AUSTRALIAN

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The national news publication of the Australian Medical Association

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AMA LEADERSHIP TEAM

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Dr Michael Gannon

Vice President
Dr Tony Bartone

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Cover: Lets make this a regular thing: AMA President Dr Michael Gannon meets with Health Minister Sussan Ley at Parliament House just days after the Coalition wins the Federal election

Prescribing better health spending

BY AMA PRESIDENT DR MICHAEL GANNON

In health policy, the last two years have been dominated by co-payments, freezes, funding cuts and a multitude of reviews – largely in the name of protecting the Government's Budget bottom line.

The Government has consistently argued that health spending in Australia is out of control.

The AMA has equally consistently argued that we do not have a health spending crisis, and we have called for better targeted funding of the things that work in health – prevention, general practice, finding the balance between public and private medical care.

We are backed by reputable economists and statistics from credible organisations like the WHO and the OECD.

The AMA strategy is about investing in the parts of the health system that will deliver better health outcomes – and importantly, savings – over time.

Our strategy – our thinking, our policies, our advocacy – is powered by first-hand experience, face to face with patients every day of the year in every part of the country at the very frontline of health service delivery in our practices, in public and in private hospitals. The Government does not have this key vantage point.

We know where new investment must be made. We know where savings can be made.

That is why doctors must be at the core of health policy and health funding.

To reinforce this key role, the AMA recently released two Position Statements, which were developed in my time as Chair of the Ethics and Medico-Legal Committee:

- the Doctor's Role in Stewardship of Health Care Resources; and
- the Role of Doctors in Stewardship of Healthcare Financing and Funding Arrangements.

These Position Statements stress the need to avoid waste, ensure health funding is directed to achieving health outcomes, and aim for sustainability.

They also stress the need for clinical input into decision-making.

Doctors are important stewards of health care funding and resources, and good stewardship is an important part of ethical, best practice care.

We, as doctors, must balance our obligation to minimise wastage of resources with our primary obligation to care for, and protect the interests of, individual patients.

Individual doctors affect health care expenditure through our clinical recommendations and decisions regarding patient treatment.

We can all apply practical stewardship in our everyday practices through appropriate clinical decision-making, minimising diagnostic error, and eliminating tests, treatments, or procedures that are unnecessary, inappropriate, or unwanted by our patients.

As the key clinicians and health care providers in the Australian health system, we have a direct interest in the overall resourcing, performance, and sustainability of health care across the nation.

Doctors must have an active role in the operation of health care financing and funding processes. We must be involved in decisions on the allocation of resources at the system level.

If we do not, there is a significant risk that health policy decisions will be driven primarily by the financial and political imperatives of governments, instead of positive public health outcomes.

To put it another way, health outcomes could be dictated by Finance and Treasury bureaucrats instead of frontline doctors. They might approve a new medical school, rather than look at measures that actually improve the care enjoyed by Australians in rural areas.

This is how governments can, and do, make big mistakes.

We have seen this too often in recent times with the flawed co-payment policies, the Medicare freeze and expensive, inefficient task substitution flops.

As the AMA attempts to embark on a positive consultative relationship with the new Government, the ethical imperatives of careful medical stewardship will be at the heart of our advocacy.

Health Care Home success depends on GP goodwill

BY AMA VICE PRESIDENT DR TONY BARTONE

General practice is the corner stone of primary care. I am sure you will all agree with this. General practice in Australia has an exemplary record compared with many other countries around the world. It is efficient and extremely low cost, especially compared with an uncomplicated ED presentation.

The public, and the public purse, is extremely well served by general practice. The cost of MBS expenditure on general practice is just 6 per cent of total Government spending on health. Fee for service (FFS) has been the predominant funding model of general practice over that time.

> "Under the model, patients have a continuing relationship with a particular GP to coordinate the care delivered by all members of the patient's care team"

The Government's Health Care Home (HCH) is a model of care for patients with chronic disease. It is also known as the Medical Home. Under the model, patients have a continuing relationship with a particular GP to coordinate the care delivered by all members of the patient's care team.

Do we need it? Especially when we consider the exceptional current performance and achievements of GP in Australia?

The significant twin burdens of burgeoning chronic disease and advancing age presentations are challenging the economic resources for delivering primary care. In an environment where fiscal resources are tight, the FFS model's ability to cope with the pressure on the public purse is under the microscope.

Superimpose this on years of cuts to GPs - years of continued underfunding and non-investment by successive governments in general practice has brought GPs to the brink.

BEACH data shows that GPs are managing more chronic disease than ever before. GPs are already under substantial financial pressure due to the Medicare freeze and a range of other funding cuts. The HCH model is certainly not a way for the Government to arrange funding to general practice in the current Medicare rebate freeze environment.

The Medical Home is fundamental to the concept of the family doctor who can provide holistic and longitudinal care and, in leading the multidisciplinary care team, safeguard the appropriateness and continuity of care.

All this is academic if the funding for HCH is not appropriate, and not simply at the expense of FFS. Which brings us to the trial (or as the Health Department wishes to view it, as phase one of the implementation).

In March, the Government committed $21 million to allow about 65,000 Australians to participate in an initial two-year trial involving up to 200 medical practices from 1 July 2017. This funding is not for services, just for the infrastructure required to support the trial, as well as its evaluation.

The Health Department is busily preparing for this implementation. There is a hive of activity as it seeks to implement this key part of the Government's strategy for reform. The overarching implementation advisory group will liaise to ensure that best practice and appropriate strategies are followed in the trial. AMA is on both the implementation group and underpinning subgroups involved in the mechanics of selecting patients and the economics of payment mechanisms.

The next few months will see many announcements, including the identification of the Primary Health Network (PHN) regions and an invitation for expressions of interest from practices in those regions to be part of the trials. The success of this policy initative will also depend on developments and further progress on the MyHealth Record and the PHNs (not without their challenges also).

The Department rightly understands that the goodwill of GPs is crucial for the success of the trial.

That goodwill will evaporate significantly if there is not the appropriate funding. However, I have made it clear that with additional funding support, GPs can provide more preventive care services and greater management and coordination of care. More important still, they can keep patients healthier and out of hospital, saving unnecessary and more expensive presentations and hospital admissions down the track - a measure which will form a key part of the evaluation of the success of the trial.

Member expertise informs AMA policy

BY AMA SECRETARY GENERAL ANNE TRIMMER

"There is a substantial process to the development of AMA policy which evolves within the councils, committees and working groups of the AMA Federal Council, often in response to current issues"

One query often received in the secretariat of the AMA is about how AMA policy is formulated. This question has arisen recently following the change in the leadership of the AMA with the election of Dr Gannon as President and Dr Bartone as Vice President, prompting people to ask whether the leadership change affects AMA policies.

There is a substantial process to the development of AMA policy which evolves within the councils, committees and working groups of the AMA Federal Council, often in response to current issues.

The deliberations of the councils, committees and working groups are informed by background research and advice from the secretariat and, increasingly, from expert advice available from AMA members.

Under the AMA's Constitution, the Federal Council is vested with responsibility for the organisation's medico-political policy. It is the Position Statements and policies approved by Federal Council that inform the public comments of elected AMA leaders.

The work of Federal Council is far-reaching, covering policies as diverse as health financing and economics; medical workforce; medical practice; and training. This is in addition to the specific agendas of the five major councils of Federal Council.

The policy considerations reflect the objects of the AMA as set out in its Constitution – to look after the interests of the members of the AMA across all facets of their lives, to promote the wellbeing of patients, take an active part in the promotion of health care programs for the benefit of the community, and participate in the resolution of major social and community health issues.

The second objective, in particular, ensures that the AMA addresses many public health issues that affect patients and the communities in which they live.

Public health issues currently under review by working groups of Federal Council cover a wide range of subject areas including addiction, firearms, obesity, foetal alcohol syndrome disorder, blood borne viruses, and rheumatic heart disease.

The Position Statements that are developed by the working groups and finalised by Federal Council serve to inform members and the public at large, as well as to guide the AMA's advocacy.

From time to time Federal Council also considers policies developed by the World Medical Association, of which the AMA is a member. WMA considers its policies at the twice-yearly meetings of its Council and annual meeting of its General Assembly.

Among current areas of work are consideration of medical tourism, the use of bio-banks, obesity in children, boxing, and medical cannabis.

The AMA draws on its own policies and Position Statements to inform its input into WMA policies.

With increased use of working groups, the Federal Council has been able to draw on the expertise of members who may not sit on the Council, but who have substantial specialised knowledge to contribute. Over coming months, members will be invited to indicate areas of special interest which will be recorded in the member database. This will assist to identify members with interests in specific areas of AMA advocacy for future communications.

