking place than you would see in a public hospital outpatient clinic.

The Government is currently conducting, or considering, 10 ongoing health reviews:

- Medicare Benefits Schedule Review (expected to be completed in 2017);
- Primary Health Care Advisory Group (awaiting response from the Minister);
- the Industry Working Group on Private Health Insurance Prostheses Reform (currently meeting);
- Review of the Drug and Alcohol Prevention and Treatment Services Sector;
- the Review of the Australian Government Rebate on Private Health Insurance for Natural Therapies;
- Review of the implementation of the national reform agenda on organ and tissue donation and transplantation;
- Expert Review of Medicines and Medical Devices Regulation (separate to the prostheses review);
- Codeine Scheduling Review, undergoing its own review within the Therapeutic Goods Administration;
- The Private Health Insurance Review; and the
- Federation White Paper (health funding responsibility arrangements between the States and Commonwealth).

While these reviews probe the fundamental aspects of our finely balanced health system, the real question in each case is, will these reviews enhance our health system or undermine it?

Reviews are often undertaken at the beginning of a Government's term, which allows for adequate consultation time and implementation of the review's recommendations.

With a Federal election certain in the next three to six months, the information and good work being conducted by the Review Committees may very well be lost in the election cycle, and unpopular or negative measures could well be kept from the public and the profession until well after the election.

Our world class health system did not occur by accident, and its future is not guaranteed. Government must keep the big picture in mind. The expertise and the data collected by the Review Committees should not be sidelined by elections and the inevitable changes they bring.

Health spending is not out of control, and the economic benefits of a healthy population must be factored into economic modelling. An Australian Institute of Health and Welfare report showed that Commonwealth spending grew by 2.4 per cent in 2013-14 – below the inflation rate – and its share of total health spending has plunged from almost 44 per cent to 41.2 per cent in five years. At the same time, individuals and families are shouldering more of the burden - non-government funding grew by five per cent, after inflation.

I reiterate - costs are not escalating in the manner that some would like to suggest.

There is an ethical obligation on doctors to improve efficiency and effectiveness wherever we can. But this should not be at the expense of undermining the pillars of the health system which have served us so well, for so long.

We take pride in our system for its expert multidisciplinary workforce led by doctors, its accessible facilities at community and hospital levels for all Australians, and its affordable medications via the Pharmaceutical Benefits Scheme. These pillars of our health system must continue to be supported and enriched, and I particularly emphasise the importance of improved communications via a workable e-health system as a target we must achieve.

The AMA has developed a wide ranging platform, highlighting the steps and enhancements that are needed in the Federal Budget, and subsequent election campaign, to maintain our health system.

The Government must invest in the future of the Australian health system to meet growing and changing demand from an ageing population, and the increased prevalence in chronic and complex conditions.

The AMA's Pre-Budget Submission is there to inform and guide politicians across the political spectrum, as well as the Australian public, about the urgent need to put the focus back on the strong foundations of the health system.

The Submission can be found at https://ama.com.au/sites/default/files/budget-submission/Budget_Submission_2016_2017.pdf

We will be closely watching and assessing their responses.

Whiff of an election

BY **AMA SECRETARY GENERAL ANNE TRIMMER**

> "The focus of AMA's advocacy remains unchanged. This includes ensuring adequate Commonwealth funding of the public hospital system, with changes required to the proposed arrangements with the states that were announced in the 2014 Federal Budget"

With rumblings of an early (or at least earlier) double dissolution election gathering pace in Canberra, the AMA is refining its pre-election strategy. The key policy issues are well documented in the AMA's pre-Budget submission, which can be read on the AMA website.

The focus of AMA's advocacy remains unchanged. This includes ensuring adequate Commonwealth funding of the public hospital system, with changes required to the proposed arrangements with the states that were announced in the 2014 Federal Budget.

The second concern is with the sustainability of primary care as the most cost-effective and efficient part of the health system. The ongoing freeze to Medicare rebates has not stopped the rise in bulk billing rates, but it does mean that general practitioners have to make difficult choices about the way they deliver optimal care to their patients.

The third concern is ensuring the value of the private health system, which will be informed by the several reviews currently underway at the instigation of the Federal Minister for Health. These include the review of the MBS, the review of private health insurance and, as a corollary to that review, a review of the benefits paid by private health insurers for prostheses listed on the Prostheses List.

The AMA also remains concerned with the gap in Indigenous health outcomes, and the impact that a series of Budget cuts have had on areas of health most relevant to Indigenous communities.

Elsewhere in this edition of *Australian Medicine* is a report on the recent forum convened by the AMA on the heath of asylum seekers in detention, particularly children.

The forum was well attended by doctors, nurses, and other health care workers, with speakers highlighting the health issues faced by detainees. The forum endorsed the call by the AMA for four outcomes, including independent oversight of the health of asylum seekers in detention.

A small number of members have queried the AMA's involvement in the debate about asylum seeker health. There is clear Federal Council policy that backs the AMA speaking on the issue – not on the question of Australia's border protection laws, but on the more focused issue of health care.

The AMA's National Conference is coming up at the end of May, with early registration now available via the Federal AMA website – www.ama.com.au.

One of the key events is a debate about assisted dying, and this presents an opportunity to explore the views of AMA members. The debate forms part of the regular five-year review of current AMA policy. The session will be facilitated by Tony Jones of Q&A fame.

Nominations have been called for several awards which are given as part of National Conference. These include the AMA Woman in Medicine Award and the AMA Excellence in Healthcare Award, as well as several more specific public health awards. I encourage you to consider nominating suitable candidates for these prestigious awards.

The sick will pay heavy price for Govt cuts

Patients are likely to face blow outs in emergency care and elective surgery waiting times from next year, and may even miss out on care altogether, unless the Federal Government acts immediately to unwind massive Commonwealth public hospital spending cuts.

AMA analysis shows a huge 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.

