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Heart attack

AMA's national plan to eradicate killer heart disease, p6

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Cover pic: AMA President Dr Michael Gannon (R) with NACCHO Chair Matthew Cooke and Labor member Lingiari, Warren Snowden at the launch of the 2016 *AMA Report Card on Indigenous Health* in Darwin on 25 November

Eradicating RHD – an achievable health goal

BY **AMA PRESIDENT DR MICHAEL GANNON**

I had the honour this month to launch the AMA's latest Indigenous Health Report Card at a special event in Darwin.

The Report Card sets out a practical plan – with an achievable and affordable target date – to eradicate Rheumatic Heart Disease (RHD) from Aboriginal and Torres Strait Islander communities.

This Report Card and this launch event were special for a number of reasons.

First, we have identified a major health problem that can be dealt with in a finite timeframe.

Second, many of the people who can make this happen – eradicate RHD forever – were present at the launch of the Report Card. We had clinicians, health workers, politicians, advocates, researchers and people with a lifelong passion to make genuine improvements in Indigenous health.

Third, we know that meeting this target – making this plan come to fruition by 2031 – is completely achievable.

We just need to bottle the mood of the room in Darwin and add some serious political commitment from territory, state and Commonwealth governments to make it happen.

The AMA will push this plan every year until the target is met, just as we have raised the profile of Indigenous health needs for decades.

We have been producing annual Report Cards on Indigenous Health since 2002.

We do this to increase awareness of the health inequalities between Indigenous and non-Indigenous Australians.

And we do this to show how governments have responded – or should respond – to these problems.

Unfortunately, successive governments have failed to deliver on all their promises to address major health issues for Aboriginal and Torres Strait Islander people.

I have to say that there has not been a lack of passion or commitment to get things done over the years.

But there has been either a lack of continuity, or insufficient funding, or a lack of cooperation and coordination to achieve lasting improvements.

As a result, Aboriginal and Torres Strait Islander people continue to have some of the worst health outcomes in Australia, and die much younger than their non-Indigenous peers.

That is why this year we put the focus on RHD. It is a discrete pathology with a finite solution deliverable in a finite timeframe.

It must be eradicated. It is long overdue.

RHD is an entirely preventable and debilitating form of valvular heart disease.

It is emblematic of the life expectancy gap between Indigenous and non-Indigenous people. It is a signature case of a social determinant of ill health.

The rates of RHD among Indigenous Australians are among the highest in the world.

From 2010 to 2013, over 700 new or recurrent cases of RHD were reported in Australia, with 94 per cent of these cases being among Indigenous people. Remember, only 3 per cent of our population is Aboriginal or Torres Strait Islander.

Disturbingly, more than half of these cases were among children aged 5 to 14 years.

The fact that RHD still occurs in Australia today is a national shame. It is a disease of poverty. It should not be occurring here in Australia – one of the world's richest nations.

Indigenous people are 20 times more likely to die from RHD than non-Indigenous people. In the Northern Territory, this rate rises to 55 times higher.

These high rates speak volumes about the fundamental underlying causes of the disease, particularly in remote areas.

We are talking about poverty, poor quality and overcrowded housing, lack of education, and inadequate primary health care.

The Closing the Gap measures are an important step forward in some ways in housing, education, and health funding.

But it is still not enough to stop the disease in its tracks, which is what we must do.

The number of potential cases is relatively small. The at-risk population represents only around one three hundredth of one per cent of the entire Australian population.

The task is achievable.

Everybody who was in the room in Darwin for the launch knows that it can be done, and will do all in their power to see that it will be done.

The AMA will now turn its attention to other targeted measures to improve the health of Indigenous Australians.

Our Report Cards are a catalyst for action, and a vital part of the core business of the AMA.

Australians deserve to die in dignity

BY AMA VICE PRESIDENT DR TONY BARTONE

Last month the AMA launched its Position Statement on *Euthanasia and Physician Assisted Suicide 2016.*

Central to the statement is the call for more investment and resources in improved end of life care, accompanied by a comprehensive education and information campaign to raise community awareness of the care, compassion, medical and nursing assistance, and expertise that is available to assist patients in the final stages of their lives.

> "What is extremely disappointing is that we know 68 per cent of Australians want to die in their own home, however, only 22 per cent who receive specialist palliative care do so ..."

What is extremely disappointing is that we know 68 per cent of Australians want to die in their own home, however, only 22 per cent who receive specialist palliative care do so, with the majority (70 per cent) dying in hospital. Patients, where possible, should be able to die in the environment of their choice.

Most Australians (82 per cent) think it is important to talk to their family about how they want to be cared for, but only 28 per cent have. Formally documenting this choice as part of an advanced care directive (ACD) is not only crucial, but needs to be formally encouraged and acknowledged by all sections of government. It needs to be resourced appropriately, including the significant component of time required to appropriately assist patients to formulate an ACD.

Despite the proven benefits of the advance care planning process, there remains low awareness and implementation rates for ACDs, as the Inquiry into End of Life Choices, Victoria established (including 'varying' awareness of advance care planning from participants in the various 'Dying to talk' seminars).

What is even more troubling is the multiple and varying rules applied by jurisdictions in regards to ACD. These differences across the country undermine the confidence that a practitioner can have when carrying out an ACD, and they also create confusion among patients and their carers. ACDs are used less than other end of life planning methods, such as wills.

The lack of equitable access to palliative care is a big concern. The truth is that access to, and quality of, palliative care services ranges considerably. Palliative care needs to be respectful of a person's values and beliefs, and this is undermined by equity imbalance.

Demand is rapidly growing, and it is clear that services are overburdened and need government investment and further funding. There is concern that we will not have the appropriate number of trained specialist palliative care physicians to meet demand. (In 2014, specialist palliative medicine physicians made up just 0.7 per cent of employed medical specialists in Australia. Australia-wide, there were 0.8 FTE specialist palliative medicine physicians for every 100,000 people. This varies across states, with 85 per cent working in major cities.) The combination of expanding need and a lack of trained professionals will only further exacerbate the current inequities in the system.

Our community needs to be educated about the reality of death and dying. Similarly, health care professionals need to be upskilled and supported to provide quality palliative care. There should be training in palliative care and grief and bereavement counselling available. (In 2014, only 71 medical practitioners – of the 192 working in Australia – undertook the Advanced Training in Palliative Medicine program, and 28 completed a Clinical Diploma in Palliative Medicine.)

We all realise that palliative care is not just care provided in the final stages of life. Appropriate funding and resourcing is essential if we are to ensure that we continue to provide all patients with autonomy, dignity and respect in the final chapter of their lives. Patients deserve options and a quality of life that respects their wishes, spiritual and cultural beliefs.

Surely all Australians deserve this right.

AMA acts to promote diversity and inclusion

BY AMA SECRETARY GENERAL ANNE TRIMMER

> "Since the change in governance structure of the AMA in 2014, Federal Council has been freed up to concentrate on more substantial policy matters, with dedicated policy debates at each meeting"

The 2016 Parliamentary sitting period has come to an end after an unusual year in politics in Australia, and globally. Unpredictable outcomes in elections might be the new normal for Western democracies.

On the domestic front, the AMA Federal Council finished the year with its final meeting in November covering a very broad agenda. Since the change in governance structure of the AMA in 2014, Federal Council has been freed up to concentrate on more substantial policy matters, with dedicated policy debates at each meeting.

The meeting in November finalised the revision of the AMA position statement on euthanasia and assisted dying, maintaining its position that medical practitioners should not be involved in interventions that have as their primary intention the ending of a person's life.

This followed a year-long process of consultation with members and State AMAs. The AMA recognises that the issue is one that has significant public interest and acknowledges that if parliaments take the lead on change to the current laws then doctors must be part of developing relevant legislation, protocols and guidelines to protect vulnerable groups, patients and doctors who do not wish to participate.

Federal Council agreed to the establishment of a committee on equity, inclusion and diversity, to report to Federal Council on steps taken to develop programs that promote the engagement of women doctors in leadership positions within the AMA, and development of principles to guide appointment to leadership positions.

Women occupy 30 per cent of the positions on Federal Council, however the level of representation varies on AMA councils and committees. Federal Council reviewed the work undertaken by the British Medical Association over more than a decade in actively promoting equality of representation on committees.

Federal Council considered the AMA's response to the interim report of the Expert Advisory Group to the Medical Board of Australia on an appropriate approach to revalidation in Australia. Federal Council established a working group to review existing AMA policy on same sex marriage.

The Council reached consensus on the AMA's approach to the issue of rents paid for collection centres located within medical practices, acknowledging the impact of the ongoing freeze of Medicare rebates on both pathology and general practice.

As 2016 comes to a close I would like to acknowledge the outstanding contributions made during the year by members of Federal Council, the Board and their respective chairs (Dr Bev Rowbotham, and Dr Liz Feeney (to May) and Dr Iain Dunlop (since May)), and the many committees, councils and working groups that feed into the AMA's advocacy. I also acknowledge the significant contribution of the talented and hardworking AMA secretariat for the high quality of its work and commitment to AMA members.

Best wishes for a restful and peaceful holiday period spent with family and friends, and for a successful 2017.

AMA sets out plan to eradicate a killer

The AMA has set out a plan for the eradication of a killer disease blighting Indigenous communities that is causing teenagers to have strokes and forcing young children to undergo open heart surgery.

Focussing attention on the damage and distress being caused by rheumatic heart disease (RHD), the peak medical group has urged all governments to sign up to a goal of preventing all new infections in Indigenous Australia by 2031.

> "RHD is a disease of poverty, and it is preventable, yet Australia has one of the highest rates of RHD in the world" - *Dr Gannon*

Nearly 6000 Australians, almost all of them Indigenous, were living with RHD or its precursor, acute rheumatic fever (ARF), last year, and the infection kills Indigenous people at 20 times the rate of other Australians – and up to 55 times in the Northern Territory.

AMA President Dr Michael Gannon said RHD was a "disease of poverty", and it was shocking that it was killing and harming so many people in one of the wealthiest countries in the world.

"RHD is a disease of poverty, and it is preventable," Dr Gannon said. "Yet…Australia has one of the highest rates of RHD in the world."

He said the fact that it was almost exclusively localised to Indigenous communities "speak[s] volumes about the fundamental underlying causes of RHD, particularly in remote areas – poverty, housing, education and inadequate primary health care".

"The lack of action is…symptomatic of a national failure. RHD must be eradicated – it must no longer occur in Australia."

The disease begins with infection by Group A Streptococcal (Strep A) bacteria, which is often associated with overcrowded and unhygienic housing, and can show up with seemingly innocuous symptoms such as a sore throat or impetigo.

As the immune system responds to the Strep A infection, people develop acute rheumatic fever, which can result in damage to the valves of the heart – RHD. This is particularly the case where there are multiple episodes of ARF.

Those with RHD or at risk of ARF can be treated with penicillin tablets or regular injections of Benzathine Penicillin G (BPG), though the regime is onerous. Patients require 13 BPG shots a year, usually for a decade or until the age of 21 or, in the most severe cases of RHD, until 40 or older.

Those with the disease can suffer strokes, and often have open heart surgery multiple times to repair and replace damaged heart valves.

The AMA said ensuring adherence to such treatment was difficult, particularly in the remote areas where many cases occurred. A study in the Northern Territory found that less than half of patients enrolled in a control program in 2013 received their required doses.

While urging action to improve the management of RHD, the AMA's 2016 *Report Card on Indigenous Health* has put the focus on prevention.

"RHD is an entirely preventable public health problem. [It] is not an intractable issue," the Report Card said. "Its devastating impact can be halted within existing medical knowledge."

It has recommended that governments commit to preventing any new cases of RHD by 2031, including the goal that by 2025 no child will die of ARF or its complications.

The AMA said achieving such a target would make an "important and necessary" contribution to close the gap in life expectancy gap between Indigenous Australians and the rest of the community.

Three activities were critical: preventing Strep A infection, detecting and treating such infections early, and using BPG shots to prevent re-infection.

The country was at a "unique juncture" to deliver on such a commitment, the medical organisation said, not least because the NHMRC-funded End Rheumatic Heart Disease Centre of Research Excellence was due in 2020 to deliver a report which would form the basis of a comprehensive strategy to end RHD as a public health problem.