Talk to doctors to avoid mistakes, Govt told

AMA President Dr Michael Gannon has urged the Federal Government to directly involve doctors in its health funding decisions to avoid repeating "big mistakes" like the Medicare rebate freeze and GP co-payments.

Dr Gannon, who has met with both Prime Minister Malcolm Turnbull and Health Minister Sussan Ley in the aftermath of 2 July Federal election, said the Government needed to heed the advice of doctors working at the frontline of the health system if it was to devise policies that improved health outcomes while making best use of limited resources.

"Doctors must be involved in decisions on the allocation of resources at the system level," the AMA President said. "If we [are] not…health outcomes could be dictated by Finance and Treasury bureaucrats instead of frontline doctors. They might approve a new medical school, rather than look at measures that actually improve the care enjoyed by Australians in rural areas. This is how governments can, and do, make big mistakes."

Dr Gannon made his comments amid mounting speculation the Government, which has a slender one-seat majority in the House of Representatives and does not have the numbers in the Senate, will backtrack on Medicare rebate freeze before the next election, due in 2019.

"I would be gobsmacked if the Government took an ongoing freeze to the next election," the AMA President said. "They got the scare of their life on health, and that was probably the policy which hurt them the most."

Health industry analyst Andrew Goodsall, of investment bank UBS, put the chances of a U-turn on the rebate freeze at 75 per cent because it was unlikely the Government would want to take the contentious policy to the next election, due in 2019, given its influence on the most recent poll.

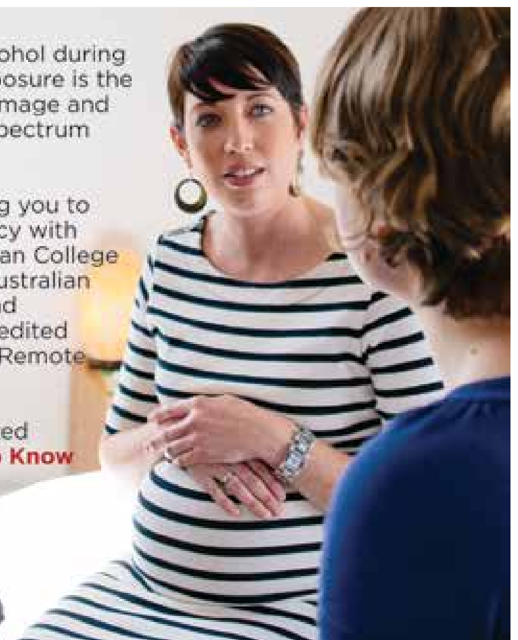
The policy is also drawing the ire of the states. A briefing note from the Victorian Government, reported in *The Age*, estimated that the decision to extend the rebate freeze for an extra two years would cost the State $230 million because of an increase in the number of patients choosing to seek treatment at public hospitals rather than their GP.

Do you know that more than 25% of Australian women continue to drink during pregnancy?

We know that it is safest not to drink alcohol during pregnancy, and that prenatal alcohol exposure is the most preventable cause of fetal brain damage and subsequent diagnosis of Fetal Alcohol Spectrum Disorder (FASD).

Training for doctors to assist in equipping you to confidently discuss alcohol and pregnancy with women is available via the Royal Australian College of General Practitioners and the Royal Australian New Zealand College of Obstetricians and Gynaecologists. This training is also accredited with the Australian College of Rural and Remote Medicine.

For more information on the free accredited training or to access the **Women Want to Know** resources visit **www.alcohol.gov.au**



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While Ms Ley is yet to make any commitments, Dr Gannon said his meeting with the Minister established common ground, including an acknowledgement that health was not the area of the Budget in need of "repair".

"It is true that the Government should try and find ways of balancing its books, but it's not true to say that health spending is out of control," Dr Gannon said. "Our discussions did focus on the fact that health is not the problem with the Budget...health should not be the focus of Budget repair in this Turnbull Government."

Balancing the books

Treasurer Scott Morrison has left open the prospect of removing the rebate freeze, though he has warned that scrapping the $2.4 billion policy would have to be offset by savings elsewhere in the Budget.

"When things come off the table, other things have to go on because our obligations to reduce the deficit, to return the Budget to balance, to address the concerns raised by the agencies which can have an impact on our [AAA credit] rating," Mr Morrison said on ABC News 24. "Holding to this trajectory we've set out in the Budget on fiscal repair and seeing that actually work through the Parliament, and seeing those measures actually being legislated...that has got my absolute focus, because that is my responsibility as Treasurer."

The AMA campaigned hard during the election on the Medicare rebate freeze amid warnings it would force many GPs to stop bulk billing, increasing the risk that the sickest and poorest would defer seeing their family doctor until they needed much more expensive hospital care.

Both Labor and the Greens promised to reinstate rebate indexation from 1 January next year, and the AMA called on the Coalition to match the commitment.

At his meeting with Ms Ley, Dr Gannon said that: "If we didn't already know it, I think that the Australian people see what they get from GPs and public hospitals is very important to them".

Ms Ley, who in May indicated that she would like to the see the freeze scrapped, responded that the Government had "listened to feedback during the election campaign, as I've talked to practitioners in the last week I've listened to feedback so we've got a really solid foundation on which to build this relationship and exciting policy for the future".

However, the Minster was non-committal on getting rid of the freeze, and the AMA President said it would be the subject of further discussions.

But he said the end of the freeze should be a priority for the Government.

Good faith

"Unravelling the freeze would be a great start, a good sign of good faith from the new Government...and the sooner the better. I will be looking for serious undertakings and a firm timeline from the Government," he said.

After springing surprise savage cuts in the health sector in its 2014 Budget, the Coalition has struggled to gain traction in the policy area ever since, and Prime Minister Malcolm Turnbull has admitted those policies, which included two failed attempts to introduce a GP co-payment and massive cuts to public hospital spending, had laid "fertile ground" for a Labor scare campaign over the future of Medicare.

Since the election, the Government has sought to reclaim some of the ground it lost by engaging more closely with the health sector, particularly the AMA.

Mr Turnbull met with Dr Gannon just days after winning the election and, in his speech unveiling his new Ministry on 18 July, made special mention of his hopes for a closer working relationship with the AMA.

Dr Gannon said it was gratifying that Ms Ley had made meeting with the AMA "her first order of business" since being reaffirmed in the Health portfolio.

"The Government has shown a willingness to listen to the AMA and a willingness to engage more closely on health policy," the AMA President said. "[From] very early preliminary discussions with the Minister today, [there] was a willingness to listen...and when governments talk to doctors, when doctors talk to government, we've got a really good chance of coming up with the best health policy."

"I don't think it's smart to get doctors offside, and I think it's smart to listen to all stakeholders in the health industry. I think that the Government will make good policy if they talk to doctors, if they talk to nurses, if they talk to other people at the coal-face, dealing with patients everyday, whether that's in the community, or in hospitals. Good health policy is listening to those people who deal with patients every day."

Mr Gannon met with Ms Ley soon after the AMA released Position Statements detailing the important role played by doctors as stewards of the health system, helping minimise waste and making best use of the available resources.

For more detail, visit: https://ama.com.au/ausmed/doctors-must-have-health-say

ADRIAN ROLLINS

Doctor rating website could hurt patients

AMA President Dr Michael Gannon has warned that posting the clinical outcomes of treatment online could result in reduced access to care, particularly for patients with chronic and complex health problems such as diabetes or obesity.

Nib Managing Director Mark Fitzgibbon has announced plans to expand the insurer's online heath care provider directory and customer review website *Whitecoat* to include medical specialists and incorporate hospital data on the clinical outcomes of specialist treatments, claiming it will make it the 'TripAdvisor' of health care.

Health Minister Sussan Ley gave her blessing to the move, which she said was in line with the Government's push for "greater transparency and choice for consumers".

Mr Fitzgibbon said that although Australia's health system was excellent, patients suffered from an "information asymmetry" when it came to making decisions, and by publishing consumer reviews and the gap fees charged by practitioners, *Whitecoat* was aimed at addressing that.

"In most markets the consumers have as much information as the sellers," the insurance chief told *The Age*. "In health care it's anything but. We know from around the world that consumers like to hear what other patients have said about their experience with a doctor or hospital."

In the wrong hands

Dr Gannon said the AMA supported patient education, and informed financial consent was a central tent of ethical practice. But he questioned the intention underpinning *Whitecoat*, voicing concerns about the "information asymmetry that might come if the insurers own all the information", and warned it could have unintended consequences for some patients.