AMA President Professor Owler said the states and territories were facing an "economic disaster" unless the Federal Government urgently restored its funding, and warned patients would be forced to wait longer for vital health care and may, in some cases, miss out altogether.

"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," Professor Owler said. "Doctors will always do the best they can by their patients, but these cuts mean the system as a whole simply won't be able to meet the demand."

His warnings came 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, which is projected to reach $57 billion by the middle of next decade.

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.

The Prime Minister has reportedly already offered New South Wales Premier Mike Baird an emergency $7 billion cash injection to tide the State's public hospital and education systems through till after the election, which could come as early as July or as late as November, and other premiers are now lining up to demand similar assistance.

Professor Owler said such handouts would help relieve pressure on hard-pressed public hospitals in the short-term, but if a financial crisis for the nation's public hospitals was to be averted there needed to be an overhaul of Commonwealth-State arrangements 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.

There is mounting evidence that the performance of hospitals is already being hurt by a squeeze on their finances, even before massive cuts detailed in the controversial 2014-15 Budget come into effect.

The human cost

The AMA's annual *Public Hospital Report Card*, released earlier this year, showed that hospital performance is already beginning to suffer as the flow of Commonwealth funds slows.

In emergency departments, the proportion of urgent Category 3 patients seen within the clinically recommended 30 minutes fell back to 68 per cent in 2014-15 – a two percentage point decline from the previous year, ending four years of unbroken improvement.

Meanwhile, improvements in elective surgery waiting times have stalled – the median delay in 2014-15 was 35 days, six days longer than a decade earlier.

Professor Owler said there was a real human cost to be paid for such a deterioration in performance.

"For a patient requiring urgent attention for abdominal pain, this could mean they are seen one to two hours after they present to the ED," he said. "Their symptoms could be consistent with indigestion, or could be a perforated bowel. The quicker a doctor can see them and make a diagnosis, then the quicker they can receive relief from their pain, and their condition can be prevented from deteriorating, potentially to a very serious situation."

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.

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.

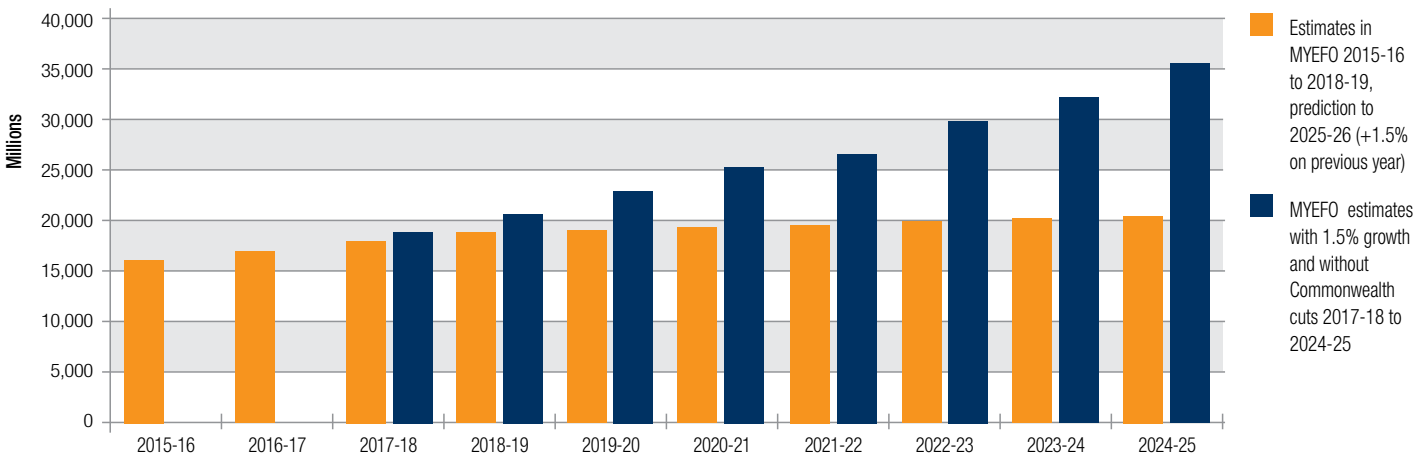
Any short-term deal offered by Mr Turnbull would only "kick the can down the road", he told ABC radio.

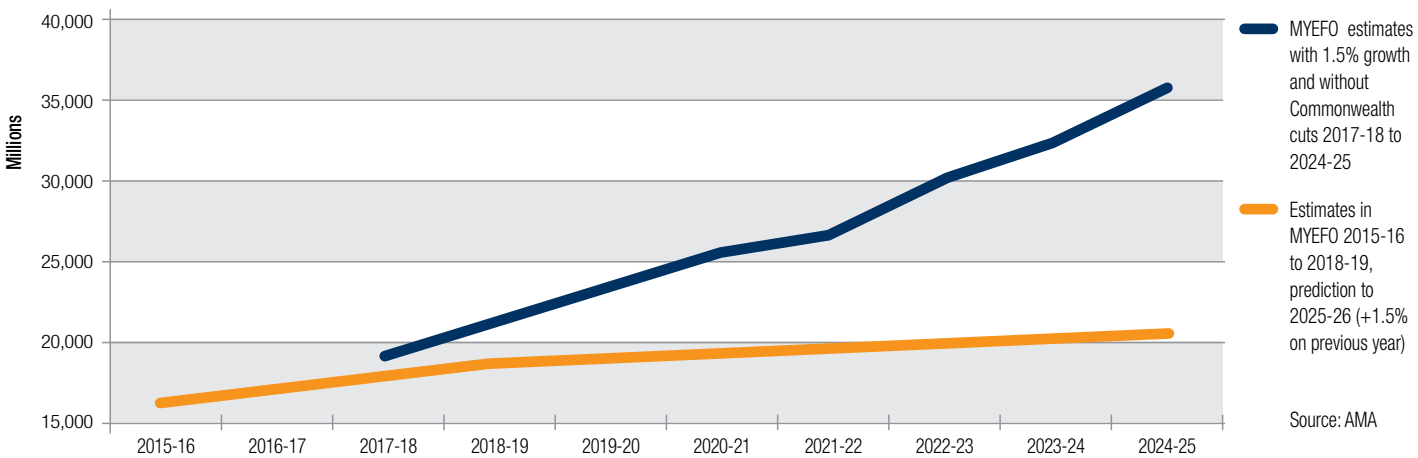
But he indicated the states were likely to accept any injection of funds offered.