But it has already identified some key steps, most importantly improvements in Indigenous living conditions.

"The Strep A bacterium thrives and spreads in overcrowded conditions," the AMA said. "Conversely, dramatic falls in the rates of ARF/RHD have been observed as social and environmental conditions improve. Improving overcrowded and unhygienic conditions is key to stopping new cases of RHD."

In its Report Card, the AMA called for action to:

- make RHD a notifiable disease and create a national register;
- ensure Indigenous community partnership and engagement;
- adopt a broad, multisectoral approach;
- closely target prevention efforts; and
- support research into a Strep A vaccine.

"The necessary knowledge to address RHD has been around for many decades, but action to date has been totally inadequate," Dr Gannon said.

The AMA is a foundation member of the END RHD Coalition, a nationally-funded research collaboration established to identify ways to tackle the disease.

It includes the Australian Heart Foundation, the National Aboriginal Community Controlled Health Organisation, RHD Australia and the Centre for Research Excellence to End RHD.

Federal Labor welcomed the release of the AMA Report Card and called on the Turnbull Government to commit to tackling RHD.

ADRIAN ROLLINS

What it means to live with RHD

The first Eddie Masina knew something was wrong was when, as a "sports mad" five-year-old, he suddenly lost the feeling in his legs while sitting at the breakfast table one morning.

His panicked parents rushed him to Cairns Hospital, where he was found to have rheumatic heart disease. That meant little to him at the time, except that he was no longer allowed to play his beloved rugby. But he remembers the anxiety of his parents, and the fibs and tricks he used to get out of taking the daily penicillin tablet he was prescribed.

The debilitating attacks kept recurring – breathlessness, sore joints, flu-like symptoms - frequently so bad he ended up in hospital. Eddie, now 35 years or so, estimates that since he was diagnosed he has spent around two-and-a-half years of his life in a hospital bed.

The first of his open heart operations came when he was a 12-year-old and in Year Seven.

He had become very sick. He had swollen ankles and was often out of breath. An x-ray revealed he had an enlarged heart and a damaged valve, and he underwent surgery.

As other valves began to leak he had surgery on them, too. He had open heart surgery when he was 16, 21, 26 and, most recently, in 2014.

There have been serious complications. Twice (when he was aged 18 and 20) Eddie had strokes after failing to take blood-thinning medication following the operations.

For Eddie, the trauma and disruption caused by the disease, and the distress felt by his parents and other loved ones, was compounded last year when he learned that RHD was entirely preventable.

"Why," he asks, "hasn't anything been done about it?"

ADRIAN ROLLINS

Home visit battle escalates

The Federal Government has been warned that cutting back on after hours home doctor visits could cost it hundreds of millions of dollars in extra hospital care.

As the Government awaits the outcomes of a MBS Taskforce review of after hours items, the National Association of Medical Deputising Services (NAMDS) has released a report claiming that the vast majority of patients seen by doctors after hours at home would otherwise end up in hospital, costing the country an extra $181 million a year, and $724 million over the Budget forward estimates.

“After hours home visits are an essential Medicare service that more than one million Australian families rely on each year,” NAMDS President Dr Spiro Doukakis said. “This report shows that without this service, emergency departments would be inundated with new patients, at heavy extra cost.”

The viability of so-called medical deputising services, which provide after-hours primary health services for patients in urgent need of care, has come under scrutiny following a rapid growth in claims.

The number of after hours GP visits has increased significantly in recent years, prompting claims that the system is being abused.

The use after hours items has been examined by a working group of the MBS Review Taskforce, but its conclusions have not yet been released for comment. The MBS Review is supported by the AMA and will follow a transparent process, including the release of a public discussion paper for comment.

But, worried that the Government might consider winding back the program, the NAMDS has released a report by consultancy Deloitte Access Economics to bolster its argument that it is saving the taxpayer money.

According to the report, since the Medicare rebate for after hours GP home visits was boosted by the Howard Government in 2005, the proportion of number of lower acuity GP-type visits to hospital emergency departments has fallen from 54 to 47 per cent of all presentations.

Access economist Lynne Pezzullo said a study of 50,000 patients who used the service found 94 per cent would otherwise have sought care elsewhere, including calling an ambulance or going to a hospital emergency department themselves.

Given the cost of these alternatives - $1351 for an ambulance-delivered ED visit and $368 for a patient who goes to emergency themselves – Ms Pezzullo estimated that the deputising services were saving the health system $181 million a year.

The AMA said medical deputising services were an integral part of the health system, providing patients who cannot wait until the next day to see their doctor with a valuable service.

But it said such services should not be viewed as a substitute for a patient’s usual GP, and deputising services should have strong links to a patient’s usual GP to ensure continuity of care.

The AMA said such services should deploy doctors who were appropriately trained and well supported, and should encourage patients who needs were assessed as less urgent to instead visit their usual GP for care.

The timing of the release of the Taskforce’s discussion is yet to be confirmed, with no recommendations having been put to Government so far.

ADRIAN ROLLINS

Bulk billing turns down

The GP bulk billing rate has fallen back and patient out-of-pocket costs have jumped in what could be an early sign that the Federal Government's Medicare rebate freeze is forcing general practices to increase patient charges to stay financially viable.

Repeated AMA warnings that medical practices were being driven by the rebate freeze to reduce or abandon bulk billing and hike patient charges have been leant weight by Health Department figures showing the bulk billing rate fell from 85.9 to 85.4 per cent in the September quarter while out-of-pocket costs surged 4.5 per cent to reach an average of $34.61.

And News Corporation has reported a Parliamentary Budget Office analysis showing that the proportion of patients bulk billed for a standard GP consultation (excluding health assessment, mental health and chronic disease management items) is even lower, at just 81 per cent.

While the AMA has urged caution in reading too much into one quarter's figures, the results could be the first confirmation of fears that Government policy is pushing up the cost of seeing a GP, including for vulnerable patients, such as those with chronic illness or on welfare.

"We know that the patient rebate is in many cases inadequate to maintain quality medical practice," AMA President Dr Michael Gannon said.

In their search for ways to stay afloat, practices appear not only to be cutting back on bulk billing but also looking to charge non-bulk billed patients more.

Government figures show the average patient contribution increased at more than six times the pace of inflation in the September quarter, a heavy financial blow to households already stretched by near-stagnant wage growth, fuelling fears that patients will increasingly defer or forego seeing a doctor.

AMA Vice President Dr Tony Bartone, a GP, said Medicare figures were beginning to reflect the experience of doctors.

"For many, many months – the best part of a few years – all doctors, all practices, have been absorbing the costs, absorbing the pressures," Dr Bartone told *Guardian Australia*. "A tipping point had to be reached sooner or later and I think we've crossed that line now. This is more than just a blip – it's a backward step."

Dr Bartone told News Corp that if patients who were routinely bulk billed, like children, pensioners and concession card holders, were excluded from the Government's figures, the bulk billing rate would be even lower, and "nowhere near even 80 per cent".

Shadow Health Minister Catherine King said the PBO's analysis showed that the true bulk billing rate was far below that claimed by the Government.

"This is more proof that under this Government, Australians are increasingly likely to be paying out of their own pocket when they visit a GP," Ms King said, though Parliamentary Budget Officer Phil Bowen said the PBO figures were an "unpublished sub-set of the official GP bulk billing statistics', and were consistent with the Government's own data and analysis.

While decrying the "obsession" of both sides of politics in using the bulk billing rate as a measure of the quality of health care people receive, Dr Gannon said the Medicare figures nonetheless highlighted the importance of the Medicare rebate in funding primary health services, and the consequences when it failed to keep pace with the cost of providing care.

"The statistics show that Australians pay above-average out-of-pocket expenses, which is a sign that patient rebates are inadequate in funding our health system," he said.

But Health Minister Sussan Ley rejected claims that the bulk billing figures were inflated, and said the latest Medicare data showed bulk billing remained at record high levels.

Ms Ley said the PBO's analysis relied on a single item for a standard GP consultation to the exclusion of other bulk billed services – a measure that did not capture the full range of patient services, and which had never been previously used by governments on either side of politics.

Instead, she said, the official figures showed the bulk billing rate in the September quarter was almost 1 percentage point higher than the same period last year (84.6 per cent).

Dr Gannon has directly lobbied Prime Minister Malcolm Turnbull to immediately end the rebate freeze, warning that the increasing financial squeeze on medical practices was forcing many to cut bulk billing and increase patient charges in order to remain financially viable.

Medicare rebates have been frozen since 2014, and under current plans will not be indexed until at least 2020.

Ms Ley has talked down hopes that the policy could be reversed soon, arguing the Government cannot afford to recommence indexation until its finances improve.

The Government is due to release its Budget on 19 December, but the Parliamentary Budget Office has reported a further deterioration in the Government's finances, projecting that the deficit will balloon to $105.1 billion by 2018-19 – an $8.9 billion blow out from the Budget.

The latest Medicare statistics show the bulk billing rate for the September quarter ranged from a high of 88.7 per cent in New South Wales to a low of 60.3 per cent in the Australian Capital Territory.

ADRIAN ROLLINS

Euthanasia: AMA says invest in end of life care

Doctors have called for far greater investment in end of life care and the establishment of nationally consistent palliative care services amid a concerted push from some for euthanasia laws.

As the Victorian Government considers its response to a parliamentary report calling for the legalisation of assisted dying, the AMA has reiterated its view that doctors should not be involved in interventions that have as their primary purpose the ending of a person's life.

Instead, in its updated *Position Statement on Euthanasia and Physician Assisted Suicide 2016*, the peak medical organisation said governments must do all they can to improve end of life care by providing proper resources for palliative care services and advance care planning and developing clear legislative protection for doctors providing good end of life care.

"Doctors should not involve themselves in treatments that have as the primary intention the ending of a patient's life," AMA President Dr Michael Gannon told the ABC. "But…if delivering treatments like sedatives to a dying patient has the secondary effect of hastening their death, that's not euthanasia."

Dr Gannon said that discontinuing treatments that were of no medical benefit to a dying patient also did not constitute euthanasia.

The AMA developed its latest Position Statement following an exhaustive year-long process that included a survey of members and consultations with State and Territory AMAs, and which took into account the policies of major national and international medical organisations, community attitudes and euthanasia and physician assisted laws in other countries.

The AMA member survey, which had around 4000 responses, found that 50 per cent of doctors agreed that doctors should not be involved in euthanasia or physician assisted suicide, while 38 per cent thought they should, and 12 per cent neither agreed nor disagreed.

Dr Gannon said the survey results showed that "a majority of doctors did not want the AMA to change its view, and they don't see a role for doctors in euthanasia".

But he admitted that the survey showed there was a divergence of views among doctors, just as there was in the broader community.

There has been a renewed push for the legalisation of euthanasia in recent months, and television presenter Andrew Denton has taken a lead role in advocating for change.

But the movement suffered a setback last month when the South Australian Parliament narrowly voted down laws to allow voluntary euthanasia. The final vote was 24-23.

Earlier this year, a cross party parliamentary committee in Victoria recommended laws to allow "adults with decision-making capacity, suffering from a serious and incurable condition who are at the end of life to be provided assistance to die in certain circumstances". The Victorian Government is considering its response.

Dr Gannon said that, ultimately, laws regarding euthanasia were a matter for governments and society.

But the AMA would act to make sure doctors and other health professionals were appropriately protected if euthanasia was legalised.

"If governments change laws then we will make sure that there is every possible protection written for not only the vulnerable in our community, but those doctors, those nurses, those other professionals, who don't see this as a part of health care, and would not wish to involve themselves," the AMA President said.

"We're keen to see laws that preserve the fundamental importance of the relationship between patients and doctors and give protections to those that might be threatened by some bad laws that we've seen proposed in this area."

Dr Gannon said the survey results showed that AMA members thought that if euthanasia was legalised to be part of medical care, doctors should be involved – but most would not want to be involved themselves.

"A majority of doctors acknowledge that if society changes laws, that those treatments should be provided by doctors. But they made the very clear point that a majority would not want to deliver those treatments themselves," he said.