"If the problem you're trying to fix is unreasonable out-of-pocket expenses there's other mechanisms of doing that, and we don't actually have a major problem," the AMA President told ABC radio, with 86 per cent of services provided at no gap to the patient, and further 7 per cent provided with a known gap.

Instead, he voiced concerns about what the impact of encouraging doctors to spruik themselves and reporting on clinical outcomes might have.

"The last thing I would want to see is medical practitioners being able to advertise and make their own outlandish claims about their abilities," Dr Gannon said. "The real concern about that is whether it really helps, and whether it might actually act to reduce the access of patients to care."

"The last thing you want is doctors being concerned about their stats being splashed all over the internet and then avoiding high risk cases.

"If you start telling me that you're going to publish all my wound infection data, will I turn around and say 'Look, I'm not going to operate on diabetics anymore, there's no way I'm going to operate on people who are morbidly obese, and I'm certainly not going to operate on patients who come down from the country where I can't keep an eye on them'. It's the law of unintended consequences.

"We can't have people determining the care they give out of fear of what a blunt instrument like an infection rate might show on the internet."

Big ambitions

Nib has received a major boost to its ambitions for the *Whitecoat* service after fellow insurers Bupa and HBF agreed to sign up, expanding its reach to six million Australians.

Mr Fitzgibbon said the aim was to develop the website into an industry-wide platform open to all providers and participants that would inform consumers.

"From the very beginning, *Whitecoat* has been all about empowering consumers with better information to make more informed decisions," he said. "*Whitecoat* is another example of how the digital world is shifting power away from the sellers of goods and services to the buyers, and *Whitecoat* reflects this trend. It is pro-consumer."

More than 35,000 practitioners, including GPs, dentists and physiotherapists have registered with *Whitecoat* since its launched in 2013, and around 250,000 consumer reviews have been uploaded.

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The ambition is to make it a comprehensive one-stop-shop, allowing consumers to use one website to find, choose, book, review and pay health providers.

Ms Ley said *Whitecoat* was a futher step in the right direction towards patients being fully-informed, and demonstrated the importance of having insurers at the table in the development of reform.

"Over 13 million Australians are covered by private health insurance – more than half the population – and the Turnbull Government is committed to ensuring that these consumers are getting value for money from their policies," Ms Ley said. "*Whitecoat* is an example of where private health insurers can take a proactive, co-operative approach to making information available to Australians to help better inform their decisions about health care, and I look forward to working with them to deliver the Turnbull Government's reforms."

To protect providers, nib, Bupa and HCF claim that all reviews and comments are carefully scrutinised and reviewed against strict guidelines. Only comments relevant to the consumer's own experience are published, and no assessment or judgement about clinical expertise, standards or clinical treatment methods are allowed. Providers are allowed to comment on reviews, and ask for them to be moderated again, before they are posted online.

ADRIAN ROLLINS

INFORMATION FOR MEMBERS

Prize for outstanding contribution to mental health

A group of eminent Australians has teamed up with the University of New South Wales (UNSW) to establish a new award to recognise Australians who have made outstanding contributions in the mental health field.

Ita Buttrose, UNSW Scientia Professor Philip Mitchell, former Australian cricket captain Adam Gilchrist and former NSW Governor Dame Marie Bashir are among those backing the Australian Mental Health Prize.

Professor Mitchell said Australia led the way internationally in many aspects of mental health, including community awareness, public advocacy and innovative services.

"Our open public discourse involving politicians and high profile individuals happens in few other countries," Professor Mitchell said.

"As all clinicians know, one in five Australians will experience mental health issues in any given year, with 65 per cent of people not accessing treatment to support them with this lived experience.

"It's time to acknowledge and raise the profile of the ground-breaking work that many Australians are doing."

The Prize is open to individuals involved in promotion, prevention, or treatment of mental health in areas such as advocacy, research or service provision.

Former Governor General Quentin Bryce, who officially launched the Prize on 13 July, said the award was long overdue.

"For far too long we have failed to recognise the hard work, innovation and dedication of professionals and researchers in mental health," Dame Quentin said.

"A Prize such as this is the least we can do to show our gratitude and respect for those working in this critical sector."

Ms Buttrose, chair of the Prize Advisory Group, said she hoped the Prize would help reduce stigma and raise awareness of mental health, and help improve care.

"It is unacceptable that suicide is the leading cause of death among 15 – 44 year-olds. This must be seen as a national emergency," Ms Buttrose said.

"There are some incredibly exciting and good things happening in the mental health area in Australia, and the Prize, the first of its kind, will highlight the important work Australians are doing.

"For something that profoundly affects so many Australians and their families, we believe this recognition is incredibly important."

Doctors, health professionals, and members of the public are encouraged to nominate anyone they feel should be recognised for their work.

The Prize will be awarded annually. Nominations close on 31 August and finalists will be announced in Mental Health Week in October. The award ceremony and announcement of the winner will be held at UNSW on 28 November.

Nomination forms are available at http://australianmentalhealthprize.org.au.

MARIA HAWTHORNE

Royal Commission must shine light on NT juvenile justice and health

The AMA has thrown its support behind the Federal Government's decision to establish a Royal Commission into the mistreatment and abuse of young people being held in detention in the Northern Territory.

AMA President Dr Michael Gannon said shocking images and revelations broadcast by the ABC's *Four Corners* program had sent shockwaves through the community, and reinforced warnings made by the AMA over many years about the treatment of people, particularly children, incarcerated in the NT.

> "Rates of incarceration among Aboriginal and Torres Strait Islander people are startlingly high – they comprise 28 per cent of all prisoners, and are 13 times more likely to be locked up than other Australians"

"The cruelty, violence, and victimisation experienced by these young people will have impacts on their mental and physical health for the rest of their lives," Dr Gannon said.

"The unacceptable abuse that took place at the Don Dale Detention Centre is clearly indicative of broader problems in the detention and prison systems in the Northern Territory. The AMA, at both the Federal and Territory level, has raised concerns over many years based on reports from doctors and other health professionals, including AMA members, about the poor condition and treatment of people in detention in the Territory, especially children - very often Indigenous teenagers."

Rates of incarceration among Aboriginal and Torres Strait Islander people are startlingly high – they comprise 28 per cent of all prisoners, and are 13 times more likely to be locked up than other Australians.

Young Indigenous people are even more likely to be imprisoned – they make up half of all children aged between 10 and 17 years held in detention, and are 17 times more likely to be under "youth justice supervision" than children of the same age in the broader community.

Dr Gannon said the Royal Commission would "put a spotlight" on juvenile justice and the health issues that were often involved in getting young people locked up, and called for "brave and creative" thinking about alternatives to imprisonment.

"Health issues – notably mental health conditions, alcohol and drug use, substance abuse disorders, cognitive disabilities – are among the most significant drivers of incarceration. We must also look at the intergenerational effects of incarceration," the AMA President said.

The Government is under pressure to expand the terms of reference of the Royal Commission to include the juvenile justice system nationwide, amid revelations that some of the practices used at the Don Dale Centre, including so-called "spit hoods" are also employed in Western Australia.

Shadow Assistant Minister for Indigenous Affairs, Senator Patrick Dodson, said the problems identified in the *Four Corners* report were not confined to the NT.

The revelations of shocking abuse at the Don Dale Centre have also focused attention on police practices that are seen to be contributing to high rates of imprisonment among Indigenous children, particularly the NT's 'paperless arrest' powers that allow police to detain people for up to four hours for minor offences.

"There must be a community debate about alternatives to incarceration, and serious investigation into alternative methods of rehabilitation for young offenders," Dr Gannon said. "This will require considering new ideas, and brave and creative thinking."

The health impacts of high rates of Indigenous imprisonment were highlighted by the AMA in its *Indigenous Health Report Card 2015 – Closing the Gap on Indigenous Imprisonment Rates* released last year.

"The rate of imprisonment of Aboriginal and Torres Strait Islander people is rising dramatically, and is an issue that demands immediate action," the Report Card said.

The AMA has called for the Federal Government to set a national target to close the gap in imprisonment rates between Indigenous people and the rest of the community, with children and young people the immediate priority.

ADRIAN ROLLINS

This is where the health system fails

The effect of where you live on your health is nowhere more apparent than on Palm Island.

Inhabitants of the small island just north of Townsville are being hospitalised for chronic obstructive pulmonary disease at almost 21 times the rate of other Queenslanders, are being admitted for epilepsy and the bacterial skin infection cellulitis at 12 times the state-wide rate, are in hospital for diabetes complications at almost nine times the state-wide rate, and are six times more likely to be admitted for a urinary tract infection.

Leading health economist Professor Stephen Duckett says these figures show a community that is being failed by the health system.