"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

Asylum seekers are 'people like us': Owler

The AMA has ramped up the pressure on the major political parties over the health care of asylum seekers, calling for the immediate release of all children being held in immigration detention and moratorium on their deportation to Nauru and Manus Island.

As doctors and nurses at Brisbane's Lady Cilento Children's Hospital scored a major victory, forcing Immigration Minister Peter Dutton to temporarily relent on plans to send a one-year-old child being treated at the hospital back to Nauru, AMA President Professor Brian Owler told a forum in Sydney on asylum seeker health that the medical profession needed to take a stand on the treatment of those being held in detention, particularly children.

"There are times, in any nation, where the medical profession must act in the interests not only of our patients as individuals, or for patients in a health system, but it must act in the national interest," told the forum, organised by the AMA and attended by around 350 doctors. "I believe that is the case when it comes to the issue of children in detention and Australia's provision of health care to asylum seekers."

Professor Owler said organisations including the Human Rights Commission had documented evidence of the great physical, mental and emotional harm detention caused to children, and it was clear those being held in detention centres – particularly offshore – were being denied access to Australian-standard health care, with sometimes fatal results.

"The fact of the matter is that the prolonged detention of children is a state-sanctioned form of child abuse, and we call for it to stop," he said, a point reinforced by other speakers at the forum, including leading child health experts Consultant Paediatrician Professor Elizabeth Elliott; Clinical Professor, Paediatrics and Child Health, Professor David Isaacs; and Paediatric Nurse Alanna Maycock.

There are currently 67 children being held on Nauru and a further 80, including 37 babies, are slated to be sent there following a High Court ruling backing the legality of the Government's offshore detention regime.

Professor Owler said this was inexplicable, particularly given the admission by former and current Ministers that detaining children for prolonged periods did nothing to deter people smuggling.

He praised the actions of the doctors, nurses and administrators at Lady Cilento Children's Hospital in refusing to discharge baby Asha while the threat of being immediately deported to Nauru hung over her, and welcomed Mr Dutton's decision to allow her to be released into community care.

"We unequivocally support the doctors and nurses working in Lady Cilento. It is an absolute ethical obligation, not to mention moral obligation, of those doctors and nurses, to not release baby Asha into a situation where they believe there's likely to be harm," the AMA President said.

AMA President Professor Brian Owler calls for children out of detention

The Minister's backdown has been hailed as a victory by refugee advocates but, asked if the case could represent a turning point in Government policy, Professor Owler was more cautious.

"I hope so, but I fear not," he said, though he added there was hope that public opinion was beginning to change on the issue.

Asylum seeker policy is highly politically charged, and both the major parties are currently in lock-step on the issue.

Politicians used language to dehumanise refugees and deliberately confused their plight with issues of security and terrorism in the public mind, Professor Owler said.

He said bipartisan political support had fostered a high degree of secrecy around the operation of detention centres and had enabled the passage of draconian laws threatening imprisonment for any who speak out about conditions in them.

Professor Owler said it was "absolutely wrong" that bureaucrats rather than doctors had the ultimate say over the care of asylum seekers.

"It is imperative that medical practitioners working with asylum seekers and refugees put their patients' health needs first. And to do this, we must have professional autonomy and clinical independence without undue outside pressure," Professor Owler.

The AMA has called for the establishment of an independent statutory body of clinical experts to investigate and report on the health and welfare of asylum seekers.

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

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.

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.

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.

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

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."

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 Professer 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.

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.

"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".

Hepatitis C cure could come at a cost

... from p15

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

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

ADRIAN ROLLINS

AMA in action

AMA leaders have been in the thick of national debates on key issues including hospital funding, asylum seeker health, private health insurance, climate change and Indigenous health in the past fortnight.

The AMA drew national attention when it held a forum on asylum seeker and refugee health in Sydney attended by than 350 doctors and other health workers. AMA President Professor Brian Owler told the forum that it was unacceptable that children be held in detention, and called for an independent statutory body of medical experts be created to investigate and report on the health care of asylum seekers. The forum also heard from leading child health experts including Consultant Paediatrician Professor Elizabeth Elliott; Clinical Professor, Paediatrics and Child Health, Professor David Isaacs; and Paediatric Nurse Alanna Maycock.

Before attending the forum, Professor Owler made a three-day visit to remote Aboriginal communities in the Northern Territory to discuss health issues and see first-hand the progress being made and the work that remained to be done.

Early this month, the AMA President met with leading State politicians including South Australian Premier Jay Weatherill and Western Australian Shadow Health Minister Roger Cook to discuss the looming hospital funding crisis. Meanwhile, AMA Vice President Dr Stephen Parnis addressed the potentially deadly effects of climate change at a conference on the consequences of extreme heat.

ADRIAN ROLLINS

Deep concern: part of the crowd attending the AMA Forum on Asylum Seeker Health in Sydney last month

AMA President Professor Brian Owler tells media outside the Asylum Seeker Health Forum of the need to immediately get children out of detention

AMA Vice President Dr Stephen Parnis with (L to R) Dr Elizabeth Hanna, Professor Fiona Stanley and Professor Lesley Hughes at the Extreme Heat and Health Summit

AMA President Professor Brian Owler meets one of the friendly locals at Ampilatwatja in the Northern Territory

AMA President Professor Brian Owler and Federal Labor MP Warren Snowden with locals in the Kintore community, Northern Territory

AMA President Professor Brian Owler with (L to R) Western Australian Shadow Health Minister Roger Cook and AMA WA President Dr Michael Gannon

AMA President Professor Brian Owler at the AMA Forum on Asylum Seeker Health with (L to R) Clinical Professor, Paediatrics, David Isaacs, Consultant Paediatrician Professor Elizabeth Elliott and Paediatric Nurse Alanna Maycock

A sign of the times: prohibition sign outside a remote community in the Northern Territory

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.