The AMA Position Statement on Euthanasia and Physician Assisted Suicide 2016, which is consistent with the Declaration of Geneva and the World Medical Association, is available at: https://ama.com.au/position-statement/euthanasia-and-physician-assisted-suicide-2016

ADRIAN ROLLINS

AMA, Govt hold talks on ‘more balanced’ approach to pathology rents

AMA President Dr Michael Gannon met with Health Minister Sussan Ley in Canberra on 24 November to discuss the Government’s proposal to change the definition of market value for pathology collection centre leases.

Dr Gannon told the Minister that the AMA was prepared to work with the Government to try and come up with a more balanced policy approach that genuinely targeted inappropriate rental arrangements and did not interfere with legitimate commercial arrangements.

The AMA President also highlighted that the Government’s proposed changes had significant implications for existing leases that had been entered into freely, and on the basis of which financial commitments have been made by practices.

The discussion followed a meeting of the AMA Federal Council which reiterated its support for prohibited practices laws, but recommended significant changes to the Government’s election policy.

The Federal Council stressed the need for a more a targeted approach that focused on inducements to refer, consistent with the original intent of the prohibited practices laws, and that pathology referrals should be solely based on the quality of services, as opposed to commercial relationships.

Federal Council resolved to support the right of medical practices to negotiate collection centre leases freely with pathology providers, provided rents were not linked to a stream of referrals and that any new definition of market value must not adversely affect those medical practices that were acting ethically when entering into leasing arrangements.

The Council stated that reasonable transition arrangements would need to accompany any changes, and the Government would need to develop an appropriate educational strategy to ensure requesters and providers were aware of their obligations under existing prohibited practices laws and ensure that these and any future laws were properly administered and enforced.

Responding to allegations of sham leasing arrangements, Federal Council agreed that the Government needed to work with stakeholders to establish whether these could be sustained and, if so, develop measures to address them with urgency.

The AMA Federal Council also expressed its disappointment in successive Federal Governments for their failure to adequately fund patient access to medical care, including the prolonged freeze on Medicare rebate indexation, which increasingly threatened the viability of pathology, general practice and other specialist services.

During his meeting with the Minister, Dr Gannon welcomed her advice that the Government would not proceed with its planned 1 January 2017 commencement date, and the Minister’s commitment to allowing more time for consultation with general practice and pathology practice over the definition of market value and what transition arrangements might be needed. In this regard, the Minister stated that the Department of Health would be expected to work closely with the AMA as it developed further advice to Government.

Worrying MBS changes could be more than skin deep

The AMA has voiced strong concerns about significant changes the Federal Government has made to the Medicare Benefit Schedule without the input of clinicians.

As part of the Government's 2016 Budget repair plans, the Health Department has used the outcomes of a recent Skin Services review to implement a number of changes to the MBS, including axing 48 skin service items and replacing them with 28 new items recommended by the Medical Services Advisory Committee (MSAC).

Separate to this, an internal decision was made by the Department, without consultation, to reclassify a number of items into a new "banding". These changes effect the clinical setting in which services can be delivered in order to be still eligible for private health insurance rebates.

Though the development of new MBS skin item numbers arose from constructive engagement between the Department and medical profession stakeholders, there was no discussion of the banding of items under the *Private Health Insurance Act.*

It is not surprising then that, in absence of advice from the medical profession, the changes to banding classification are now having a deleterious effect on patient care.

The banding classification disadvantages patients, in particular children and patients with complex medical needs who may require these procedures to be carried out in the hospital setting. Under the new banding classifications, these items are no longer indicated for hospital stay unless a written certification is carried out, which is still no guarantee of complete insurance coverage.

The harm caused by these changes has been magnified by the Department's decision to announce them just days before they were due to come into effect on 1 November, seriously undermining informed financial consent. In many cases, patients had already been scheduled for procedures, including the excision of malignant melanomas which, after 1 November, were no longer automatically eligible for private health coverage when carried out in a private hospital setting.

In some instances, MBS rebates have also been reduced, resulting in many patients now being potentially out-of-pocket.

These changes, and the manner in which they were undertaken, do not instil confidence in the current MBS Taskforce reviews, which follow a similar process.

Alarm bells are ringing because it seems that clinical input is not being taken into account when the final policy decisions are made.

Hopefully this past process will not be replicated in the future MBS Taskforce Review work, as it would drive a wedge between the Government, doctors and their patients by undermining the collaborative decision making required to deliver an efficient and sustainable health system.

The AMA has consistently sought that MBS clinical committees and working groups conduct a complete review. To that end, the Government needs to address how they will accurately link clinician recommendations to implementation throughout the MBS Taskforce reviews – in each and every tranche.

AMA President Dr Michael Gannon has already written to the Minister for Health calling for a rollback of the problematic banding determinations relating to skin items, while also reinforcing the need for transparency and collaboration with medical profession before further substantive changes to the MBS are made.

The AMA's support for the MBS Taskforce reviews continues to be contingent upon our concerns, and those of our colleagues, being addressed.

The AMA is urging members, together with the medical colleges, associations and societies to keep the Government accountable by highlighting the key principles considered necessary to enable complete reviews. This includes:

- seeking reassurance that the reviews will not have unintended consequences for patients;
- being vigilant in shaping the clinical narrative and review framework to ensure the reviews do no negatively impact clinician scope of practice;
- engaging clinical committees and working groups in translating their findings to policy design; and
- supporting the clinicians who are directly involved in the review.

The AMA will continue to influence the MBS reviews through meetings with the Minister, in public commentary, and in more direct engagement with the Health Department.

A forum of the AMA and the colleges, associations and societies is planned for the first quarter of 2017 to provide stakeholders with an update and policy direction regarding the MBS reviews.

ELIISA FOK

TGA backed over codeine deliberations

The AMA has backed the medicine watchdog over its decision to re-visit plans to make codeine a prescription-only drug.

The Therapeutic Goods Administration has sparked debate after announcing, and then deferring, action to upgrade codeine so that it is no longer available over-the-counter (OTC).

The delay follows an outpouring of concern by patients and consumer groups worried that taking codeine off the shelves would make it much harder for people to manage chronic pain and force some to pursue unsafe alternatives.

Following an interim proposal in October last year to end over-the-counter access to the drug and reclassify it as a schedule 4 poison, the TGA received 127 submissions, including 113 opposing the move and just 14 in support.

In response, the watchdog said it would hold off on making a final determination until at least March next year.

In a submission to the TGA during its first round of consultations, the AMA did not come to a definitive position on the proposal.

While accepting that codeine dependence was “a real concern” and acknowledging the serious side effects caused by excessive consumption, the AMA voiced reservations that re-scheduling the drug would not necessarily solve these problems.

It said there could be an argument to restrict access to higher dose and compound codeine preparations, and noted inconsistencies in current regulations that allowed over-the-counter sales of Panadeine Extra, while Panadeine Forte (one tablet of which is equivalent to two Panadeine Extra pills) was only available by prescription.

“Up-scheduling in isolation is unlikely to address the problems of misuse,” the AMA said, arguing that any such move needed to be accompanied by better education about safe and effective pain management options.

But in its interim decision, the TGA indicated it was persuaded by concerns about the potential harm caused by inappropriate use of codeine and the availability of effective alternatives, paracetamol and ibuprofen.

The TGA said OTC codeine was intended to help manage acute, self-limiting pain, but instead people were using it to help treat chronic pain, potentially creating dependence and toxicity.

In addition, it said, at least 10 per cent of the population were “ultra-rapid metabolisers” of the drug, making codeine potentially deadly at even normal doses.

A review of 99 hospitalisations caused by the misuse of OTC analgesics containing codeine found they cost, on average, $10,000 per admission.

The study, presented to an Australasian Professional Society on Alcohol and Other Drugs conference last month, found patients were taking a mean 28 tablets a day for 606 days prior to admission, and some reported taking up to 90 a day.

The mean length of hospital stay was six days, and 10 per cent of patients in the study required treatment in intensive care units.

The United States and Britain have acted to more closely regulate OTC access to codeine. In the UK, OTC codeine can only be sold in packets of 32 tablets or less, and in the US only low-dose codeine formulations are available over-the-counter.

This action by authorities in the US and UK prompted a review in Australia, and in 2010 the maximum size of packs available OTC was cut from 96 tablets to 40.

The AMA said codeine dependence was a real concern, and the side effects of excessive consumption could be very serious.

But, while backing the independence of the TGA and its role in regulating drugs, it said any changes in the classification of codeine should be based on the latest evidence.

It recommended that changing the scheduling of codeine should only be undertaken where there was strong evidence it was safe to do so, was of demonstrated patient benefit, and where it would not adversely affect appropriate access to medicine.

The peak medical organisation said it would await the outcome of the TGA’s deliberations.

But whatever the outcome, the AMA urged the adoption of a national Electronic Recording and Reporting of Controlled Drugs system to provide doctors and pharmacist with real-time information on the prescription of medicines prone to misuse and harm.

It has also suggested that pharmacies be required to record codeine sales in the same way as they do for pseudoephedrine.

ADRIAN ROLLINS

Medical board told revalidation plan needs more work

The AMA has told the Medical Board of Australia to go back to the drawing board over a plan to profile doctors in an attempt to identify those at greatest risk of providing sub-standard care.

The peak medical group has told the regulator that its proposal for a system of revalidation for the medical profession needs far more work, particularly its suggestion that doctors be targeted for review simply because of their age, gender and complaints history.

Older male doctors who have been the subject of several patient complaints would be targeted under Medical Board proposals to "proactively" identify those most likely to pose a risk to patients.

In a discussion paper on options for revalidation released earlier this year, the Board proposed that doctors undertake a strengthened Continuing Professional Development (CPD) program. Simultaneously, there would be a "proactive" screening process to identify and assess doctors who may be performing poorly and pose a risk to patients.

It said CPD alone could not ensure the safety of the public, and the Revalidation Expert Advisory Group has recommended using indicators to screen for practitioners most likely to harm patients, including age, gender, complaints history, specialty, practice type and level of impairment.

But in a submission to the Medical Board, the AMA has warned that such a blunt approach could have serious and unintended consequences.

It said the system could result in thousands of doctors being targeted for review even though only a small fraction were underperforming or unfit for practice, and warned that it could deter practitioners from caring for high-risk patients because of the fear of being singled out for review.

While not opposed to revalidation in principle, the AMA said the Medical Board needed to do much more work to develop and refine its plan.

"The AMA does not support the current proposal to identify and actively manage doctors at risk of poor performance as it is described. This proposal requires a considerable amount of further work," it said, adding there was no evidence to justify it, and warning it was potentially costly.

The AMA said the Board had yet to clearly establish that a system of revalidation was necessary, "particularly given that only a small proportion of doctors are the subject of complaints from patients or colleagues".

It said further research was needed to "provide robust evidence of the problem that should be addressed and the nature of the proposed solution".

"Like many overseas jurisdictions, the Board appears to be grappling with the question of the role of revalidation," the AMA said.

The Board has raised concerns that current CPD requirements are not sufficient to maintain or improve the performance of all doctors, and that doctors who are at risk of under-performing are not identified early enough.

But the AMA said the regulator did not identify deficiencies in the current CPD system, and added the medical profession was already working on strengthening the CPD process, including improved peer review and partnership for performance development.

Furthermore, the medical profession worked in a highly regulated environment in which fitness to practice was continuously being assessed.

"The processes of annual renewal of medical practitioner registration, professional indemnity insurance, and re-accreditation of health care facilities, ensure that there is constant, ongoing validation within the existing regulatory environment," the AMA said.

"The AMA's key concern with the Expert Advisory Group's report does not clearly identify the public safety problem that the proposed revalidation system is intended to fix. Clearly articulating and quantifying the problem would allow the medical community to examine, comment and identify potential solutions."

The Revalidation Expert Advisory Group will provide a final report to the Board in mid-2017.

For further details, including copies of the discussion paper and interim report, go to: http://www.medicalboard.gov.au/News/Current-Consultations.aspx

ADRIAN ROLLINS

Patients left waiting as EDs struggle to meet demand

Barely two-thirds of patients in need of urgent care are being seen on time by emergency departments as hospitals struggle to meet burgeoning demand.

Australian Institute of Health and Welfare figures show hospitals are slipping further behind national emergency department treatment targets, underlining AMA warnings that government funding is increasingly inadequate.