“When people end up in hospital for diabetes, tooth decay or other conditions that should be treatable or manageable out of hospital, it’s a warning sign of system failure. Australia’s health system is consistently failing some communities,” he says.

Palm Island is among 63 locations in two states – Queensland and Victoria – identified by Professor Duckett and his colleagues at the Grattan Institute in their report *Perils of place: identifying hotspots of health inequality* where rates of preventable hospitalisation are at least 50 per cent above the state-wide average for a decade or more. These include conditions such as asthma, diabetes, high blood pressure and malnutrition.

“Persistently high rates of potentially preventable hospitalisations are not normal,” the health economist says. “They are a signal that the existing health policies are not working or are insufficient.”

What causes these areas to have such high rates of health disadvantage are as individual as the places themselves, and influences include air and water quality, housing standards, employment, services like schools, clinics, roads and public transport, crime and community cohesion.

Professor Duckett says that while these areas tend to be more disadvantaged, “we found that potentially preventable hospitalisations are actually generally widely spread, and the places where hospitalisations are most concentrated are quite different for different diseases”.

The complex picture means that policy prescriptions have to be tailored to the individual characteristics of each location: “There is no single solution. The driving forces will be different in each place”.

But just because they defy generalisation and a one-size-fits-all solution, that is no reason not to address the issue, and the rewards in improved health and lower expenditure are considerable - Professor Duckett calculates that reducing preventable hospitalisation rates in the 63 areas identified in the Grattan Institute report to the state-wide average would, conservatively, save between $10 and $15 million a year in direct health costs alone, without taking into account indirect savings from fewer sick days and improved workforce participation.

Professor Duckett says the Commonwealth should fund trials, led by local Primary Health Networks, to test solutions and, crucially, commission rigorous and independent evaluations to identify what works and what does not.

PHNs should also develop tools to more precisely identify and target preventable hospitalisation hotspots. As data from trials is accumulated and lessons drawn, PHNs should use this information and experience to strengthen and expand their efforts.

Professor Duckett admits the priority areas identified in his report represent only a fraction of the problem, and “prevention efforts in these areas alone will not substantially reduce the overall burden of potentially preventable hospitalisations”.

“But,” he added, “they will help to efficiently reduce the worst health inequalities and will build the evidence base for how to address health inequalities more broadly.”

The bottom 10

The nation’s worst preventable hospitalisation hotspots

Palm Island

Yarrabah

Mount Isa

Mount Morgan

Northern Peninsula

Donald

Langwarrin South and Baxter

Broadmeadows

Frankston North

Kingaroy

Source: Grattan Institute

ADRIAN ROLLINS

Advanced drugs grab big PBS slice

New-generation treatments for leukaemia, multiple sclerosis, arthritis and eye disease are grabbing an increasing share of the Commonwealth's medicines budget, eclipsing spending on drugs for common ailments such as high cholesterol and stomach ulcers.

As expensive and advanced drugs to treat cancer and autoimmune conditions make their way onto the Government-subsidised Pharmaceutical Benefits Scheme (PBS), they are supplanting cheaper and far more common medicines at the top of expenditure rankings.

In a sign of the effect advances in pharmaceutical treatments are having on the public purse, figures released by NPS Medicinewise show six of the top 10 subsidised drugs cost more than $1500 a prescription, including the leukaemia treatment rituximab, which cost the Government $3348 per prescription.

For years cholesterol-lowering medications like atorvastatin and rosuvastatin, and proton pump inhibitors like esomeprazole have, by virtue of their widespread use, grabbed the lion's share of PBS spending. More than seven million prescriptions were filled for each drug during 2014-15.

But, for the first time in 20 years, a statin medication has been supplanted at the top of the expenditure list, which has been instead claimed by the anti-inflammatory biologic adalimunab, a drug used to treat rheumatic and psoriatic arthritis, Crohn's disease and chronic psoriasis.

NPS Medicinewise figures show the Government spent $311.6 million on 176,062 prescriptions of the drug in 2014-15 (an average of $1770 each), far more than the second-placed rosuvastatin, which cost the Government $206.5 million for 7.07 million prescriptions (an average of $29.20 each).

Reflecting the twin effects of scientific advances and the ageing population, treatments for macular degeneration were the third and fourth most costly drugs on the PBS expenditure list – almost $193 million was spent on 123,123 prescriptions of aflibercept ($1566 a script) and close to $180 million on 116,311 prescriptions of ranibizumab ($1544 a script).

The asthma treatments fluticasone and salmeterol were ranked fifth, with a joint cost of $175 million arising from 3.1 million prescriptions ($55.67 a piece).

The results underline concerns about the increasing pressure on the PBS from the development of advanced biologic medicines, some of which can cost more than $100,000 for a course of treatment.

The cost of, and access to, biologics has become a major point of contention in public policy, including in the negotiation of the Trans-Pacific Partnership trade agreement. US negotiators pushed hard for extended patent periods of up to 12 years for biologics, while countries such as Australia argued for a five-year limit. The terms of the TPP agreement are being debated in the US Congress, and the prospects for the agreement have dimmed after both the presidential candidates, Democrat nominee Hillary Clinton and her Republican opponent Donald Trump declared their opposition to the deal.

Top 10 drugs by cost to the Government

Drug	Cost to Govt (A$m)	Prescriptions ('000)	Cost/ prescription
adalimunab	311.6	176	$1770
rosuvastatin	206.5	7070	29.2
aflibercept	192.8	123	1566
ranibizumab	179.6	116	1544
fluticasone, salmeterol	175.2	3147	55.67
esomeprazole	174	7170	24.3
etanercept	164	93	1752
rituximab	156.5	46	3348
insulin glargine	142.7	347	410
fingolimod	134.7	58	2289

ADRIAN ROLLINS

Nation 'on track' to eliminate hep C

Australia could become the first country in the world to be hepatitis C-free if a recent stunning upsurge in the number of people being treated for the potentially fatal disease is sustained.

The number of people being treated for the illness has increased almost ten-fold since a new generation of drugs were added to the Pharmaceutical Benefits Scheme earlier this year, according to figures compiled by the Kirby Institute, fuelling hopes hepatitis C might be eradicated within a decade.

> "It is estimated that around 233,000 Australians are infected with hepatitis C, and the number receiving treatment has soared from less than 3000 to 22,470 in the past five months"

"Australia is leading the world in the treatment of hepatitis C, with the most rapid uptake of new treatments seen anywhere in the world, thanks to the unique approach Australia has taken in making these medicines available without restriction," Kirby Institute Program Head Professor Greg Dore said.

Since March, patients with hepatitis C have been able to get subsidised access to advanced antiviral drugs including Sovaldi, Ibavyr, Harvoni and Daklinza through the PBS following the Government's decision to commit $1 billion to their listing. Sovaldi, in particular, is hugely expensive. A 12-week course of treatment costs around $110,000.

It is estimated that around 233,000 Australians are infected with hepatitis C, and the number receiving treatment has soared from less than 3000 to 22,470 in the past five months.

Health Minster Sussan Ley said the huge uptake showed the Government's commitment to eradicate the disease within a generation was paying off.

The Minister said that around 5000 had already completed their course of treatment, and the early indications were that they were free of the disease.

"The Turnbull Government made the world-first decision to invest over $1 billion subsidising these cures for hepatitis C on the PBS, no matter the severity of a person's condition or how they contracted it," Ms Ley said. "And while it's still early days, it's already starting to pay off, with better than expected take-up rates and some people even now hep C-free, just a few months after starting treatment."

Hepatitis C is a blood-borne virus most commonly transmitted through the sharing of dirty needles and drug injecting equipment. There is no vaccine. It is estimated that 170 million people worldwide are chronically infected with the disease, which kills around 500,000 a year as a result of hep C-related liver damage.

Many with the disease have been reluctant to seek treatment because of the serious side effects of older drugs.

But Hepatitis Australia Chief Executive Helen Tyrrell urged those with the illness to talk to their doctor about the new drugs available, which had far fewer side effects.

Ms Tyrrell lauded the role played by family doctors in getting so many people onto treatment.

"This is a huge achievement and testament to the critical role of GPs, who can prescribe hepatitis C medicines for the first time – and the vision of the Australian Government in making these therapies available without restriction," she said, adding that because the amount the Government would pay for the medicines was capped, "the more people treated over the next five years the better".

Professor Dore urged those with the disease to immediately seek treatment.

"Treatment for hepatitis C is vital to prevent liver damage which can lead to liver cancer, liver cirrhosis and liver failure – and treatment is now better and easier than ever," he said.