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.

Health on the hill

POLITICAL NEWS FROM THE NATION'S CAPITAL

... from p23

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.

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

Compliance – not just an individual responsibility

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

Most GPs know that, under the *Health Insurance Act*, if they engage in inappropriate practice they will be held to account by a Professional Services Review Committee comprised of their peers.

> "What seems to be less understood is that it is also an offence under the Act if a person or officer of a body corporate knowingly, recklessly or negligently causes or permits a practitioner employed by them to engage in such conduct"

What seems to be less understood is that it is also an offence under the Act if a person or officer of a body corporate knowingly, recklessly or negligently causes or permits a practitioner employed by them to engage in such conduct.

Now that the responsibility for compliance policy has shifted from the Department of Human Services (DHS) to the Department of Health (DoH), it can be expected we will see an increased focus on the forces within a practice that encourage or silently condone inappropriate practice. While it has previously been difficult to assess this, the DoH is moving to make greater use of data analytics and behavioural economics to identify potential problems.

In utilising these tools, the DoH hopes that it will be able enhance the Department's understanding of how policy impacts compliance, and better identify clusters of divergent billing behaviour. This will also inform compliance feedback, as well as the Department's education resources and activities.

This shift in focus has in part come about following the findings of the Large Practices Project. This project was undertaken in recognition of the changing nature of general practice, with the increasing shift from small owner-operated medical practices to large corporate medical practices.

The Large Practices Project found that practice managers and staff have more responsibility for billing than expected. Most GPs learn about billing Medicare on the job or via word of mouth, and practice or business protocols affect the accuracy of Medicare billing. It was found that the culture of the practice, rather than its size, can have a significant influence on claiming behaviour.

These findings have reinforced the need for accessible education materials, and for targeted feedback on billing practices. Feedback has to be specific and directly relevant if it is to be valued and truly informative.

Medicare compliance and appropriate billing is not only an issue for each of us individually, but also as a profession. It goes to our professionalism as GPs and, when inappropriate billing practices are allowed to flourish, a knee jerk policy response is often the result, with MBS rules invariably tightened to reduce the risk of inappropriate use of MBS items. The recent restriction on claiming an item 23 with 721 is a case in point.

Thanks to AMA advocacy, practitioners who are unsure about what a MBS items covers or can be claimed for have available at their fingertips an enquiries email and a number of educational resources. Using the medicare.prov@humanservices.gov.au email for a MBS interpretation or claiming question ensures you receive the answer in writing, which is handy should a compliance issue on that matter arise. Various education resources are also available at https://www.humanservices.gov.au/health-professionals/subjects/education-services-health-professionals.

The AMA will continue to work with the DoH and the DHS to ensure compliance activities focus on supporting GPs and offering meaningful feedback and effective education.

We all know that GPs are very busy, and try to work within the system as they understand it. Punitive approaches don't work, and compliance breaches are often simply the result of overly complex rules that are difficult to interpret or not reflective of modern clinical practice.

Rural health: the continuing challenge

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

Rural health is frequently inferior to city health. This old generalisation covers much contradictory detail, and exceptions abound: according to the Australian Institute of Health and Welfare, the life expectancy of non-Indigenous women in 2002-04 was much the same – 84 – whether they lived in big cities or very remote areas. For men, the difference is a matter of six months or so. And it is not a rigid generalisation: increasingly sophisticated broadband-enabled communications and ever-more efficient transport have reduced the gap between city and country.

Nevertheless, the numbers and the facts suggest that the accumulation of wealth, talent and many other features of contemporary city life confer a small advantage in life expectancy and wellbeing on city-dwellers. This disparity challenges those who hold the value that one of our social duties is to ensure, as far as possible, equality of opportunity to health and health care to all Australians. What should we do?

Two pathways to action present themselves for our consideration.

The first, and the one most easily grasped by the medical profession, concerns access to medical care in the rural setting. Massive technologically-based services can only be provided in large cities, and lesser technology-dependent services need at least strong regional bases.

We are getting better at finding ways to make these technologies available in relation to services such as radiotherapy, relieving the pressure on country women to favour radical breast surgery because they cannot afford the time and separation for chemo and radiotherapy.

But as we concentrate on providing rapid care for people with acute coronary syndrome and stroke (an increasing possibility in cities), the challenge of providing similar care in remote parts of the country may be beyond us at present.

The attitude of some to this problem – that those who live in remote parts of the country do so entirely by choice – is similar to saying that drowning people should be left, as they chose to swim or go boating.

But with telehealth, and many large city medical services increasingly interested in providing networked services to places that lack them, the problem is being partially addressed.

The search for equality of access may well require affirmative funding, and this has been recognised to some extent in fee structures and remuneration.

Equality does not mean paying the same for the care of people in different places: we need to accept that services provided beyond cities will cost more, and ensure that we finance them accordingly.

There are also concerns, raised most recently by Max Kamien, Emeritus Professor of General Practice at the University of Western Australia in *Medical Observer*, that the relaxation of hiring rules in many rural areas will "open the floodgates" to corporate practices.

While on the surface of it, a boost to the number of doctors working in rural areas would be welcome, this is not the case if they are being employed on short-term contracts to simply churn through large numbers of patients, and leave more challenging and time-consuming cases to existing practices. The focus needs to be on quality of care, not just quantity.

The extent to which the learned colleges have recognised the need for greater action on behalf of their rural members has been variable.

A framework for rural health developed by representatives of all Australian states, territories and the Commonwealth in 2011, recognised the need to be sensitive to the special needs of older people, babies and children, Aboriginal and Torres Strait Islander people, people with chronic disease, refugees and people from culturally and linguistically diverse backgrounds.