Last financial year just 67 per cent of urgent patients received emergency department treatment within the recommended time, down from 68 per cent a year earlier and well short of the 80 per cent target that was to have been achieved three years ago.

Hospitals are also no closer to reaching the benchmark four-hour goal. The proportion of emergency department visits completed within four hours has remained stuck at 73 per cent for the third year in a row, far below the 90 per cent standard that was meant to be achieved by the end of last year.

The figures come against a backdrop of continued Commonwealth-State wrangling over hospital funding.

Since 2010-11 the Federal Government's share of public hospital funding has slipped below 40 per cent and in 2014-15 was at 37.8 per cent. The State and Territory government share has also eased lower, from 54.2 per cent in 2013-14 to 53 per cent in 2014-15. By contrast, non-government spending on public hospitals is increasing and reached 9.2 per cent in 2014-15.

Earlier this year, the Commonwealth promised an additional $2.9 billion over three years to mid-2020, capped at growth of 6.5 per cent a year, but the extent and terms of funding beyond that is yet to be thrashed out.

The funding uncertainty is unsettling the public hospital sector, which the AIHW data shows is struggling to keep up with growth in demand.

Earlier this year, AMA President Dr Michael Gannon said that both the Commonwealth and the States had failed to take adequate account of the effects of the ageing population and health epidemic like obesity and drug use in driving up demand for hospital services, including emergency department care.

The AMA said the "real message" behind the AIHW data was the need for greater investment in hospital capacity.

"If demand for ED services is increasing, governments are responsible for ensuring resources are provided to enable performance to keep up and to achieve the targets agreed by governments," the AMA said.

ADRIAN ROLLINS

MEMBER CONSULTATION

Have your say on Prostheses Funding

The Federal Health Department has approached the AMA for assistance in gaining member feedback regarding the reform of prostheses benefits.

This is the first stage in developing a benefit-setting framework for prostheses, and is being managed by the Department with guidance from the Prostheses List Advisory Committee.

This project leads on from the Industry Working Group on Private Health Insurance Prostheses Reform, which identified a number of areas for improvement and potential change, including creating a more competitive basis for the purchase and reimbursement of prostheses.

Stakeholder feedback is sought on "information on the current arrangements in supplying, purchasing and reimbursing medical devices, including the consideration of innovative approaches that may support:

- a more competitive and value-for-money basis for purchasing and reimbursement;
- improved transparency in benefit setting for a device, taking into consideration appropriate costs for inclusion in the benefit); and
- timely access to a reasonable choice of prostheses".

The AMA has been generally supportive of the Government in establishing processes to reduce prosthesis costs.

Noting the important interaction that many in the medical profession (particularly, but not limited to surgeons) have with prostheses, the Department is interested in the views of a range of practitioners.

To represent the views of the medical profession in these initial stages, the AMA has developed a short survey for members who have interest and experience in this issue.

Members are encouraged to register interest by emailing Eliisa Fok, Policy Advisor on efok@ama.com.au – to receive a link to the short survey.

Please note, there is a short timeline and comments are required by COB 19 December 2016.

Alternatively, those wishing to make comments directly to the Department can do so by emailing prosthesesreform@health.gov.au

Doctors hold private costs down

Doctors have cut out-of-pocket expenses for privately insured patients and the proportion being cared for without being charged a gap is approaching 90 per cent, blowing apart attempts to blame medical practitioners for the rising cost of health insurance.

Australian Prudential Regulation Authority figures show 86.2 per cent of all privately insured medical services in the September quarter were provided at no gap to the patient, while a further 6.4 per cent were provided with a known gap.

Furthermore, where patients were charged out-of-pocket expenses, the average bill fell more than 5 per cent to $128.99.

The results will increase the pressure on health funds, whose image has taken a battering from a succession of hefty premium increases and mounting consumer dissatisfaction with the quality, value and affordability of their product.

In recent years health insurers have attempted to variously blame doctors, private hospitals and now, prostheses manufacturers for the remorseless rise in their premiums.

The increases, coupled with poorly-communicated changes to cover, have infuriated policyholders, and funds are bracing for a fresh wave of departures and policy downgrades when the Federal Government approves premium increases for 2017.

Speculation is mounting that Health Minister Sussan Ley will give the green light to an average premium increase of around 5 per cent from 1 April next year, exacerbating consumer dissatisfaction with the value and affordability of health insurance and likely prompting more to opt for cheaper policies with multiple exclusions or higher excess.

Ms Ley has kept up the pressure on insurers to limit the size of their 2017 premium increases after announcing reforms to the Prostheses List that are expected to save insurers $394 million over five years.

"I expect insurers to be doing everything possible to keep premiums low," Ms Ley told the *West Australian*. "We have taken action as promised and it's now time for insurers to deliver on their promise to substantially lower premium increases for their customers next year."

The prospect of another hike in premiums comes against the backdrop of near-stagnant wages and desultory economic growth. While unemployment dipped to 5.6 per cent in October, wages have grown by just 1.9 per cent in the past year, barely more than the pace of inflation.

In these circumstances, some insurers are finding it difficult to retain members.

The results will increase the pressure on health funds, whose image has taken a battering from a succession of hefty premium increases and mounting consumer dissatisfaction with the quality, value and affordability of their product

Medibank Private has lost its mantle as the nation's biggest health fund following an exodus of 96,661 members last financial year that pushed its overall membership base down to 3.6 million policyholders. BUPA, with 3.7 million members, is now the market's largest insurer.

The insurance industry is using the backdrop of declining membership and downgraded policy coverage to push the Government for further regulatory reforms, claiming another $720 million in savings could be had from more changes to prostheses pricing.

Medibank Chief Executive Craig Drummond said growth in the health insurance market had slowed sharply in the last couple of years, and the industry was facing a "challenging" environment.

"I think affordability is a key issue for our industry, and when you have got incomes growing at 1 to 2 per cent per annum and premiums growing at 6 per cent per annum for an extended period, that is challenging," Mr Drummond told *The Australian*. "That is why we are looking quite hopefully at regulation and regulatory change. Prostheses is one of those important parts of regulatory change."

But private hospitals have challenged the health insurance industry's claims.

Ramsay Health Care Chief Executive Chris Rex said assertions that up to $1 billion in savings could be realised from prostheses pricing reform were "ridiculous".

There have been claims that private hospitals earn multi-million dollar rebates from prostheses manufacturers for using their products, but Mr Rex vehemently rejects this, and told the *Australian Financial Review* his company received a "low single-digit" fee for the cost of handling prostheses.

And the health fund industry's pitch for further prostheses price cuts has been undermined by the release of figures showing the sector's after-tax surplus reached above $1 billion last financial year.

The Australian Prudential Regulation Authority reported that the health insurance industry's net margin jumped 1 percentage point in 2015-16 to reach 5.4 per cent, pushing the after-tax surplus to $1.25 billion. Medibank was the most profitable, with a surplus of $433 million, followed by BUPA ($353 million).

ADRIAN ROLLINS

Health effects of climate change tracked

Australian scientists and health workers are expected to take part in a global initiative to track the health effects of climate change amid predictions that 2016 will be the hottest year on record.

As the World Medical Association called for doctors to play a lead role in combating climate change, *The Lancet* journal unveiled its plan for an international collaboration of experts to report on the health effects of global heating, including heatwaves, floods, droughts and other natural disasters, as well as work be done to adapt health care and services to the changing environment, the benefits of mitigation efforts, and issues around political and broader engagement.

The initiative, called the Lancet Countdown, will provide annual reports on global, national and regional trends regarding health and climate change, timed to be released before the yearly negotiations of the UN Framework Convention on Climate Change.

The move follows a call by the AMA in 2015 for "urgent international cooperation" to mitigate the effects of climate change, and comes as the World Meteorological Organisation warns that 2016 is on track to be the hottest year in recorded history, with global temperatures about 1.2 degrees Celsius above pre-industrial levels and 0.88 degrees higher than the 1961 to 1990 average.

In a revised Position Statement issued last year, the AMA said the world's climate was being altered in ways that would have significant direct and indirect effects on health, and recommended emission reduction targets as well as the development of a National Strategy for Health and Climate Change.

In 2012 the World Health Organisation estimated that about 12.6 million deaths were attributable to changes to the environment, many influenced by or related to climate change.

And an Australian Academy of Science study released earlier in 2015 said the country was already seeing the fatal consequences of extreme weather events, including 374 Victorians who died during a searing heatwave that swept the State ahead of devastating bushfires that claimed 173 lives.

President of Australia's Climate and Health Alliance, Dr Liz Hanna, said the Lancet project would pull together a growing body of research detailing the many ways in which climate change hurt health and wellbeing.

"No one is immune to climate change. We must find ways to protect Australian communities against this growing threat to health and safety," Dr Hanna said. "There are simple and cost-effective measures that we should be putting in place, and health experts around the country are looking to policy makers at all levels of government for leadership on this."

A World Medical Association delegation, meanwhile, attended the UN climate talks in Marrakesh to push for health considerations to be taking into account in the implementation of the Paris climate change agreement.

WMA President Dr Otmar Kloiber said physicians had an essential role to play in alleviating the health effects of climate change.

"We want to ensure that physicians are involved in local, national and international plans to combat climate change," Dr Kloiber said. "[The Paris agreement] gave us all hope that the world's governments recognised the serious consequences for health as a result of climate change. We now mean to make sure that we turn that hope into action."

The Lancet said the aim of its project was to "track the impacts of climate change and the speed of the transition to a decarbonised global economy".

It would document successes and blockages in the shift to lower emissions, and engage with politicians and the broader health community on how to respond to climate change, "both for health and more broadly".

The AMA's Position Statement on Climate Change and Human Health can be viewed at: https://ama.com.au/position-statement/ama-position-statement-climate-change-and-human-health-2004-revised-2015

ADRIAN ROLLINS

Calls for new meningococcal vaccines to be subsidised

Health groups are calling for two meningococcal vaccines to be included in the National Immunisation Program, following an increase in cases of the previously uncommon W strain.

Cases have been recorded this year in Western Australia, Victoria, New South Wales, South Australia, and Queensland, prompting the Meningitis Centre Australia to launch a campaign to lobby the Government to subsidise the Men B and ACWY vaccines.

Vaccines are available in Australia for five strains, but only the C strain vaccine is available free as part of the free National Immunisation Program.

Centre chairman, Bruce Langoulant, said cases of W strain were expected to double in 2017.

“This is a vaccine preventable disease. All children should be protected against it and the Federal Government should put this on the National Immunisation Plan,” Mr Langoulant said.

Dr Richard Kidd, Chair of the AMA Council on General Practice, said it was a “nasty infection” that was on the rise.

“With the other strains where we’re seeing maybe one person in 10 die with those infections, with this new W strain ... it’s more like one in four people die,” Dr Kidd told the ABC.

He called on the Australian Government to follow Britain’s lead and introduce a program to vaccinate teenagers against A, C, and W strains, as people can unknowingly carry the germ without being sick.

“If we can vaccinate enough people, we can even stop the carriers who spread it like Typhoid Mary without even knowing they’ve got it,” he said.

A meningococcal B strain vaccine being used in Britain had also been shown to give young children significant protection against the W strain, he said.

“What’s happened is that, because Australia is at the end of the supply chain, we can’t get that vaccine at the moment because England and some other countries are gobbling it all up and they’re in front of us in the supply chain,” Dr Kidd said.

Associate Professor Charlene Kahler, of the University of Western Australia, said that with 12 cases of the W strain recorded in WA this year, the vaccine was needed.

“We’ve been watching strain W for the last three years,” she told the Perth launch of the lobbying campaign.

“It’s been doubling each year since 2013, and we would predict next year it will double again without any intervention.

“The most at-risk individuals are the very young – under the age of two – and young adults.”

Head of clinical research at the National Centre for Immunisation Research and Surveillance, Professor Robert Booy, said while other strains of the virus affected certain age groups, the W strain affected all ages, and could put healthy people “at death’s door” within 12 hours.

Meanwhile, the shingles vaccine is now available free to for people aged 70 years under the National Immunisation Program, with a catch-up program for people aged 71 – 79 years.

It is the first adult vaccine for a new disease to be added to the Program since 2005.