ADRIAN ROLLINS

Practices lag on e-health registrations

Medical practices and private hospitals are lagging well behind patients in registering with the Federal Government's My Health Record system.

Health Minister Sussan Ley has hailed figures showing almost four million people, roughly 17 per cent of all Australians now have a My Health Record after an average of 2200 a day joined the scheme last month.

Ms Ley said it meant that more and more patients and health professionals were able to gain immediate access to important health information online.

"This can improve co-ordinated care outcomes, reduce duplication and provide vital information in emergency situations," the Minister said. "It also enables us, as a consumer, to become more active in managing your health and provide links between the multiple services many of us may need through our lives."

But although the Government has, since May, threatened to withhold incentive payments from general practices that do not upload a minimum number of shared health summaries to the system, only a fraction have so far signed up.

Department of Health records show that, as at 31 July, 5647 practices had registered with My Health Record – around a sixth of those operating nationwide – while just 69 private hospitals and clinics had done so, less than a tenth.

The desultory uptake has underlined AMA warnings that the Government was rolling out a system that continued to have significant shortcomings and was providing insufficient support for GPs to use it.

AMA President Dr Michael Gannon said that although the association "strongly backed" the introduction of a national e-health record, the Government's approach, particularly imposing financial penalties on practices unready or unable to use the system, was wrong.

Practices surveyed by the AMA estimated that if they could not meet the upload quota it would cost them up to $60,000 a year in lost PIP Digital Health Incentive payments, which Dr Gannon said was a severe financial blow, especially coming on top of the freeze of Medicare rebates.

"The extension of the rebate freeze has already pushed many practices to the financial brink, and the last thing they need is to have thousands of more ripped away from them because of a flawed process to introduce a national e-health record system," he said.

My Health Record

The AMA has urged for a moratorium on the upload requirement until problems with the system are sorted out.

Dr Gannon warned that pushing ahead now put the support of the medical profession at risk.

The most common documents stored on the system so far have been to do with Medicare – almost 325 million benefits reports have been uploaded.

In addition, more than 3.2 million prescriptions and 1.1 million dispensing reports have been uploaded.

Almost 820,000 clinical documents have been filed with the system, including 462,000 discharge summaries, 228,000 shared health summaries, 86,000 event summaries, 21,518 specialist letters and 18,654 diagnostic imaging reports.

Consumers themselves have uploaded 63,677 health summaries and 29,000 notes.

One of the benefits of My Health Record is as a repository of care preferences, and so far 10,632 Advance Care Directive Custodian reports have been uploaded, but only 285 Advance Care Planning documents.

Regarding organ donation, almost 406,000 Australian Organ Donor Register documents have been lodged with the system.

ADRIAN ROLLINS

Parents jabbed into action by vaccination laws

Almost 150,000 children have had their vaccinations brought up to date and the parents of thousands of other have dropped their objection to immunisation following the introduction of No Jab, No Pay laws.

The Federal Government has claimed its policy of withholding childcare and tax benefits rebates from parents who do not immunise their children is a major success after the number who conscientiously object to the vaccination of their children has plunged from 40,057 in late 2014 to 24,500.

Since the No Jab, No Pay laws came into effect on 1 January last year, the parents of 5738 children have dropped their objections to immunisation, and a further 148,000 have brought the vaccination of their children up to date.

Social Services Minister Christian Porter said the results were "extremely encouraging", and showed the rules were helping to achieve the Government's goal of 95 per cent vaccination rate among children.

Australian Childhood Immunisation Register records show that, for the first time, immunisation rates among one- and five-year-olds has reached 93 per cent, while for two-year-olds it lagged at 90.7 per cent in late 2014.

"It's great to see that families are getting their children immunised," Mr Porter said. "To give our kids the best protection against diseases such as whooping cough, we're aiming towards a herd immunity level of 95 per cent, and it's clear that the No Jab, No Pay policy is helping achieve this."

Under the laws, parents have to ensure their child' vaccinations are up to date if they are to be eligible to receive the Child Care Benefit, the Child Care Rebate and the Family Tax Benefit Part A supplement payment.

The rules were introduced because of concern about low immunisation rates in pockets of Sydney, the NSW north coast and southern Queensland where parents claiming conscientious objections to vaccination were considered to be putting the health of their and other children at risk.

The AMA has endorsed a booklet produced by the Australian Academy of Science about vaccination, including evidence showing that that the small risks associated with immunisation are vastly outweighed by the benefits.

ADRIAN ROLLINS

Medical Room

Going private

Private hospital beds are increasing at almost three times the pace of growth in the public system as Government funding cuts bite and the number of privately-insured patients swells.

In the first five years of the decade, the public hospital system grew at an average annual rate of 1.1 per cent to reach 60,300 beds. But over the same period the private hospital system expanded at a much faster 2.9 per cent a year, and its capacity reached almost 32,000 beds by mid-2015.

While two-thirds of the beds added in the public system were for overnight stays, virtually all of the extra beds in the private system were for overnight care.

Underlining the pressure on public hospitals from patients with complex and chronic conditions, figures compiled by the Australian Institute of Health and Welfare showed 57 per cent of funded services were for admitted patients, while 17 per cent were for outpatients and 10 per cent involved emergency department care.

The most common reason for hospitalisation was for dialysis (14 per cent of the total), followed by cancer (11 per cent). About a quarter of hospitalisations involved surgery, and 60 per cent of operations were conducted in private hospitals. The most common surgical procedure was cataract removal.

Culture of humiliation

Almost two-thirds of medical students were victimised or witnessed workplace bullying last year, according to an Australian Medical Students' Association report.

The report, presented to the National Centre Against Bullying Conference, showed that of 519 students surveyed, 60 per cent reported being bullied or harassed themselves, or witnessing such treatment of another.

And, in a sign of how much work needs to be done to encourage victims and bystanders to report such behaviour, just 32 per cent said they had taken some action.

The AMSA report included accounts of students being sexually harassed in the presence of other health workers, being sent sexually explicit text messages after hours and being abused in front of patients.

AMSA President Elise Buisson told Fairfax Media such behaviour had a baleful effect on the workplace and learning environment, and cultural change was needed in the profession.

AMA President Dr Michael Gannon said the peak medical organisation had no tolerance for bullying and harassment.

"This behaviour is unacceptable in so many ways," Dr Gannon said. "It is morally wrong and sometimes illegal."

Road safety off target

A national goal to cut road deaths and injuries by a third by the end of the decade is "slipping out of reach" following a spike in fatalities in the past 12 months.

Figures compiled by the Australian Automobile Association show that 1269 people died on the nation's roads in the 12 months to 30 June, 99 more than in the previous 12 months, including 612 drivers, 228 motorcyclists and 168 pedestrians.

AAA Chief Executive Michael Bradley said that since all the nation's governments had signed up to the National Road Safety Strategy in 2011, there had been a just a 6.1 per cent drop in the annual road toll, which was far short of what was required to reach the target of a 30 per cent decline by 2020.

"Clearly we are heading in the wrong direction, and there is the need for all governments to step up their efforts by developing policies and programs that deliver a safer transport network, safer drivers and safer vehicles," Mr Bradley said.

The AAA said there had been an increase in road deaths in every State and Territory except Western Australia and South Australia, but the declines achieved in those two states were less than was required to reach to 2020 target.

Mediscare texts cleared

The Australian Federal Police will not take action over a polling-day text sent out to voters claiming Medicare was under threat form the Coalition.

The text, sent under the name "Medicare", claimed that the Turnbull Government planned to privatise Medicare and urged recipients not to vote for the Coalition.

The Liberal Party lodged a formal complaint about the messages following the tight election result, and Attorney-General George Brandis said they appeared to breach the law.

But the AFP said the matter had been "evaluated…and no Commonwealth offences were identified".

ADRIAN ROLLINS

Health on the hill

POLITICAL NEWS FROM THE NATION'S CAPITAL

AMA questions counter-terror access to mental health records

The AMA has raised serious concerns about the possibility that security authorities be given the power to access to mental health records as part of efforts to prevent so-called 'lone wolf' terror attacks.

AMA President Dr Michael Gannon said such a move raised the risk of "literally thousands of people not accessing appropriate care", and would not necessarily improve national safety.

"I think there's the potential for much greater harm if people with mental illness didn't seek medical care, didn't seek treatment," Dr Gannon said. "I think that if we had a case where people didn't ask for help, that would potentially be a great deal more dangerous."

In what he admitted would be a "huge step", Prime Minister Malcolm Turnbull has asked Counter-Terrorism Coordinator Greg Moriarty to examine the possibility of police and intelligence service access to the mental health records of terrorist suspects as part of a review of the nation's defences.