The second approach to rural health disparities takes us well beyond the surgery.

Even with networked services, e-health, and affirmative funding, we are faced with residual differences in health status that are attributable to the social and economic context of rural and remote life.

Medicine cannot, for example, diminish the vast distances many country people have to drive, every kilometre increasing their risk of a serious accident. At best, it can be sensitive to distance when arranging care of patients with continuing problems.

Medicine cannot do much to promote high-quality educational opportunity, although the development of regional universities and technical education capacity has been impressive in the past three decades.

Rising rural champion

BY DR DAVID RIVETT, CHAIR, AMA RURAL MEDICAL COMMITTEE

Congratulations to Fiona Nash, sworn champion of rural health, on her ascension to the deputy leadership of the National Party and inner cabinet.

In addition to Rural Health, she now is also Minister for both Regional Development and Regional Communications. Quite a workload. Along with trying to rein in some of Barnaby's enthusiasm, she now has an enormous responsibility.

As I write, the media ownership rules look like being radically changed and, with rural Australia keen to retain some local news media reflecting country town issues, she has a lot of barrows to push and policies to settle.

Changes to the granting of District of Workforce Shortage status announced by the Minister in February are indeed welcome, and will make it easier for small towns to both attract and retain GPs, be they international medical graduates or bonded scholars. This, along with the announcement of additional funding to train doctors in the bush, are good first steps in finding a solution to the rural medical workforce shortage.

The Rural Classification Technical Working Group met in Canberra on 25 February 25. Overall feedback was positive regarding the roll-out of the Modified Monash classification system for the General Practice Rural Incentives Program (GPRIP). However, all GP groups cautioned against extending it more widely to cover 10-year moratorium payback destinations and incentives under the Practice Incentives Program, in place of existing classifications of rurality.

On being questioned about the total spend on GPRIPs – given that Cairns, Townsville, Darwin, Hobart and other cities no longer qualify for the incentive -the Department advised it was too early to have an answer, a reply that surprised me, as I would expect them to know such a costing very well, long before the change was made.

Similarly, when asked what outcomes were being measured to assess the workforce impact of the GPRIP changes, the reply was it was too early. Without answers to these questions, one cannot say Modified Monash is the best thing since sliced bread.

The Department did advise that a review of outcomes would occur in 2018. I hope my successor as Council of Rural Doctors Chair will ensure such measurements are made public at that time.

The first GPRIP payments under Modified Monash will be made in July or August this year.

Surprisingly, there were only a handful of appeals against the Modified Monash changes, and these were dealt with seriously and meticulously.

The First Assistant Secretary of the Department's Health Workforce Division, David Hallinan, and Lisa La Rance of the Rural Access Branch, were both present and showed an enthusiasm to address rural workforce issues and to consult widely.

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Rural clinical schools have done a remarkable job in acquainting future medical practitioners and other health professionals with the challenges and opportunities of rural practice, and the long-term effects of this intervention will be seen in the next 20 years.

Medicine, though, has no influence over agricultural and extractive industry policies, all of which have great significance for employment and economic sustainability in rural communities.

These environmental factors – the social determinants of health – set the health agenda.

Some fall within the sphere of influence of public health, but many are well beyond even its wide reach.

Their importance was reviewed in a paper by Jane Dixon, from the ANU, and Nicky Welch, from Waikato University, in *The Australian Journal of Rural Health* in 2000. 'What is it about rural places or the rural experience that contributes to different health outcomes?' they ask.

The broad-spectrum advocacy of the Rural Doctors Association of Australia and the Rural Health Alliance contribute to the wider political and policy agenda that may help us to answer this question and to make serious progress.

It is vital for medicine to respond to the needs of rural communities as they are, not as they might be in a reimagined ideal world.

My sense is that we are making steady progress. The indicators that we have favour an optimistic view.

Patients pay for hobbled hospitals

BY AMA PRESIDENT PROFESSOR BRIAN OWLER

Since the Commonwealth's unilateral changes to public hospital funding announced in the 2014-15 Budget, the AMA has highlighted the impact of dramatically reduced funding on an already underperforming public hospital system.

In May 2014, the Australian Government walked away from the National health Reform Agreement, abandoning its promise to make public hospital funding sustainable and contribute an equal share towards growth in public hospital costs.

From July 2017, the Commonwealth will instead limit its contribution to public hospital costs based on a formula of the Consumer Price Index (CPI) and population growth only. This represents the lowest Commonwealth contribution to public hospital funding since the Second World War.

According to Treasury, the indexation change will reduce Commonwealth funding to the states and territories by $57 billion between 2017-18 to 2024-25.

The CPI measures changes in prices faced by households only, and is not an appropriate measure of increases in hospital costs. Increasing funding on the basis of population growth does not address cost increases associated with changing demographics, or the costs of new health technologies.

The Finance and Economics Committee resolved last year that the Commonwealth's contribution to public hospital funding must be sufficient to address real increases in actual costs of the goods and services used by hospitals, and provide for demographic change – not only for population growth, but also for changes associated with ageing and health needs.

The Government's ongoing justification for its extreme health savings measures, including cuts to public hospital funding, has been that Australia's health spending is unsustainable.

This is simply not substantiated by the evidence.

The Government's own figures show that health spending grew by 3.1 per cent in 2013-14. This is almost 2 percentage points lower than the average growth over the last decade (5 per cent). The previous year (2012-13) growth was even slower – just 1.1 per cent, which was the lowest annual increase since Government began reporting on health spending in the mid-1980s.

Clearly, total health spending is not out of control. The health sector is doing more than its share to ensure health expenditure is sustainable.

There have now been two years where growth in health expenditure has been well below the long-term average annual growth of 5 per cent over the last decade.

As part of this slowdown, growth in Commonwealth funding for public hospitals in 2013-14 was just 0.9 per cent, well below inflation and virtually stagnant. This is off the back of a 2.2 per cent reduction in Commonwealth funding of public hospitals in 2012-13.