“This new program is an important reminder that vaccinations don’t stop at childhood,” Health Minister Sussan Ley said.

MARIA HAWTHORNE

GPs targeted in national plan to curb antibiotic resistance

> "Less than 10 days after researchers sounded the alarm over the arrival in Australia of a superbug capable of overcoming the last line of defence against salmonella infection, the Federal Government has detailed its plans to implement the National Antibiotic Resistance Strategy"

GPs will be targeted over their antibiotic prescription practices as part of a national strategy to tackle the threat from rising antibiotic resistance.

Less than 10 days after researchers sounded the alarm over the arrival in Australia of a superbug capable of overcoming the last line of defence against salmonella infection, the Federal Government has detailed its plans to implement the National Antibiotic Resistance Strategy.

Health Minister Sussan Ley said the inaugural plan, covering the period 2015-19, had as one of its main targets reduced recourse to antibiotics by GPs.

"A particular focus will be Australia's high use of antibiotics in general practice, which is 20 per cent above the OECD average," Ms Ley said. "Bringing prescribing rates down is critical, as high antibiotic use is the number one driver of the increasing resistance to antimicrobials."

Despite this focus Ms Ley, who launched the strategy in conjunction with Agriculture Minister and Deputy Prime Minister Barnaby Joyce, said the plan encompassed a broad "one health" approach which recognised the inextricable links between human, animal and ecosystem health.

"[This means] that combating resistance to antimicrobials requires action in all sectors where antimicrobials are used," the Health Minister said.

The plan calls for, among other things, better support for doctors and vets in educating patients about the need for care in antibiotic use; the implementation of effective stewardship practices among health professionals; improved national surveillance of antibiotic use; better infection control measures; and intensified research efforts.

The plan has been developed amid mounting international alarm regarding the threat posed by antibiotic resistance. A recent British Government report warned the world was on track to a future in which even common infections and medical procedures could become potentially deadly because of the risk of infection.

The UK report estimated that antimicrobial resistance could kill 10 million a year by 2050, and cost the world a cumulative USD$100 trillion in reduced economic output without effective action to slow the rate of drug resistance.

The threat to Australia has escalated following the discovery by Murdoch University researchers of a strain of the Salmonella bug that is resistant to carbapenems, the drug used as the last line of defence against such infections.

The superbug was discovered in a pet cat admitted to Concord Veterinary Hospital in New South Wales with an upper respiratory tract infection that subsequently developed into a gut infection.

A sample of the infection sent to a team of researchers at the Concord Hospital identified a strain of Salmonella never before seen in the country. It was found to be carrying the highly resistant IMP-4 gene.

A further three animals at the veterinary clinics were also found to be infected with the superbug. The outbreak has been contained.

Dr Abraham said the identification and containment of the bacteria was "an example of Australia's One Health capabilities, where animal and human health specialists work together to prevent the spread of infection".

ADRIAN ROLLINS

E-cigs a gateway to smoking for young: study

The AMA's call for a cautious, evidence-based approach to the use of e-cigarettes has been underlined by research that 'vaping' can lead to heavy smoking among young users.

As debate rages over the effectiveness of e-cigarettes as an aid in avoiding or giving up smoking, a study published in the *Journal of the American Medical Association* has cast doubt on the idea that they can divert people from the deadly habit.

The longitudinal study involving 3084 public high school students in Los Angeles County found a "positive association" between the use of e-cigarettes and subsequent smoking, particularly when those taking up the vaping habit were non-smokers.

"In this study of adolescents," the researchers said, "vaping more frequently was associated with a higher risk of more frequent and heavy smoking six months later."

Furthermore, the positive association between baseline vaping and follow-up smoking frequency was stronger among baseline non-smokers than infrequent or frequent smokers, the research found.

The findings follow a United States Centers for Disease Control and Prevention investigation that found a large number of non-smoking middle and high school students had used an e-cigarette, and were twice as likely as those who hadn't to report that they intended to start smoking tobacco cigarettes.

The findings back AMA concerns that e-cigarettes are undermining tobacco control efforts and should be subject to the same restrictions as on cigarettes, including a ban on sales to children and adolescents, and tight restrictions on their marketing and promotion.

In a Position Statement released late last year, the Association warned that many e-cigarettes were being marketed to appeal to young people, including through the use of flavourings, and voiced fears that they could act as a gateway for young people to progress to become smokers – a concern borne out by the JAMA study.

The AMA said the evidence that using e-cigarettes helped people to give up smoking was "mixed and low-level", and the risk they posed meant governments should take a precautionary approach.

"Currently, there is no medical reason to start using an e-cigarette," the Association said. "There are legitimate concerns that e-cigarettes normalise the act of smoking. This has the potential to undermine the significant efforts that have been dedicated to reducing the appeal of cigarettes to children, young people and the wider population.

"In fact, using an e-cigarette may significantly delay the decision to quit smoking," the AMA warned, adding that the longer-term health implications of inhaling e-cigarette vapours produced by illegally imported and unregulated solutions were unclear.

The best approach, it said, was restrict their promotion and ban sales to young people until further evidence as to their safety and efficacy was available.

The AMA's Position Statement, *Tobacco Smoking and E-Cigarettes – 2015*, can be downloaded at: https://ama.com.au/position-statement/tobacco-smoking-and-e-cigarettes-2015

ADRIAN ROLLINS

INFORMATION FOR MEMBERS

AMA Indigenous Peoples Medical Scholarship 2017

Applications for the AMA Indigenous Peoples Medical Scholarship 2017 are now open.

The Scholarship, open to Aboriginal and Torres Strait Islander people currently studying medicine, is worth $10,000 a year, and is provided for a full course of study.

The Scholarship commences no earlier than the second year of the recipient's medical degree.

To receive the Scholarship, the recipient must be enrolled at an Australian medical school at the time of application, and have successfully completed the first year of a medical degree (though first-year students can apply before completing the first year).

In awarding the Scholarship, preference will be given to applicants who do not already hold any other substantial scholarship. Applicants must be someone who is of Aboriginal or Torres Strait Islander descent, or who identifies as an Australian Aboriginal or Torres Strait Islander, and is accepted as such by the community in which he or she lives or has lived. Applicants will be asked to provide a letter from an Aboriginal and/or Torres Strait Islander community organisation supporting their claim.

The Scholarship will be awarded on the recommendation of an advisory committee appointed by the AMA's Indigenous Health Taskforce. Selection will be based on:

- academic performance;
- reports from referees familiar with applicant's work regarding their suitability for a career in medicine; and
- a statement provided by the applicant describing his or her aspirations, purpose in studying medicine, and the uses to which he or she hopes to put his or her medical training.

Each applicant will be asked to provide a curriculum vitae (maximum two pages) including employment history, the contact details of two referees, and a transcript of academic results.

The Scholarship will be awarded for a full course of study, subject to review at the end of each year.

If a Scholarship holder's performance in any semester is unsatisfactory in the opinion of the head of the medical faculty or institution, further payments under the Scholarship may be withheld or suspended.

The value of the Scholarship in 2017 will be $10,000 per annum, paid in a lump sum.

Please note that it is the responsibility of applicants to seek advice from Centrelink on how the Scholarship payment may affect ABSTUDY or any other government payment.

Applications close 31 January 2017.

The Application Form can be downloaded at:

https://ama.com.au/system/tdf/documents/Application%20Form_0.pdf?file=1&type=node&id=45143

Information on previous recipients can be found at https://ama.com.au/advocacy/indigenous-peoples-medical-scholarship

The Indigenous Peoples' Medical Scholarship Trust Fund was established in 1994 with a contribution from the Australian Government. The Trust is administered by the Australian Medical Association.

The Australian Medical Association would like to acknowledge the contributions of the Reuben Pelerman Benevolent Foundation and also the late Beryl Jamieson's wishes for donations towards the Indigenous Peoples' Medical Scholarship.

Doctors a vital source amid diet confusion

BY TIM O'DOWD

Doctors are expected by patients to give dietary advice, to help with setting realistic weight goals and to give exercise recommendations. Yet, for various reasons, Australian doctors do not appear to be following recommended suggestions to monitor and manage obesity. The ability to give good general nutrition advice should be a central component of patient care.

The three pillars of evidence-based practice are the integration of the doctors' expertise with the patient's values and preferences, and the judicious use of the best available evidence. The aim of this article is to address the question of whether doctors have the training and knowledge (expertise) to give nutrition advice; and what the "best available evidence" is in regards to nutrition.

Do doctors have the expertise to give nutrition advice?

Through the intensive study of biochemistry, physiology, pathology, and the patho-physiology of disease, doctors obtain a solid foundation of nutrition and its effects on the human body. After some years in practice, doctors gain enormous experience dealing with various disease states and the contribution of diet to prevention and treatment.

As a consequence, doctors are uniquely qualified to give nutrition information to patients.

What is the best available evidence?

The Australian Dietary Guidelines (ADG 2013) and other international dietary guidelines tend to follow a similar paradigm. Their recommendations over the last 40 years have been with the express purpose of improving community health. However, governments and medical professionals remain concerned about the continued rise in rates of obesity, diabetes and cardiovascular disease.

The task of determining what is the best available evidence has been complicated by claims from some that medical research is less-than-perfect, and that evidence-based medicine has been hijacked and is in crisis. Moreover, researchers caution that it is difficult to attribute the occurrence of a chronic disease to any single food or nutrient item and, consequently, any observed relationship between a food or nutrient item and chronic disease must be interpreted with care and replicated in multiple studies. And patients are assailed with nutrition suggestions from a wide array of sources, including diet organisations, books, television and the internet, and many look to their doctor for definitive advice.

Doctors, in their turn, rely on academia to analyse and rate the enormous pool of nutrition research that is produced every year, and to compress it into recommendations and guidelines. Several Australian organisations recommend following the ADG 2013, including the Royal Australian College of General Practitioners, the Dietitians Association of Australia, and other organisations who promote low saturated fat intake and reduced fat dairy products.

While this would appear to suggest a degree of consensus on what is the best evidence, support for national dietary guidelines, including ADG 2013, is far from unanimous. Increasingly there are articles questioning long-held beliefs, in particular in relation to the macronutrient percentages (protein, fat, carbohydrate) in the diet. There is major dissent about whether our diet should be composed of lower or higher carbohydrate, and lower or higher fat content, especially saturated fats.

The medical profession and nutrition advice

Our patients expect us to include dietary advice in the management of their health.

The medical profession should strive to reclaim and protect the central role of doctors in discussing and advising patients regarding nutrition in their overall care. Given the importance of nutrition to health, medical schools and the various specialty colleges have a responsibility to increase emphasis on nutrition science from the biochemistry, physiology and pathology sciences, in undergraduate and postgraduate education, including at annual scientific meetings.

Doctors who delegate their role regarding diet advice for their patients are disregarding the fact that nutrition is recognised as a major modifiable factor for the prevention and management of obesity, diabetes, heart disease and other chronic disorders including dementia, cancer and non-alcoholic fatty liver disease.

Nutrition research should be considered a complex 'work in progress'. The ADG 2013 can be accepted as a substantial interim report reflecting the considered views of the academics who wrote the guidelines. While there is considerable support for the guidelines from important medical and dietician

Doctors a vital source amid diet confusion

organisations, adherence to these guidelines cannot be regarded as mandatory.

Rather than relying solely on ADG 2013, or indeed referring directly to a dietitian, doctors could broaden their understanding of the issues confronting their patients.

Conclusion

Good nutrition is important for general health and the prevention or amelioration of obesity and many chronic diseases.

The medical profession should reclaim its central role in all aspects of patient care and regard nutrition advice as a central component of care. This is what our patients expect.

Doctors have the training, experience and expertise to consider giving nutrition advice to their patients.

At present, deciding what is the “best available evidence” from the clinical research in nutrition is contentious. The evidence, such as it is, should be limited to assisting the clinical decision-making, rather than overriding it.

INFORMATION FOR MEMBERS

Specialty Training Pathways Guide – AMA Career Advice Service

With more than 64 different medical specialties to choose from in Australia, making the decision to specialise in one can seem daunting.

AMA members now have access to a new resource – one designed to assist in making decisions about which specialty pathway to follow. We know that concerns about length of training, cost of training and work-life balance are important factors in making these decisions, and information on the new site will help here too.