"It is important this be looked at carefully. Let me come to another point, you've got a number of important interests to balance here. Mental health alone, leaving aside issues of terrorism, is a gigantic challenge," Mr Turnbull said. "But my most important obligation, my most important responsibility to Australia, is to keep the people of Australia safe, and so that is why we are constantly improving, upgrading our legislation – that is why we provide additional resources to our police and security services."

But the AMA and other health groups have warned that such a breach of patient confidentiality was not only ethically problematic, but could also prove counter-productive by deterring people who need help from seeing a doctor.

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Health on the hill

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"The ethical principles are that the confidentiality of the doctor-patient relationship is fundamental to patients speaking frankly and honestly about deeply personal issues," Dr Gannon said. "One of the reasons that patient confidentiality is so important is that people must feel that they have the ability to seek help if they're sick. What you don't want is encouraging a system where patients fear coming to see the doctor."

The Prime Minister said a change in approach was necessary because a recent spate of attacks, including in Orlando, Nice and Germany, suggested the terrorist threat was evolving to include individuals not previously considered to be a threat but who were socially, emotionally or mentally unstable and were susceptible to rapid radicalisation.

"What we are seeing at the moment is people being radicalised or adopting Islamist, murderous Islamist ideology very, very quickly. So that you have people that are not on the counter terrorism radar screen who then often, as a result of mental illness, will then attach themselves to this murderous ideology and then act very quickly," Mr Turnbull said on radio 3AW. "They appear to be drawn to Islamist extremism very late and very fast, not necessarily because of a long-term religious or ideological belief, but as a means of filling a void and providing meaning or rationalisation. The Lindt Café attacker, who converted from Shia to Sunni in the days leading into the siege, might also fit this profile."

But he admitted giving the security services access to mental health records would involve brushing aside "very significant privacy protections".

There are also doubts about whether the huge breach of doctor-patient confidentiality involved would necessarily achieve much in detecting or heading off potential terror attacks.

"It is not necessarily plausible that one act of terror could be prevented by such a change in the law," Dr Gannon said. "I'd be very surprised if a would-be terrorist with some sort of perverted ideology of some sort confided in their GP or their psychiatrist that they were intending to drive a bus into a public area."

Attorney-General Senator George Brandis said on ABC radio that doctors and health workers should report patients who show signs of being "susceptible" to radicalisation.

But Dr Gannon said "the ethics of medicine, the law of the land, state that a doctor has to form the view that it would be overwhelmingly seen to be in the public interest [to breach patient confidentiality]. That's a very high threshold."

Royal Australian and New Zealand College of Psychiatrists President, Dr Malcolm Hopwood, warned that asking doctors to dob in people simply on grounds of suspicion was dangerous.

Dr Hopwood said doctors already had an obligation to inform authorities if they believed a patient was at immediate risk, but Senator Brandis's comments "suggests we might be nominating people to authorities who are not really yet showing any clear signs of risk to other people".

"There's a clear balance problem there with their right to privacy. If we breach privacy too readily, we run the risk of turning away people from mental health treatment because they won't feel comfortable and confident they can talk about the things that concern them," he said.

Mr Turnbull admitted that there would need to be a balance struck between patient confidentiality and being alerted to a possible terror attack.

ADRIAN ROLLINS

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Health on the hill

POLITICAL NEWS FROM THE NATION'S CAPITAL

Doctors challenge Border Force gag laws

Controversial Federal Government laws to suppress information about the operation of immigration detention centres are being challenged by a group of doctors who claim they are being used to intimidate health workers.

The group Doctors for Refugees and the Fitzroy Legal Service have jointly launched action in the High Court challenging the constitutionality of secrecy provisions in the Australian Border Force Act which threaten up to two years imprisonment for workers who disclose conditions in detention centres.

In a Statement of Claim filed with the High Court on 27 July, Doctors for Refugees said it was bringing the action to "advocate for the public's right to know what their Government is doing in their name, and to support the public health imperative of transparency to mitigate harm occurring in detention centres on and offshore".

The action asks for the High Court to rule on whether the public disclosure of information regarding the operation of detention centres, including conditions, health care, mandatory detention and offshore detention, are protected by the freedom of political communication implied in the Constitution, and whether the ABF Act invalidly prohibits such communications.

The Act, which was introduced last year, includes provisions which make it a criminal offence for those contracted to provide services to the Department of Immigration and Border Protection to record or disclose information obtained in the course of their work. The penalty is up to two years' imprisonment. The legislation was passed with support from Labor.

The Act was introduced amid concern regarding conditions in detention centres, including reports of widespread sexual abuse and significant physical illness and mental health problems, particularly among children.

The Moss review substantiated allegations of sexual abuse at the Nauru Detention Centre, and operator Transfield Services reported 67 claims of child abuse, 33 allegations of sexual assault or rape, and five alleged instances of sexual favours traded for contraband.

Soon after being elected, the Coalition Government abolished an independent panel of medical experts that was overseeing health care in detention centres, and has so far ignored AMA calls to replace it with a group of health experts empowered to investigate and report on detention centre conditions directly to Parliament.

Doctors have protested that the secrecy provisions in the ABF Act conflict with their ethical duties and their obligations under the Medical Board of Australia's Code of Conduct, most particularly their paramount obligation to the health of their patients.

These concerns have been magnified by a number of cases in which, it is claimed, authorities have sought to intervene in or override clinical advice on the transfer of detainees in need of medical attention, including the death of Omid Masoumali, who was medically evacuated to Australia from Nauru more than 24 hours after setting himself alight.

Suspicion that the Government has sought to interfere in the clinical decisions of doctors has been heightened by documents obtained by *The Australian* under Freedom of Information laws showing Immigration officials devised a strategy to prevent detainees from being evacuated to Australia for medical treatment because of a "propensity of those transferred to Australia to join legal action which prevents their subsequent return to PNG or Nauru".

The Government has denied that the intention of the law is to prevent doctors from speaking up on behalf of their patients, and Immigration Minister Peter Dutton has indicated he thinks it unlikely that health practitioners would be prosecuted under the Act.

But it has since been revealed that Dr Peter Young, who oversaw the mental health care of detainees for three years, was the subject of an Australian Federal Police investigation, including access to his electronic communications.

At its most recent National Conference, the AMA passed an urgency motion asking the Federal Council to "look into the matter" of AFP surveillance of doctors.

In its Statement of Claim, Doctors for Refugees said the Government's assurances had "not altered the perception that the ostensible intent of the ABF Act is to silence doctors, teachers, social workers and others working in detention centres".

"Regardless of whether prosecutors exercise a discretion to charge health practitioners working with refugees and asylum [seekers], the law remains in place," the Statement said. "Practitioners speaking out are subject to a Sword of Damocles, unsure when or if they might be investigated or charged for adhering to their ethical (and moral) obligations."

Doctors for Refugees said that even if the High Court found that the ABF Act's secrecy provisions served a legitimate purpose, it would also have to decide whether the constraint they imposed on political communication was "proportionate".

Health on the hill

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"The ultimate question is whether the secrecy provisions... undermine the proper functioning of our democracy and the right of electors to be informed accurately, openly and truthfully about matters of national political importance," the group said.

ADRIAN ROLLINS

All quiet on the health policy front

The success of Labor's Medicare campaign and the Coalition's slender margin of support in Parliament have virtually killed off the chances of significant health reforms in this term of government, according to investors.

While re-appointed Health Minister Sussan Ley is pushing ahead with the Medical Benefits Schedule review, the Health Care Homes trial, pilots of the My Health Record e-health system and reforms to mental health, analysts at Macquarie Group and UBS think the window to further major health changes has been slammed shut by the tight election.

UBS healthcare analyst Andrew Goodsall has put the chances that the Government will abandon the Medicare rebate freeze by next election at 75 per cent, and told *The Australian* it would be leery of undertaking any other major policy initiatives.

"Classically, the political cycle allows more substantial reform to occur in a post-election Budget," Mr Goodsall said. "However, the success of the Labor Party campaign against the privatisation of Medicare may limit Government reforms on Medicare in the near-term," Mr Goodsall said.

His doubts were shared by Macquarie analysts who, in a note to clients, said the Government would have little appetite for "meaningful" reform in the short- to medium-term given the resistance it has faced in Parliament and its near-run election result.

This period of relative policy stagnation would help ensure those parts of the healthcare industry that were prospering under current arrangements to continue enjoying solid growth.

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"In our view, the benign political outlook for healthcare reform suggests private hospital growth is set to continue unabated at the lofty levels seen historically," they said.