This austerity has come at a cost, and has been reflected in the performance of our public hospitals. The AMA's *Public Hospital Report Card 2016* shows that, against key measures, the performance of our public hospitals is virtually stagnant or, in many cases, declining. This is the direct effect on patient care of reduced growth in hospital funding and capacity.

The most recent data shows waiting times are largely static, with only very minor improvement. Emergency Department (ED) waiting times have worsened. The percentage of ED patients treated in four hours has not changed, and is well below target. Elective surgery waiting times and treatment targets are largely unchanged. Bed number ratios have also deteriorated.

The Commonwealth's funding cuts are already having a real impact as a result of almost $2 billion being sliced from programs to reduce emergency department and elective surgery waiting times.

But the most acute impact will be felt from July next year, when the new funding arrangements take effect.

Without sufficient funding to increase capacity, public hospitals will never meet the performance targets set by governments, and patients will wait longer for treatment, putting lives at risk.

Despite these warnings, we have yet to see a solution to the serious and rapidly approaching crisis in public hospital funding.

This is a crisis that has been created by political and budgetary decisions. It is one that will require political leadership to resolve.

Getting to grips with the training experience

BY DR KATE KEARNEY, COUNCIL OF DOCTORS IN TRAINING

In 2015, the medical colleges produced a combined 2954 new fellows – that is virtually 3000 new consultants ready to practice across all specialties, on a yearly basis.

As a junior doctor at the other end of the pipeline, I hear consistent reports of how difficult it is to gain employment, and how I will need to complete years of further study in the form of a PhD and international fellowships to be able to be considered a highly employable candidate.

Is that a realistic assessment of the concept of "exit block", or are we seeing maldistribution in the workforce?

> "Rural and regional trainee networks address maldistribution by giving trainees exposure to working in regional areas and, secondly, increasing engagement by helping trainees to establish their lives and families in these areas"

We constantly hear about medical workforce shortages in rural and peripheral metropolitan areas, necessitating that about 25 per cent of newly graduated fellows are recruited from among overseas trained doctors.

The AMA advocates for rural and regional training networks as the major, evidence-based strategy to address this – the current Specialised Trainee Program resources 900 positions in regional areas a year, and is under review.

Rural and regional trainee networks address maldistribution by giving trainees exposure to working in regional areas and, secondly, increasing engagement by helping trainees to establish their lives and families in these areas.

Vocational medical training is a long and arduous process in all specialties, and the support networks that trainees establish in this time make a lasting impact. The AMA strongly supports the establishment of these networks to allow trainees to forge careers in these settings.

So, is vocational training meeting trainee and workforce needs? Where do these intersect, and how do we help trainees plan their careers and their lives to ensure fulfilling medical careers for doctors that meet the community needs and utilise the massive training investment by the community in creating new specialists? How do we keep trainees safe through an intense, stressful training process?

One of the tenants of reform has to be identifying where we are at presently.

In the United Kingdom, the National Trainee Survey (NTS) has been an important reform tool since its inception in 2006. The NTS has helped address patient safety concerns, improve training environments, strengthen performance management and, as a centralised tool, it has provided unbiased, anonymous feedback about what works and what undermines training.

The AMA has coordinated a specialist trainee survey as well as a GP registrar survey since 2010, both of which have identified a gradual improvement in training environments for those in vocational training programs.

This is a major undertaking, but a significant start towards the goal. Good quality data is sorely missed in this space.

A yearly national trainee survey would take an annual temperature check of where training is at for Australian junior doctors. It would capture anonymous information about how training sites are faring, how colleges treat their trainees, and could identify potentially deleterious situations before they escalate.

We undergo all number of formal registration processes annually, including renewing our general medical registration - this would be the perfect time to capture valuable data about where junior doctors are based, what are their training experiences like, where they intend to go and how these change over time.

Documenting this kind of longitudinal data would make an enormous contribution to providing the kind of reliable information that is needed for us to accurately describe our current workforce situation - and to model future patterns.

Australia's internship crisis: a national process

BY MATT LENNON, VICE PRESIDENT, AUSTRALIAN MEDICAL STUDENTS' ASSOCIATION

You're 23. You're in your final year of medical school and you're very worried. It's now December, and you're waiting to hear back on your very last chance to obtain an internship in Australia.

It's been a difficult six year slog that you moved countries to undertake; you're now $300,000 in debt and, if you don't obtain this internship, you will never graduate as a fully licenced doctor.

This, sadly, is the reality for many final year medical students around Australia. By the end of 2015, 40 students had contacted AMSA because they had not received an internship. It is the greatest weakness of the current system that we cannot know for sure what has happened to those students since then.

As it stands, there is no public data that tells us how many of them never found a last minute offer in Australia, or what the outcomes have been for those who missed out. This makes workforce planning for internships incredibly difficult. Worst of all, it makes it difficult for these young doctors to make a plan for their lives.

The issue stems from the radical increases in medical student numbers and medical school starting back in the late 1990s. Since 2005, the number of medical graduates around the country have doubled. Despite losing local graduates, Australia still imports more than 2000 overseas trained doctors annually – more than any other developed country – and many of these are only on temporary visas, brought in to plug gaps created by the poor planning decisions of the past. Retaining Australian-trained doctors who are graduating today will help to address the shortages of the future.

An imbalance between supply and demand has made it increasingly difficult for students to secure internships – and as a result, students may seek to maximise their chances by applying to a variety of agencies at great financial, logistical and emotional cost. In 2011, 41 per cent of applicants for 2012 internships applied to more than one jurisdiction.

Agencies are then hampered by applicants who have received multiple offers but may fail to reject unwanted offers in a timely manner, if at all. In 2011, there were twice as many applicants who accepted multiple internships than there were in 2010.

Because of this complexity, State health departments have to meet over several months to manually work out which graduates have one or more offers. This usually lasts from July to September, during which time the rounds of offers for internships are slowly going out. It is this period that is really crucial for medical students who are likely to miss out. They are making decisions around moving overseas and doing further study that will direct the rest of their working lives.