The absence of a comparative and definitive guide was raised by our doctors in training and medical students.

Responding to this need from our doctors in training and medical students, the AMA Career Advice Service has developed a comprehensive guide to the specialties and sub-specialities which can be trained for in Australia. The Guide will be updated annually to reflect changes made by the Colleges, and the 2017 update will be uploaded shortly.

The web-based Guide allows AMA members to compare up to five specialty training options at one time.

Information on the new website includes:

- the college responsible for the training;
- an overview of the specialty;
- entry, application requirements and key dates for applications;
- cost and duration of training;
- number of positions nationally and the number of Fellows; and
- gender breakdown of trainees and Fellows.

The major specialities are there as well as some of the lesser known ones – in all, more than 64 specialities are available for comparison and contrasting.

For example, general practice, general surgery – and all the surgical sub-specialities, paediatrics, pathology – and its sub specialities, medical administration, oncology, obstetrics and gynaecology, immunology and allergic medicine, addiction medicine, neurology, dermatology and many, many more.

To find out more, visit www.ama.com.au/careers/pathway

This new addition to the Career Advice Service enhances the services already available which include one-on-one career coaching, CV templates and guides, interview skills “tips” and, of course, a rich source of information available on the Career Advice Hub: www.ama.com.au/careers

For further information and/or assistance, feel free to call the AMA Career Advisers: Annette Lane and Christine Brill – 1300 133 665 or email: careers@ama.com.au

Please note current information within the guide relates to 2016 requirements. Information will be updated to reflect 2017 requirements soon.

Let the AMA’s specialty training pathways guide help inform your career decisions.

Govt trying to do primary health reform on the cheap

BY **DR RICHARD KIDD, CHAIR, AMA COUNCIL OF GENERAL PRACTICE**

May you live in interesting times goes the saying, which is meant as a curse. When it comes to general practice policy, I think it nicely sums up the last 12 months.

Despite the fact that health proved to be a key issue in this year's Federal election, I am not seeing much from the Government that gives me any confidence they understand the importance of investing in general practice.

> "General practice is on the verge of the biggest reform since Medicare was established, with the trial of Health Care Homes. In principle, this should bring opportunities to maximise the use of our multidisciplinary health care team, and to innovate in how we deliver health care services to our patients"

While the Government says it wants to combat the growth in obesity and chronic disease and manage the health of an ageing population, all we are seeing is a shuffling of the financial deck.

General practice is on the verge of the biggest reform since Medicare was established, with the trial of Health Care Homes. In principle, this should bring opportunities to maximise the use of our multidisciplinary health care team, and to innovate in how we deliver health care services to our patients. The care coordination and other services that we provide for our patients for their chronic care will be funded in the future in a bundled payment.

It is expected that this bundle will fund the majority of care provided to eligible registered patients. Let's be clear that this "bundle" is not a set of defined services and will, in fact, be a capitated payment. In the initial trial of Health Care Homes it will only be for those patients identified as needing extra support to manage their chronic conditions, and the focus is really on hospital avoidance. While the initial funding framework of the trial will target chronic and complex care services provided by a practice, in time, who knows what a capitated payment will cover. Will we be frogs in the pot of water, that is increasingly getting hotter, unaware of the increasing danger?

Under the Government's current trial, general practices are expected to do more with no additional support and to take on more financial risk when caring for patients.

Practices who are thinking of signing up to become a Health Care Home are going to have to consider carefully the financial implications. Aside from the $10,000 sign-on payment to support initial practice change management for the trial, these practices will be paid retrospectively on a monthly pro-rated basis based on the number of enrolees in each risk stratified tier. The big question for participating practices is, how will those payments support innovation, and fund the health care team?

This has all sorts of implications, with the role of GPs and other members of the team being a key one. Tax implications are another, and will GPs and other team members be paid a proportional salary, or will they bill the practice for the services they provide? What care falls within the boundaries of chronic disease and is covered by the bundled payments, and what care is acute care, billable as a normal MBS item?

Under the trial, it will still be possible to privately bill enrolled patients for their chronic care, although the Government is clearly expecting that out-of-pocket costs will be kept to a minimum. Practices that patient bill can expect to have to make changes to their billing procedures. Tracking patient out-of-pocket expenses in the future is going to very different, and there is a risk that this information will disappear into the ether.

As you can see, there is a lot to contemplate and I encourage those interested in being part of the trial to fully consider what it will mean for you and your patients.

Before doing so you may also wish to review the AMA Position Statement on the Medical Home 2015 (https://ama.com.au/position-statement/ama-position-statement-medical-home) to compare what we support against what the Government is offering.

Medical tourism – be careful what you wish for

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

Globalisation has had a bad rap lately, especially because it so influenced the US presidential election. Barring a serious international conflict, however, global tourism might well flourish, whatever constraints are placed on other aspects of globalisation.

Of the billion tourists annually, perhaps 750,000 are seeking treatment. While it is commonplace for the wealthy sick from poorer countries to travel for sophisticated care elsewhere, travel in the opposite direction is increasing. When the price or/and waiting time in an affluent country far exceeds those in a sophisticated city in a poorer nation, patients are increasingly dusting off their passports. National boundaries are of diminishing significance. The range of treatments is vast – liver transplants, dentistry, cosmetic surgery and even doctor-assisted suicide.

Globalisation is global!

Globalisation has penetrated deeply into our lives. Technological advance, telecommunications and transport bear witness. Language, too, is no longer limited by national boundaries: of the 1.26 billion Indians, 125 million speak English, the first language of 230,000.

Few technological developments are under governmental control. Economist J K Galbraith's 1966 'technological imperative' is no respecter of protocol: "new technologies are inevitable and essential and ... must be developed and accepted for the good of society". Medical therapies and surgery are caught in its vortex, often favourably, producing new therapies and diagnostic tools.

But the interaction of globalisation – driven largely by private enterprise – with civil society has its downsides. One is its capacity to neuter government control over major elements of the economy, especially in the developing world. Nobel Laureate economist Joseph Stiglitz, in his book Globalization and its discontents, recalled his unhappy experience, especially with the International Monetary Fund. He wrote that:

IMF structural adjustment policies—the policies designed to help a country adjust to crises as well as to more persistent imbalances—led to hunger and riots in many countries; and even when results were not so dire, even when they managed to eke out some growth for a while, often the benefits went disproportionately to the better-off, with those at the bottom sometimes facing even greater poverty.

We have not had long, in historical terms, to adjust to globalisation and to distinguish good from bad. We see serious errors repeated, especially those fostering inequality and lack of concern for the less well-off. Reversing them is devilishly hard.

A globalised medical workforce?

Globalisation could seriously disturb medicine in Australia. We must strike the right balance – discouraging citizens from going elsewhere for care and not encouraging other citizens to come here – balanced against the needs and capacities of the home and host countries. This is not impossible; we simply need to think carefully and act responsibly. Of course, individual freedom is crucially important, but sage advice can be responsibly offered.

Does globalisation make national registration of practitioners redundant? I don't think so. Any sophisticated health system depends on government and broad-scale community support, with citizens contributing to deciding its shape and polity. This includes assessing the qualifications, experience, skills, ethics and character of practitioners authorised to offer health services.

I was never greatly impressed with the easy flow across borders in the European Union. Rather, it was one among several manifestations of diminished recognition of distinctive cultural and, especially, linguistic differences, along with the associated monetary policies which have plagued the EU.

Conclusion

Globalisation gathers strength from new technologies – especially in travel, communication and trade. It brings huge benefits for medicine, but with them comes the challenge of maintaining access to care in the face of inevitably rising costs.

Keeping control over the movement of doctors into Australia might sound draconian, but the market has no credible claim to meet these goals of a civil society. Likewise, with the movement of patients internationally having good and bad elements, the market alone is insufficient to ensure ethical and socially responsible professional behaviour.

At the end of another year, we should thank our lucky stars that we live in Australia.

My Christmas greetings to you.

Roundtable highlights pressing rural health issues

BY DR HIROWATARI, CHAIR, AMA COUNCIL OF RURAL DOCTORS

Last month, Assistant Minister for Rural Health Dr David Gillespie chaired a Roundtable of Rural Health Stakeholders.

I was privileged to be in the company of about 20 leaders in rural health. Our friends from the Rural Doctors Association of Australia, Australian College of Rural and Remote Medicine, the Royal Australian College of General Practitioners and the Australian Indigenous Doctors' Association were there, as well as representatives from nursing, midwifery, allied health, dentistry, medical education and students. We were all from rural Australia and all passionate about the need to discuss the challenges of providing rural primary health care.

Dr Gillespie clearly was listening to us all. The proof of this was that he paraphrased what was said in his own words and from his perspective. An idea sounds new when another person takes the thought and views it from a different angle.

This was a true roundtable, where attendees were questioned around the table. I was glad to see that women made up half the roundtable, and there were three Indigenous representatives.

Rural Health Commissioner

The Rural Health Commissioner will not be announced until there is a legislated position created.

This is to ensure the Commissioner will be at arms-length from the Government and able to provide politically unbiased recommendations. So we won't find out who will be leading the Commission until the autumn sitting of Parliament.

The attributes of the commissioner?

The adjectives flew around the table: knowledgeable about the industry; impartial; reasonable; articulate; ability to work in alignment with a multidisciplinary caregivers; a change agent; a worker; an educator; a hero for the rural patient. Someone said this person sounds absolutely awe-inspiring.

The job of the commissioner?

The wish list was huge: dental program, midwifery support, podiatry in all areas of the Outback, physiotherapy, tackling Indigenous suicide, mental health issues, liaising with the public, address the social determinants of health. Nurses expressed a wish to increase the scope of practice, to prescribe.

The focus the job?

The focus should first be the rural generalist pathway. Focus on "doability". Focus on things that are working, and build on them.

Dr Gillespie summarised by saying the Rural Commissioner cannot be a fairy godmother - He or she could not deliver the whole wish list, and would struggle to do all the work hoped for given that the pie was not big enough.

Rural generalist pathway

It was agreed that the Queensland pathway, although the most mature and established, will not work for all regions. Suggestions included the need to teach "rural clinical courage", described as the ability to be alone, rural and competent. Stakeholders begged that the pathway be flexible in terms of entry, exit, and mobility between private clinics and public hospitals, including the freedom to be educated in the cities. It was agreed that the end of the pathway should be with either of the colleges.

It was pointed out there is a need to make the program a national one, with consistent remuneration, expectations and standards. Also that it should not be a "tack on" to the end of medical training, but rather permeating throughout training. To that end, rural candidates should be identified even before the start of training.

Dr Gillespie made it clear that not all the funding could come from the Federal Government, and that the States needed to contribute. The possible participation of private corporations was also discussed.

Since the pathway is to train only doctors, the allied health and non-medical participants expressed a wish that their fields also had a rural generalist pathway.

Other initiatives

The roundtable also discussed Health Care Homes and workforce retention.

I was disappointed that we did not discuss recent changes to the PIP program which, among other things, will see the end of the Indigenous Health Initiative PIP - a disaster for those of us working in Aboriginal medical services.

My one victory at this meeting was advocating for a longer meeting next time. Those attending came from all parts of rural Australia, and four hours of discussion was just not enough.

The next roundtable is set for April next year.

Bowie is dead; long live Bowie

BY **DR JOHN ZORBAS, CHAIR, AMA COUNCIL OF DOCTORS IN TRAINING**

Twenty years from now, when you're sitting at your quiz night table, I've got a safe bet for you. If the question starts with "in what year…" the answer will be 2016. Harambe, Brexit, Syria, the South China Sea, Trump. The list goes on, and on the whole it hasn't been a year of rainbows and sunshine. Some would argue that David Bowie was the glue holding the universe together and it's all going to be downhill from here. I'm inclined to believe that to some extent.

There's one thread in the public commentary that I'd like to focus on, as it has strong implications for the delivery of health care in Australia.

There has been a rash of articles trying to make sense of the social and political turmoil that seems to be spreading across the world.

John Brogden, of the Australian Institute of Company Directors, made an interesting observation on public policy in a 2016 kind of world. He stated that, "public policy reform was achievable if there were more winners than losers; now there can be no losers at all". It's not-in-my-backyard-ism on a global scale, and the sentiment is growing.