ADRIAN ROLLINS

PM takes direct role in health

Prime Minister Malcolm Turnbull has taken a much more hands-on role in health policy as the Coalition Government seeks to improve its performance in an area that emerged as a major area of political weakness at the Federal election.

Just days after winning the knife-edge 2 July poll, the Prime Minister met with AMA President Dr Michael Gannon, and it has been revealed that late last month he took the unusual step of personally attending the first high-level meeting between Health Minster Sussan Ley and senior Health Department bureaucrats since the election.

In a speech announcing his new Ministry on 18 July, Mr Turnbull revealed he had already met with Dr Gannon and anticipated working closely with doctors over the next three years.

"I am confident we will have a better working relationship with the AMA and its GP membership," the Prime Minister said.

The Prime Minster followed this up a week later by joining with Ms Ley in meeting Government health officials to discuss the Coalition's election agenda and plans for health.

The intense focus on health at the highest levels of the Government reflects widespread acceptance in Coalition ranks that it was an area of vulnerability that was ruthlessly exploited by Labor during the election campaign, costing it many votes and bringing it to the brink of a first-term loss.

The importance of health in the election was underlined by an Essential Media report that found health trumped all other policy concerns in the minds of voters, including the economy.

Sixty per cent of voters said health policies were very important in deciding who they voted for at the recent election, with Medicare a close second at 58 per cent. Economic management came third at 53 per cent.

Reflecting this, a majority of voters (55 per cent) said investing in health should be the top priority for Government, compared with 31 per cent for education and 27 per cent who wanted spending cut to reduce the deficit.

Ms Ley, who was accused by some within the Coalition of 'going missing' during the election campaign, welcomed the Prime Minister's interest in her portfolio.

"I am delighted that we have kicked off the current term of Government with a high-level conversation, because of course he is interested in health, as he is in every single area of government," the Health Minister told ABC radio. "It's terrific for me to have a Prime Minister so dedicated to the cause and so understanding of the need for a health system that supports all Australians, one that we can both pay for and deliver."

Reflecting on the tight election result, Mr Turnbull indicated that the Coalition needed to change its approach in health, raising hopes that unpopular decisions like the Medicare rebate freeze and public hospital funding cuts might be revisited, though Ms Ley was non-committal.

"I understand people's concerns and I am very keen that we take those concerns into account as we move forward. MYEFO [Mid-Year Economic and Fiscal Outlook] is at the end of this year, the Budget is next year, all of these things will play into to usual business of Government."

ADRIAN ROLLINS

Pharmacists: shopkeepers or health professionals?

Pharmacists could face restrictions on the amount of shelf space they devote to selling vitamins, shampoo, toothpaste and other retail products as their dual role as health care professionals and shopkeepers comes under scrutiny in a Federal Government review.

The Government's Review of Pharmacy Remuneration and Regulation is looking into whether there should be limits imposed on the retail activities of community pharmacies amid accusations that pharmacists are misleading consumers and undermining their own professional integrity by selling vitamins, herbal remedies and other complementary medicines that have no proven health benefit.

While dispensing prescriptions is the principle source of pharmacy earnings, generating 61.5 per cent of income in 2015-16, sales of cold and flu remedies, cough syrup and other non-prescription medicines contributed 16 per cent of revenue, purchases of vitamins, herbal remedies and other complementary medicines provided 15.5 per cent of earnings and sales of cosmetics and beauty products generated 7 per cent of income.

Health on the hill

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The review panel, led by Professor Stephen King, has been told that community pharmacists face a conflict of interest between their role as a health care professional and a shopkeeper, particularly when stocking their shelves with products for which there is no evidence of efficacy.

As community pharmacists push for an expanded role as health service providers, they are coming under scrutiny over their business practices, particularly regarding the sale of complementary medicines.

The issue is probed in a discussion paper released as part of the review, which has been set up to examine the role of pharmacists and community pharmacy in delivering health services, now and in the future.

The review panel said it had heard of numerous examples where community pharmacists had gone "above and beyond in providing additional services that are in the patient's best interest, even though they may not be compensated for these valuable services".

But, it added, there were those who objected to the current direction in which community pharmacy was headed, and were concerned that issues around their dual roles as a retailer and health service provider were yet to be resolved.

"It was put to the Panel that community pharmacists face conflicts of interest between their role as retailers and as health care professionals," the discussion paper said. "This tension between treating consumers as customers or patients was attributed to the contrast in the remuneration from dispensing and the revenue generated from the sale of over-the-counter medicines and complementary products."

The Panel said it had heard concerns that financial pressures might cause pharmacists to compromise on the professional advice they provide, such as recommending medicines or products that were not necessary.

"It was also claimed that many complementary products do not have evidence-based health benefits and, as such, the sale of these products in a pharmacy setting may misinform

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consumers of their effectiveness and undermine the professional integrity of community pharmacists."

The review has been set up under the terms of the current Community Pharmacy Agreement, and the panel is seeking comment on possible reforms in the sector, including changes to the pharmacy business model.

The discussion paper cited Guild Digest data showing that community pharmacies have an average annual turnover of $2.8 million, and a net profit of $107,000 (excluding proprietor salaries).

Among the proposals up for consideration is that Government funding, which is worth $13.2 billion under the life of the current five-year agreement, should be made conditional on the amount of revenue pharmacists generate from other sales.

"Should Government funding take into account the business model of the pharmacy when determining remuneration, recognising that some businesses receive significant revenue from retail activities?" is one of the question raised in the discussion paper.

"Should there be limitations on some of the retail products that community pharmacies are allowed to sell? For instance, is it confusing for patients if non-evidence-based therapies are sold alongside prescription medicines?"

It noted that some hospital pharmacies have designed their service area to resemble a clinic, getting rid of a counter and "providing a private environment without distraction, which maximises the professionalism of patient-pharmacist interaction".

The review is being undertaken in the context of a sustained push by pharmacists for an expanded role as health providers.

Health Minister Sussan Ley said pharmacists were already taking on a greater role, including providing routine vaccinations and blood pressure checks, and the industry is pushing to be allowed to undertake broader screening and patient health checks.

The AMA has raised concerns about the risk to patients from pharmacists providing services beyond their realm of expertise, and is expected to make a submission to the review.

The Pharmacy Guild said the discussion paper raised many "thought-provoking questions" about the pharmacy sector and was preparing a formal response.

The review panel will conduct a series of public forums over the next five weeks, and those interested have until 23 September to provide a written submission.

Details of the review, including the discussion paper and the consultation process, are at: http://www.health.gov.au/internet/main/publishing.nsf/Content/review-pharmacy-remuneration-regulation

ADRIAN ROLLINS

INFORMATION FOR MEMBERS

Essential GP tools at the click of a button

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

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

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

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

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

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

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

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

Looking for a new medical job?

Sign up to the jobs board dedicated to medical professionals:

jobs.doctorportal.com.au

In pursuit of global health

BY PROFESSOR STEPHEN LEEDER

Striving for truly healthy growth

The limitations of political slogans - the 'privatisation of Medicare' or 'jobs and growth' - are severe. Ideas are shorn of nuance and words stripped of definition. What is meant by 'privitisation' and 'Medicare', and what by 'growth'?

While privatising Medicare may at first blush be the phrase of greatest interest to doctors, I suggest that 'growth' is of deeper concern. Growth - unqualified - could be a curse and not a cure, a health hazard rather than a health promoter, a cancerous thing rather than a positive developmental pathway.

True, decades of free market-based economic growth have achieved remarkable improvements in global health. Whole nations have been lifted from poverty, death and suffering. In economically-advanced nations unimaginable affluence has been achieved with improved average life expectancy.

But with this growth have come unintended side effects. The global challenge of climate change is one such consequence. Inequality is another. In the US, the rich have become disproportionately richer without improvement in economic well-being among workers. This has substantial political effects. Commentators speak of how this inequality, present also in the UK, has contributed to Trump and Brexit.

Growth with attitude

Jeffrey Sachs, an economist at Columbia University with a long-standing passionate interest in sustainable development and health in less developed economies, wrote recently in the Boston Globe about the need for a fresh understanding of what we mean by growth. Sachs played a major part in the development of what are called the Sustainable Development Goals, or SDGs, under the auspices of the United Nations. The goals were agreed upon one year ago by more than 100 nations, including Australia.

In brief, the SDGs, to quote Sachs, aim at economic growth, but defined in a manner that promotes decency and environmental sustainability. The 17 goals involve the achievement of more than 100 specific objectives. They fall into three groups: those associated with classical economic progress; those that have to do with ensuring environmental sustainability; and those that concern justice and social fairness.