Establishing a National Internship Application Process would solve this. It would mean that, rather than taking several months, all internships in Australia would be sorted out in a single day, and a job that is best done by a computer would not consume hundreds of government staff hours.

The process would not mean that all states would have to align priority systems or methods of application. Rather, in its simplest form, it would be an alignment of the computer systems and portals used by each of the states to detect and prevent any double offers.

States and territories would be relieved of an unnecessary duplication of services, and it would be impossible for applicants to accept multiple places.

There would also be ancillary benefits: collation of internship data would be centralised and more readily accessible and, in light of national registration standards for medical practitioners, the Commonwealth may find benefit in being more closely involved in the internship allocation process.

Most important of all, streamlining the process, aligning dates and providing solid data on those that have missed out from day one would give governments time to ensure spots are created for the remainder.

For many this is a story about bureaucracy and numbers. But for medical students the internship is an indispensable part of our training without which we will never become doctors. For us it is a story about aspirations and a future.

An up-close view of Indigenous health – good and bad

BY **AMA PRESIDENT PROFESSOR BRIAN OWLER**

AMA President Professor Brian Owler meets with local staff at a remote community health service in the Northern Territory

No running water, overcrowded and non-functional houses, lack of affordable healthy food, no essential services and crippling rates of diabetes, kidney disease and communicable infections – these are just some of the issues that people living in remote Northern Territory communities such as Utopia, Ampilatwatja and Kintore endure every day. On a recent visit to these three communities, I gained a deeper understanding of local health issues and the challenges that doctors and nurses face in delivering health services in remote areas.

In meeting with local Aboriginal leaders and health and medical staff, I found that each community has their own unique challenges; but the overall messages that I heard were strikingly similar. Funding for local health services is inadequate, it is difficult to attract skilled health and medical professionals to work in remote areas, it is logistically challenging to provide health care in remote communities (particularly when patients need to be transported for specialist care), and the level of chronic diseases in these communities are alarming.

Take diabetes, for example. In Kintore, 130 of the community's approximately 450 residents have non-gestational diabetes – almost a third of its entire population - and in every three houses, one person is on dialysis due to the onset of kidney disease. What is even more concerning is the young age that Aboriginal people are being diagnosed with diabetes. In Utopia, a seven year-old girl was recently diagnosed with type 2 diabetes, and in Ampilatwatja, a 13 year-old girl was diagnosed with the same condition. Among the broader Australian population, or perhaps anywhere in the world, it is unheard of for child so young to be diagnosed with type 2 diabetes, yet it is clearly visible in remote Aboriginal communities.

The lack of water and affordable healthy food in remote communities is strongly linked to the epidemic levels of diabetes among Aboriginal people in these areas. Sugary drinks are more readily available than diet soft drinks, and in some communities they are more accessible than running water. It is unfathomable that in Australia, communities are going without water – a basic human right and a necessity for good health and wellbeing. This is an issue that demands immediate attention and action by all levels of government – without it, the health gap between Indigenous and non-Indigenous Australians will remain wide and intractable.

An up-close view of Indigenous health – good and bad

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Member for Lingiari Warren Snowden and Professor Owler with an Ampilatwatja Health Centre staff member

One important lesson that I did learn while visiting these communities is that it is not all doom and gloom when it comes to Indigenous health. Yes, Aboriginal people in remote areas face great adversity, but they are patient, resilient, strong-willed and are determined to take control of their own health – there are some real positives happening.

At the Purple House, an Aboriginal-controlled dialysis service based in Alice Springs, I was told an inspiring story of Aboriginal people taking action to generate funds for more dialysis sites. Kidney disease is rife across central Australia, with many Aboriginal people developing this condition as a result of poorly controlled diabetes.

The need for dialysis in remote Aboriginal communities is extremely high and for many, treatment means leaving family and country to be treated in Alice Springs. To allow people to be treated on country and near family, Aboriginal artists from across the western desert region grouped together and painted artworks that were auctioned to raise funds. The auction raised more than $1 million, and Purple House was able to expand their dialysis services. They now operate across nine remote communities in the Northern Territory and Western Australia. Purple House also provides a mobile dialysis service via their 'Purple Truck', which travels to remote Aboriginal communities.

It is very rare that good news stories such as this are widely publicised, which is disappointing. We need to shed more positive light on Indigenous health, and Indigenous affairs more broadly in Australia.

The POCHE Centre for Indigenous Health and Wellbeing in Alice Springs is also making a positive contribution to the health of Aboriginal people. At the POCHE Centre, I learnt about the research currently being undertaken by PhD candidate Maree Meredith, a young Aboriginal woman from Queensland. Her research project aims to determine the role that art centres play in contributing to positive health outcomes for Aboriginal people across the Anangu Pitjantjatjara Yankunytjatjara (APY) lands. To ensure that this research was in line with cultural protocols and to ensure that appropriate data was collected, Ms Meredith worked with Anangu people to design and deliver a survey in the local language.

For many years, anecdotal evidence has suggested art centres make a significant contribution towards health and wellbeing, but there has been no empirical data. This study aims to provide reliable evidence that art centres improve the health and wellbeing of Aboriginal people in remote communities. This is also a clear example of building the capacity of local Aboriginal people to participate in the local workforce.

Aboriginal people know what they want – they know the best way to improve their health and wellbeing, and this must be acknowledged and supported if we are to truly close the gap.

While in Kintore, I spoke with Aboriginal leaders who mentioned that the local people prefer a traditional social and emotional wellbeing framework to be implemented in their community, rather than a Western one.

The community developed a proposal for Government funding for this initiative, but unfortunately it was not accepted.

Connection to culture is important to the health and wellbeing of Indigenous people, and is known to produce positive health and life outcomes, such as reduced incarceration rates.