Coupled with a parliamentary age in which minority and marginal governments have become the norm as a manifestation of this discomfort, it's near impossible to get meaningful reform across the line. This leaves us with a health care system where real modernisation is an extremely difficult task.

We're starting to see fringe ideas gain mainstream acceptance, and this is a problem for patients around Australia.

Rapid fringe solutions to health care problems almost always involve someone other than doctors and nurses trying to fix the problems of patients. They almost always trade efficiency and expense against quality and safety, and this does not serve the interests of Australians as a whole.

Patients do not have the ability to command front page headlines in newspapers. Patients do not lobby government in a regular and organised fashion to advance minority opinions. Most importantly, patients are patients because they are suffering from ill health, and this has a nasty habit of reprioritising your life against your will; when you are sick, you lose the luxury of independence.

The AMA is often cited as a politically powerful organisation, and this air of mystique often brings with it ideas of malice and self-interest. We've seen this during the public debate on euthanasia, where bodies and people with a fringe understanding of the AMA have tried to discredit the stance of the AMA as "special interest by stealth".

Having seen the time and effort that has been put into this year-long process of review on our position, I can confidently state that this is just blatantly untrue, and the truth is much more boring than the conspiracy.

On an issue as divisive as euthanasia, the fact that a workable position was even attainable is nothing short of a miracle.

This isn't by accident though.

Every single decision the AMA makes has the patient at its centre. Respect, autonomy, justice, beneficence and non-maleficence. These aren't just words that doctors throw around. They're at the core of every decision we make on a daily basis.

The world is full of sarcastic people who can easily roll their eyes at the idea of a beneficent AMA, but they have the luxury of never having to supply evidence to support their position, nor are they ever forced to challenge often incorrect preconceived notions.

So, let's return to our quiz night. In what year did the AMA help to repeal areas of the Border Force Act that prevented doctors for reporting the mistreatment of refugees?

In what year did the AMA complete a year-long review on euthanasia, and conclude that the will of patients and the legislature should be our prime motivator for change, with a focus on protecting the vulnerable patient?

In what year did the AMA form an Equity and Diversity Committee to review its internal structures around gender equity and equal opportunity?

In what year did the AMA fiercely lobby Government for the protection of pre-vocational doctors, a group at increasing threat on a year-on-year basis, while others decided "she'll be right mate"?

In what year did the AMA lead the public charge on obesity and sugar control?

In what year did the AMA again call attention to the travesty that is rheumatic heart disease in the most remote corners of Australia?

2016. And you should be proud to have been a part of it.

Here's to 2017; a year full of rainbows, sunshine and Bowie.

Mind-altering drug a (legal) Australian obsession

BY **ELISE BUISSON**

In my late teens I went overseas for the first time - a week in Bali with my prolific traveller of a mum.

My first time experiencing a new culture, every sight left me awed. I was struck by the towering temples; by the creative approach our bus driver took to the road rules; and by the audacity of the Balinese long-tailed macaque that hitched a ride on my backpack when I got too close.

However, even among all of that, it didn't take long to see my own culture reflected back at me. Walking down the street in Denpasar, my mum and I passed a bar with a large chalkboard sign: "Australians: Get Drink, Get Drunk, Fall Down, No Problem Mate!"

We've recently seen a rekindling of the national debate on illicit substances.

The 'war on drugs' rages on and, despite being described as a battle, there are no signs of impending 'victory'. Political parties debate the merits of a rehabilitation and treatment approach that supports recovery, against a law and order approach that wins votes and makes the general population feel safe.

A spokesperson for Health Minister Sussan Ley recently urged caution to those promoting the legalisation of illicit drugs, saying: "the Australian Government will never legalise a drug that destroys brain function, mental wellbeing, general health, employment, relationships, lives and families."

Of course, we have such a drug. It's legal, it's available at every shopping centre and the average Australian takes their first full dose aged 15.7 years.

Overlooked in the drug debate is the Australians' dramatically different attitude to our nation's most widely used mind-altering substance - alcohol.

When the National Binge Drinking Campaign ("Don't turn a night out into a nightmare") was announced in 2008, the Government released background information regarding their decision to target this safe drinking message at young Australians.

Those figures showed that more than 20 per cent of 14 to 19-year-olds consumed alcohol on a weekly basis, and that around 40 per cent drank at levels that risked imminent harm - which doesn't begin to take into account the accumulative health risks later in life. It was also noted that the 15 to 24-year age bracket accounted for 52 per cent of all alcohol-related serious injuries, and 32 per cent of all alcohol-attributable hospital admissions for violent injuries.

We, as Australians, hold a national reputation as an island of drinkers. 'Cheers' when we're happy; 'I'll buy this round' when we're socialising; 'Let's get you a drink' when we're sad. It's part of our social fabric. As Schoolies Week wraps up and 18-year-olds stagger home from their hotels on the Gold Coast or in Bali, that drinking culture is alive and well in the next generation of Australia's youth. Where does our nation go from here?

In setting goals and achieving change, author Mark Manson has a perspective that's applicable even to national problems. He makes the point that while everyone wants to achieve their goals (Get fit! Become a famous singer-guitarist!) few have the same enthusiasm for the sacrifices inherent to those achievements (Aching muscles! Years of low-paying pub gigs while living in a share house subsisting on a diet of two-minute-noodles!). He says that in order to set goals we can reach, we should instead begin by asking ourselves, "What is the pain that you want to sustain?"

To change our drinking culture, what kind of pain are we up for?

Toppling drinking from its prominent place in Australian culture will be painful - it will leave a gap in our way of relating with one another that will need to be filled. But that pain will be representative of a significant step towards a happier, healthier, better-connected society.

The alternative is the pain Australia is currently suffering, and that is pain that we as a society cannot tolerate. It is the pain of young lives lost to alcohol-fuelled road accidents, the pain of families and communities devastated by a single coward's punch.

Alcohol is a drug that destroys brain function, mental wellbeing, general health, employment, relationships, lives and families. For the sake of our young people today and for generations to come, let's choose growing pains instead.

Regulation of the medical profession

BY **DR ROBYN LANGHAM**

The Australian Health Ministers' Advisory Council and the Medical Board of Australia have kept the Medical Practice Committee busy with two major projects this year: the proposed revalidation scheme in Australia and the Independent Review of Accreditations Systems within the National Registration and Accreditation Scheme (NRAS).

We have recently been formulating the AMA's submission to the Medical Board of Australia's interim report on Revalidation. Because of the far reaching implications of the proposed system, this submission was also considered by Federal Council prior to lodgement with the Medical Board.

The AMA has been working with the Medical Board from the start of the process to help in ensuring a sensible approach to revalidation in Australia. Our fundamental principle has been to only support a revalidation system where the benefits to the community clearly outweigh the costs.

The AMA has consistently argued that if any form of revalidation is to be developed and introduced, the Medical Board must clearly define the problems it believes exist, and demonstrate that its proposed response will address these problems, especially given that only a small proportion of doctors are the subject of formal complaints from patients or colleagues.

Our submission advocates that the colleges, societies and associations be fully involved in the development of any changes to CPD requirements to minimise the risk that 'the goal posts will be moved' once a system is in place.

The submission also notes that without a problem or an end goal, the impact of a proposal to mandate a strengthened CPD program remains unknown.

We do not support the '*At risk and poorly performing medical practitioners*' proposal in its current format. This proposal requires considerable further development before it can be properly considered. Any further changes to the requirements should simply enhance the operation of the existing regulatory system, rather than impose an additional burden.

The AMA has requested that the Medical Board consider the feedback received from the public and the medical profession and refine their proposal with a view to conducting another round of consultations with the profession.

The Australian Health Ministers' Advisory Council has commenced the Independent Review of the Accreditation System within the NRAS and appointed Professor Michael Woods as the independent reviewer on 10 October 2016.

The Accreditation Systems Review will address:

- the cost effectiveness of the existing systems for the delivery of accreditation functions;
- governance structures, including reporting arrangements;
- opportunities for streamlining accreditation processes, including consideration of other educational accreditation processes;
- the extent to which accreditation arrangements support educational innovation in programs including clinical training arrangements, use of simulation and inter-professional learning; and
- opportunities for increasing consistency and collaboration across the profession.

The Medical Practice Committee considered the implementation of the NRAS and noted that the NRAS has met the expectations of the medical profession in respect of:

- registration arrangements that enable medical practitioners, who are qualified and safe, to work anywhere in Australia;
- independent accreditation of medical education and training that meets international guidelines; and
- medical practice registration standards set by the Medical Board, with clear jurisdiction over all health care provided by medical practitioners.

Committee members also agreed that while there is a robust process to oversee applications for prescribing by non-medical practitioners, there remain concerns that patient safety has not been a primary focus.

Of greater concern were non-medical practitioner bodies setting guidelines that seek to increase their scope of practice without any independent oversight.

The first issues paper on governance arrangements for the scheme has been disseminated and the Medical Practice Committee will shortly be developing a submission to this review. The paper focuses on the governance structures within the NRAS, with a view to removing gaps in the accountability arrangements for the scheme.

The AMA submission is due on 23 December.

Plenty of grads, but where are the training places?

BY AMA VICE PRESIDENT DR TONY BARTONE

At the recent AMA Medical Workforce Committee (MWC) meeting I was reminded that 20 years ago the Federal Government was pushing the idea that Australia had far too many doctors. This was driving widespread over-servicing of patients and sending health spending out of control by hundreds of millions of dollars, or so we were told.

Though there was never any hard evidence to justify these claims, they drove the Government's conscious decision to restrict the growth in medical student numbers and make it harder for foreign doctors to work in Australia. For most of us in the profession it was clear, even then, that the country was facing a big shortage of doctors.

Successive governments have listened to the profession and the public and acted to address workforce shortages by increasing the number of medical student graduates from 1500 a year in 2004 to an estimated 3700 by 2018. The most recent Health Department data shows there are nearly 17,000 students training in our medical schools at the moment. Indeed, I understand that we are now graduating more doctors than most other OECD countries.

What is patently clear, even to the most casual observer, is that for this large cohort of new medical students coming through our university system, post-university training needs are more acute than ever.

It makes no sense to ratchet up the levers on entry training without a commensurate focus on the postgraduate training pathway - a pathway needing not only an increased number of accredited training positions, but also positions with sufficient flexibility and geographic spread to cater for an increasing diversity of training requirements and trainee needs.

Australia's substantial investment will be wasted, and the desired future medical workforce outcomes lost, unless complemented with comprehensive workforce planning arrangements and extra training places for these graduates once they have finished their courses.

What especially worries the MWC is the lack of attention being paid to improving vocational training capacity and ensuring this larger workforce is evenly distributed by location and specialty so it can meet the expected community demand for medical services.

Let's look at the problem in more detail. Health Workforce Australia's final medical workforce report made projections to 2030. These made it clear that Australia is struggling to provide adequate numbers of training positions for junior doctors. For specialist training positions, HWA's modelling said that by 2018 there would be a shortfall of 569 first-year advanced training places, worsening to 689 places in 2024 and to 1011 places in 2030.

Too many people think medical training ends at the university gates.

Policymakers and the public have failed to recognise the magnitude of the problem, and not enough effort is going into finding the required vocational training places.

The situation is not being helped by the performance of the National Medical Training Advisory Network (NMTAN), the Commonwealth's main medical workforce advisory body.

It was due to deliver a snapshot of workforce status in almost a dozen craft groups by the end of this year. Currently, only two have been formally released (anaesthetics and psychiatry), with another two very close to release. General practice has been delayed to at least the end of 2017.

NMTAN's vital workforce modelling program is well short of what is required, and the organisation is being diverted from delivering on this core function by irrelevant activities imposed on it by the Department of Health. There is an increasing belief that timeframes for delivery of the reports will blow out significantly, making meaningful planning very problematic.

This is something we are actively and robustly taking up with the Minister. Vocational training will continue to be a significant high priority for the MWC.

Health on the hill

POLITICAL NEWS FROM THE NATION'S CAPITAL

Rural GPs teaching grants streamlined

GPs applying for Federal Government grants worth up to $300,000 to upgrade their teaching and training facilities will have access to a simplified two-step process under changes announced by Assistant Minister for Rural Health Dr David Gillespie.

Dr Gillespie has announced that grants will be available under the new Rural General Practice Grants program, which is a streamlined version of the former Rural and Regional Teaching Infrastructure Grants program.

"General practice in rural Australia faces unique challenges in health care, including the ability to attract and retain a health workforce," the Minister said. "The RGPG program will enable existing health facilities to provide teaching and training opportunities for a range of health professionals within the practice, and for practitioners to develop experience in training and supervising health care workers."

The program provides grants for a range of works, including building, fitting out and renovating existing general practices, and the supply and installation of IT, communications and medical equipment.

"I want our health professionals who live and work in rural, regional and remote Australia to have access to teaching and training opportunities so they remain in general practice, and in the communities that need them the most," Dr Gillespie said.

ADRIAN ROLLINS

Call to cut doctors from skilled migration program

Australia has "more than enough" doctors to meet its long-term needs and should remove all medical occupations from the Skilled Occupations List that is used to underpin independent applications for permanent residency, the AMA has said.

The Association has told a Federal Government review of the Skilled Occupation List that a surge in the supply of medical graduates in the past decade means the country is quickly shifting away from its reliance on international medical graduates (IMGs) to plug gaps in the workforce.

Instead, it has urged a shift in policy focus toward improving the distribution of doctors by encouraging locally trained practitioners to work in under-served specialties and locations.

The number of medical students has soared from 2004, when just 1500 graduated. It is expected that there will be 3700 medical graduates in 2018, and modelling by the now-defunct Health Workforce Australia indicated there could be an oversupply of practitioners by 2030.

The AMA said IMGs had played a critical role in helping fill gaps in the medical workforce caused by a past under-investment in medical schools, but that reliance was coming to an end with so many future doctors in the training pipeline.

Instead, it warned the country was in danger of wasting its substantial investment in undergraduate medical degrees because of a shortage of postgraduate training places.

HWA has predicted that, without a boost in funding for postgraduate training, there will be a shortage of 569 specialist training places a year by 2018, rising to a shortfall of 1011 places by 2030.

"Too many people think medical training ends at the university gates," said AMA Vice President Dr Tony Bartone. "Policymakers and the public have failed to recognise the magnitude of the problem, and not enough effort is going into finding the required vocational training places."

The AMA said the situation meant the country needed to reduce its reliance on skilled migration, and any short-term workforce needs could be met through other avenues of migration such as the 457 visa program and employer sponsored migration.

"The available data highlights a potential medical workforce oversupply, and shows that there are more than enough doctors in the medical training pipeline to meet our medium-to long-term medical workforce needs," the Association said. "HWA recommended that the policy focus needs to shift towards encouraging locally trained doctors to work in the specialties and locations where they are needed, and we think this is the right approach."

Health on the hill

POLITICAL NEWS FROM THE NATION'S CAPITAL

There are currently 33 medical occupations on the Skilled Occupation List, including GPs, surgeons, anaesthetists, cardiologists and oncologists, and the review of the List comes amid mounting political tension over skilled migration.

Last month the Government announced a crackdown on 457 visa holders, giving those who have lost their jobs just 60 days to find a new one or face deportation, down from 90 days. The change came just hours after prominent conservative Coalition backbencher George Christensen called for a total ban on 457 visas for central and northern Queensland.

But Deputy Prime Minister Barnaby Joyce has mounted a strong defence of 457 visas for foreign doctors.

Writing in the Guardian, Mr Joyce said that many rural areas relied on doctors working on 457 visas to provide vital health care because so many locally trained medical professionals chose to work in metropolitan areas.

"When a home grown workforce is either unavailable or reluctant to move to regional Australia, we don't see 475 visa holders as a threat, we see them as a benefit," the Nationals leader said.

ADRIAN ROLLINS

Govt refuses to budge on Health Come Homes trial

Health Minister Sussan Ley has rebuffed medical profession calls for the Health Care Homes trial to be pushed back.

United General Practice Australia (UGPA), which includes the AMA, the Royal Australian College of General Practitioners and other medical representatives, warned the Health Care Homes pilot project, due to start on 1 July 2017, has been rushed, and urged the Federal Government to delay it by at least three and six months.

UGPA said the Government's haste in beginning the trial put the reform at risk.

"The implementation of the Health Care Home, including the model, the tiers and supporting practice tools, has been rushed and risks undermining this vital opportunity to get the model right," the peak GP group said.

"An extended timeline would allow the profession time to ensure the instruments and tools being used are appropriate and validated by evidence.

"This will allow a comprehensive understanding of the framework and ensure we get the funding mechanisms right in order to support the roll out of the pilot."

The appeal follows warnings that the entire reform could collapse because of a lack of funding.

The Government has allocated $100 million to support the phase one trial of the reform, which involves 65,000 patients and 200 medical practices in 10 regions across the country.

Under the Government's plans, practices will receive monthly bundled payments worth an average $1795 a year to manage patients with chronic and complex health conditions. Payments will vary from $591 for chronically ill patients who can largely self-manage their condition to $1267 for those who need more intensive care and $1795 for those with the most complex health demands.

The allocations mean that patients on the lowest level of subsidy will be funded for just 16 visits to the doctor a year, rising to 48 visits a year for those deemed in greatest need.

But Ms Ley has stood firm on the Government's arrangement, despite GP concerns.

The Minister ruled out delaying the trial or providing additional funding.

"It is voluntary for medical practices and patients, and no doctor is required to participate if they do not want to," she said.

Ms Ley welcomed the input of the AMA and other organisations and promised to listen to suggestions, but she insisted the Government would stick by its timetable for the roll-out of the scheme.

It means medical practices that want to participate will have until just 15 December to lodge an Expression of Interest.

Nonetheless, the Minister said the Health Department would "take advice" on key factors associated with the trial, and promised to consider any advice received regarding its effective rollout.

ADRIAN ROLLINS

The Big Man tells all

BY **DR MICHAEL RYAN**

A unique opportunity was seized upon when, through a friend of a friend, an acquaintance who was divorced from someone's sister told me that Santa was doing a "recon". Apparently he was feeling jovial and granted me an exclusive interview.

At first I thought I could discuss world peace or ask how the new non-gender discrimination of toys was going etc. But, through a casual remark, he started telling me about some of the beverages that had been left for him, especially from the medical world. The following is a brief but true description of his tale.

"Hmm, neurosurgeons. They can be pretty uptight and precise. Not super flashy but, like to let you know they are at the top of their game. So, often I find a good glass of vintage champagne, say a 2008 Paul Louis Martin Blanc de Blanc, 100 per cent Chardonnay, with a deep yellow colour and soft, fine beads of bubbles. The nose is fresh with peach and citrus notes. The aging toasty aromas are starting to develop. Full sweeping fruit and acidity make this a well-structured wine.

"Orthopaedic surgeons. Most of them are mad wine drinkers, with a penchant for Pinot Noir, sorry, I mean Red Burgundy. Once this ortho from Toorak left me a vertical tasting of four vintages of Nuit Saint Denis. But I must say his poorer country cousin from Ipswich did leave me some 1994 Bass Phillip Pinot Noir from Gippsland. Strawberries and truffles and funky notes with a broad sustained palate really excited me.

"Plastics. These guys are a bit regionally variant, say the flashy Gold Coast or the Hunters Hill mob. But they all seemed to have discovered Nebiollo from Piedmont in Italy. No doubt on their way to the fashion capital Milan. A patriotic plastics guy left me out an Amant Margaret river Nebiollo - complex nose of plums roses and herbal notes. Juicy palate, but a little less tannin than the Italian ones.

"Breast surgeons. This amazing female breast surgeon, who once helped Mrs Claus, left me out a sensational but sensible wine. A David Franz Adelaide Hills 2014 Brothers Ilk Chardonnay. Vibrant yellow colour. A bouquet of white peach, lemon and hints of funky lees notes. The palate was sublime, with hints of lemon curd and supporting acids. It was a Goldie locks wine – just right.

"Family physicians. Yes well, these guys have hearts as big as Texas. Occasionally a grateful patient gives them a good tipple for Xmas. In their true spirt they will often leave me a taste. Usually a good decent Shiraz does the trick, like a Woodstock, the Stocks 2008 Shiraz. Deep red to purple with aging brown colour. A complex nose of stewed plums and dates, but with McLaren Vale spicy notes. Luscious palate and great tannins.

"Anaesthetists. They are like nocturnal animals; you know they exist, but it's hard to see them. A Riesling is often their choice. They know it's understated and shunned by most. But they realise its potential. A Frenchman's Cap 2015 Tasmanian Riesling made by Julian Alcorso hit the spot. I know Julian well, and he has just retired from winemaking. The wine has a classic Coal River bouquet of melon and limes. The palate appears rich and there is an amazing raft of acidity. Julian, Santa will miss you. Maybe I'll visit you on your yacht, The Last Vintage.

"There are many more specialties I could go onto. But it is always a privilege to sample these gifts from a group of people who are sometimes underappreciated, attacked from all sides of politics and bureaucracy, not to mention medico-legal areas.

"Doctors do this from an innate sense of caring, and it is not about the money (or, in the case of GPs, the lack thereof).

"So, when Santa tries these wines he feels the love.

"Merry Xmas everybody Ho (hic) Ho."

Jaguar XE - the best of British

BY DR CLIVE FRASER

In 1600 the English East India Company was established to exploit the riches of the Far East.

Trading with Asia meant that Britain would need something to sell to its Far Eastern trading partners.

From 1730, India was the conduit via which illegal opium went to China and tea and spices were shipped back to England.

When China confiscated 20,000 chests of opium in 1839, England responded by confiscating a small island off the Chinese coast named Hong Kong.

But the British always saw India as its most valuable Asian asset.

Over nearly 350 years Britain extracted tons of tea, mountains of spices and piles of precious stones from India.

By the time of Indian independence in 1947 the British had left behind a legal system, democracy, railways and a game called cricket.

Fast forward to 2008 and a reversal of fortunes, when the Indian-based Tata Group purchased the iconic British brands Jaguar and Land Rover.

Under Indian ownership these brands have gone from strength to strength.

Last year, Jaguar launched an all new mid-sized XE model.

The previously released X-Type from 2009 was, disappointingly, just a re-badged Ford Mondeo.

But the Jaguar XE is mostly not borrowed from a parts bin.
It has a new Ingenium diesel motor coming from Jaguar's Wolverhampton factory, and an all-new aluminium monocoque body assembled at Solihull.

My first Jaguar XE experience began compliments of a colleague who'd traded in his one-year-old Mercedes C250 for a Jag.

He just didn't like the harshness of the Mercedes run-flat ride or the noisiness of the Mercedes diesel.

The petrol XE Jaguar was definitely ahead of the Mercedes on both fronts.

While the Mercedes C-Class is undoubtedly attractively styled, the Jaguar XE is also particularly pleasing to the eye.

That styling does seem to limit the space in the rear seat though.

Under the bonnet there are four engine options, starting with a 2.0 litre four cylinder petrol with either 147 kW or 177 kW.

Then there's Jaguar's 2.0 litre four cylinder Ingenium diesel with 132 kW.

The Ingenium diesel engine is a modular design which can be mounted longitudinally or transversely.

Finally, there is a 3.0 litre super-charged V6 with 250 kW.

Performance from the lowest spec petrol engine is acceptable rather than outstanding, taking the driver from 0 to 100 kilometres per hour in 7.7 seconds.

There is an eight-speed ZF automatic transmission.

As usual, the ride and handling of the Jaguar are its outstanding features.

It has double wish-bone suspension and electric power steering, which has excellent feel.

So how will the Jaguar XE fare against its German competitors?

Pretty well, I think.

While the pricing is on a par with rival BMW, Audi and Mercedes models, servicing costs are way less.

There also seems to be plenty of room to negotiate a deal, as my colleague found out when the Jaguar salesman offered him $20,000 more on his C250 as a trade-in.

And just in case anyone is wondering how my colleague was offered such a great deal, I can assure you that no opium was exchanged.

Safe motoring,

Doctor Clive Fraser
doctorclivefraser@hotmail.com

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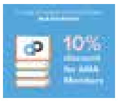

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