Aboriginal people needed to be provided with a reason to stay in the communities where they are connected to their land, culture and families. Recent comments made by certain members of Parliament about subsidising the 'lifestyle choices' of Aboriginal people in remote areas are extremely concerning.

Within each of these communities, I was disheartened to see a world-class health system fail the Aboriginal people in remote communities. But, I was truly impressed by the resilience and determination of the local Aboriginal people and the passion, commitment and dedication of doctors, nurses and other health staff who work tirelessly such challenging environments.

I am extremely grateful to Warren Snowden, Member for Lingiari, for making visits to these communities possible, and for accompanying me throughout the trip. I am hopeful that we will see further progress made in improving health and life outcomes for Indigenous people across Australia.

Review of the AMA's policy on assisted dying – an update

BY DR MICHAEL GANNON

I would like to take this opportunity to update members on the review of AMA policy on assisted dying (euthanasia and physician assisted suicide) and outline the next steps in the review process.

As highlighted previously, the AMA is conducting the review as part of our five- year policy review cycle, employing a variety of methods to consult with members during the process.

> "I want to take this opportunity to thank all of those who took the time and effort to provide us with a submission – many were incredibly detailed, and all were heartfelt; in particular, those members who described their own personal experience when facing terminal illness"

In November 2015, we provided AMA members with an opportunity to submit open-ended comments on the current AMA policy (the *Position Statement on the Role of the Medical Practitioner in End of Life Care 2007. Amended 2014*) through *Australian Medicine*.

We received more than 50 submissions from medical students and junior doctors, through to senior and retired doctors. Both female and male doctors were well represented, as well as a range of specialties.

Perhaps not surprisingly, the scope of opinions expressed in the submissions was diverse – ranging from those who strongly oppose, to those who strongly support, assisted dying. However, I never cease to be amazed by new intelligent insights into this complex and vexed issue.

I want to take this opportunity to thank all of those who took the time and effort to provide us with a submission – many were incredibly detailed, and all were heartfelt; in particular, those members who described their own personal experience when facing terminal illness.

The next step in the consultation process is to survey members' attitudes to assisted dying.

In the near future, we will send out a survey electronically to every AMA member asking a range of questions on assisted dying. Your views are important - I strongly encourage all members to fill out the survey, the results of which will be used to inform the review. If there are any members unable to receive an electronic copy of the survey, please contact the Ethics Section of the Federal AMA at ethics@ama.com.au or by phoning (02) 6270 5400.

In addition to the member survey, on 27 May I will be chairing a Q&A session on assisted dying at the 2016 AMA National Conference in Canberra.

The session will be moderated by Tony Jones, known to most of you as the host of ABC TV's Q&A program. There will be a panel of between four and six medical practitioners, equally representing those known to oppose or support assisted dying.

Our aim is to provide doctors, in particular AMA members, with the opportunity to have an intra-professional discussion on assisted dying as it relates directly to the medical profession.

While anyone can attend and observe the session, audience questions will be limited to medical practitioners. Please refer to the AMA's website for information regarding conference registration and session updates at https://ama.com.au/nationalconference.

Following this, we will update members on the survey results and National Conference deliberations as well as the next steps in the review process.

If you have any questions in relation to the review, please send them to ethics@ama.com.au.

Mazda MX-5 - too much fun?

BY DR CLIVE FRASER

As a Baby Boomer, I've become accustomed to having to work hard for all of the pleasures in life, unlike those Gen XYZs, who expect the world to land at their feet.

But, there are some pleasures that I think I'll never have.

For starters there's a Mazda MX-5.

When it was first released in 1989, I'd just completed my specialty training.

But with a big mortgage there was no way that I could see myself splurging on a toy like the MX-5, with its sexy pop-up headlights.

When the second generation model was released in 1998, I still couldn't see any practicality in a car that only had two seats.

Sure, I could pick up my children from school one at a time, but parental responsibility weighed heavily at that point in my life.

The MX-5 now came with a rear window made of glass, and the head-lights weren't concealed any more.

The third generation MX-5 arrived in 2005 with a bigger two litre engine - at exactly the same time as mountains of homework and sky-rocketing school fees.

Fast forward to 2015, to an empty nest, a smaller mortgage, everyone's education completed and the fourth generation Mazda MX-5.

With stunning styling, it was certainly looking like an attractive proposition.

But having mastered the art of delaying gratification, will I say no once more?

The current MX-5 has certainly impressed the motoring elite, having scored the 2016 Wheels Car Of The Year award, along with two previous COTY awards in 1989 and 2005.

What did they like so much about the new model?

For starters it's much, much less expensive, with an entry-level 1.5 litre manual starting at $31,990 plus on-road costs.

It had to be cheaper than the old model to stand a chance against the Toyota 86, which is hugely popular in this demographic.

The sharper pricing is scaled back even further by offering a 1.5 litre variant motor, which is livelier and revs better than the two litre.

Buyers save $2500 with the smaller motor, but no one is short-changed.

The new MX-5 is also lower, wider, lighter, faster and more economical than the out-going model.

An MX-5 cabin is an intimate, and some might say claustrophobic, space.

In an effort to save weight, it is more about leaving things out than packing them in.

This time around there's no cigarette lighter, just a USB socket. And the glove box has disappeared completely from the cabin.

There But back at the dealership I spotted a Mazda 6 which somehow still better suited my style.

Is a Mazda MX-5 for me?

Maybe one day.

Safe motoring,

Doctor Clive Fraser

doctorclivefraser@hotmail.com

MX-5	2015 NC	2016 ND	2016 ND
Engine	2.0 litre	1.5 litre	2.0 litre
Power	118kW @ 7000rpm	96kW @ 7000rpm	118kW @ 6000rpm
Torque	188Nm @ 5000rpm	150Nm @ 4800rpm	200Nm @ 4600rpm
Transmission	6 speed manual	6 speed manual	6 speed manual
Kerb Weight	1167	1009	1033
Power to Weight Ratio	104.4	97.5	117.4
Price + ORC	$48,380	$31,990	$34,490

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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.

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