Now, almost a year later, in New York on July 20, ministers and country representatives at the annual UN High-Level Political Forum attended the launch of an index, a measuring device, designed to allow countries to assess how they stand now in relation to the SDGs, and how they can judge their progress. The index is aimed at strengthening the commitment to growth in a way that is consistent with improving human decency and honouring the environment. It provides a current assessment for 149 of the 193 UN member states. It asks each nation to rank itself on indicators of poverty, nutrition, health care, education and pollution - all elements of the SDGs.

The goals include universal education, gender equality, clean water and sanitation, affordable clean energy, decent work and economic growth, reducing inequalities and developing sustainable cities.

Three are of special interest to medical and other health professionals. They concern further efforts to reduce poverty; to do what is needed to promote health and wellbeing; and to ensure food security for all.

In one sense these goals could hardly be disputed. But the real question is whether they have enough grunt to motivate change.

Critics, including *The Economist,* refer to the goals as "sprawling" and not sufficiently specific, especially when compared with the much fewer (12) Millennium Development Goals that were associated with great progress in infant mortality, HIV and other forms of health promotion and disease control for example.

Nevertheless, despite the ambitious spread of the SDGs, they take account of current urgent global challenges from which Australia cannot hope to remain immune.

Moving Australia toward sustainable growth

The world leaders on the SDG index are the Scandinavian countries, followed by others from Northern Europe. Canada was 13th, Australia 20th and the US 25th. Sweden's homicide rate is around one-seventh of America's, and its incarceration rate one-tenth. Infant and maternal mortality rates are lower, as is income inequality.

In summary, the SDGs are an international expression of an attempt to seek truly global health - for people, the environment and the planet.

While achieving these goals is a lofty ideal, we can only make progress if we use words like 'growth' accurately. If we mean growth that advances the economy while also promoting environmental sustainability and reducing social inequality, then we will be on a solid path to the future.

Making a difference

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

As a doctor, one of my key objectives is to improve my patients' health, wellbeing and quality of life. I'm sure that you share this goal. Making a real difference in someone's life is what gets me up every day. But how do I really know that I'm making the difference I think I am?

Often the results of my interventions are more immediate. I help a patient make an informed decision about an immunisation, or I clean and stitch a wound minimising the scar and risk of infection. I might have diagnosed a case of pneumonia and prescribed a course of treatment to relieve and eradicate my patient's symptoms.

Other times it is less immediate. I might work with a patient to empower them to better manage their chronic disease, aiming to minimise its advance, the risks of associated multi-morbidities and its impact on their everyday life. This is much harder to measure and assess.

Aside from what I can see with my own eyes at an individual level, to confirm I am making a difference, the reality is that I need to record my actions, review the outcomes of my actions and evaluate this against my peers, or a best practice benchmark.

Understanding how I am performing can enable me to identify where I could do better and provide a personal benchmark from which I can follow a process of continuous improvement that will improve the efficiency of my practice and the quality of the health care I provide my patients.

While this can be challenging, it is very important to ensure my clinical practice is evolving in line with my peers, enhancing my effectiveness and helping me to deliver the health care my patients value.

Continuous quality improvement is often sold as a package of principles, methods and techniques that can be overwhelming and seemingly unsustainable for a busy GP. The best way to eat an elephant, I've been told, is one mouthful at a time. This is the approach I believe is required to implement a sustainable process of continuous quality improvement in general practice. But where to start?

The key to any objective evaluation is quality data. The key to quality data is standardised clinical terminology - in other words, coding. Before the end of this year it is expected that the two largest providers of clinical software will have enabled mapping of their coding systems to the SNOMED clinical terminology. This will be a huge enabler for many practices when extracting and analysing their data. They will be able to undertake simplified data extractions and compare apples with apples.

Accreditation and incentives such as those provided under the Practice Incentive Program, Quality Improvement and Continuing Professional Development requirements have been instrumental in facilitating GPs in improving their practices and processes, and in keeping their knowledge and skills up to date. But at the end of the day, the question that really matters is - did we make a difference.

The challenge is how to answer this question. Much of the answer is potentially at our finger tips or sitting in front of us, in our clinical data. For example, what percentage of our patients have their cholesterol levels recorded, what percentage have improved their levels in 12 months since a diagnosis of high cholesterol. How many have levels within the optimum range. Do our patients feel better, can they cope, can they move more freely, is their pain managed, did we listen to them, did we help them understand their condition and treatment options, did we follow up on them?

The discussion about quality improvement in general practice has started. The Health Care Home initiative will look at how practices can develop quality assurance processes, and it is important for general practice to do more to demonstrate to Government just how good our standards of care are. This is not about pay-for-performance but rather, how we ensure that GPs have the tools and information they need to better support a culture of continuous quality improvement.

The strength of flexibility

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

They say if you want to truly understand an organisation, then you shouldn't bother looking at their policies and guidelines. Nope. The gold is in the spreadsheets.

If that's true, then I'm starting to think that modern day hospitals and practices are truly, irreducibly complex. This is probably also the reason why the single easiest way to terrify any employer of doctors is to sneak up to them and whisper the words "flexible work arrangements". They'll instantly fall into a catatonic state, as their intricate web of Excel comes crashing to the ground, with the ringing of empty cells filling the corridors and the endless cry of "#VALUE!".

Yes, there are successful examples of part-time and flexible employment in Australia. Yes, there are fantastic support programs for parental leave in corners of Australia.

However, this isn't a vision shared across the entire country and the entire workforce.

Part-time work is more often seen as a chore. It's the domain of a group of doctors who want it all. It's a lot of hassle for no long-term investment. It's a waste of time because they'll quit after all of the work has been done to establish the position. Which to me, is bizarre.

Medicine is certainly not an island, and there are countless professions who have been able to make flexible work arrangements not just a normal occurrence, but an almost preferable one to full-time employment.

I don't see flexible work as a threat. What I see is the ability for a workforce to become agile to the demands of a modern health care system, rather than a stagnating roster of single digit FTE that can't be modified to demand.

I see rates of absenteeism that are practically non-existent, rather than sick call after sick call as a consequence of a deteriorating culture due to excessive workloads and a lack of leave.

I see doctors that are able to diversify their professional and personal experiences to the benefit of their employers and workplaces, rather than arriving every day to simply be another turning cog in an endless machine. Hell, I should be worried that a couple of part-time doctors are going to replace me in my full-time job!

Flexible work arrangements aren't new; they're just not well publicised.

The AMA first commissioned a work-life flexibility project in 2001 and identified that flexibility was a significant factor for doctors in training when choosing specialist training pathways. This appetite amongst doctors has since increased, and not just doctors in training.

In my conversations with employers, the vast majority support the concept of flexible work practices. They're just limited in their ability to implement them.

To really gain ground on this issue, we need to understand the needs of the employer.

Pretend for a moment that you are a medical administration manager in a major Australian hospital. Your starting point is a tight medical budget with very little room to move. You don't have enough FTE to service your leave liability. Your executive expects a greater service delivery at the lowest reasonable cost. You can see the pressures adding up. To really achieve sustainable flexible work arrangements, we have to work together.

To this end, the AMA Council of Doctors in Training have taken the AMA's Position Statement on flexible work and training practices and we're developing a National Code of Practice. This code is similar to the one we've previously developed on safe working hours and shift rostering patterns. That code led to a significant change in the way employers approached safe working hours by enabling them to turn aspiration into practice, and we're hoping to gain similar traction around flexible work arrangements.

I'm a glass half-full kind of person.

I don't think the service demands of modern healthcare and flexible work arrangements are mutually exclusive. If anything, I think they make an employer stronger.

Through the development of the code, we're hoping to bring employers and employees together on the issue, to the benefit of everyone involved.

It's a long road ahead, but I'm confident we'll get there. I promise. After all, I'm tracking our progress in a spreadsheet.

How do you choose a leader (hint: it may not be what you think)

BY ELISE BUISSON

In 2016, women are less likely to be our leaders in the highest levels of medical education, hospital management and representation of the medical profession. This remains true even at the level of student leadership, despite a little over 50 per cent of medical students being female.

> "In choosing leaders and in judging their success, we all do our best to make the right decision. But our inherent biases have a nasty habit of getting in the way"

There are many societal reasons why women are underrepresented in leadership roles, such as absorbing a higher load of unpaid domestic work and a paucity of female leaders to model themselves after. There's also something going wrong with the way that all of us - men and women alike - perceive our female leaders.

In choosing leaders and in judging their success, we all do our best to make the right decision. But our inherent biases have a nasty habit of getting in the way.

So how does gender impact the people we promote and the leaders we vote for? Research says 'quite a lot', and it starts long before we're reading a person's CV or hearing their election pitch. In spite of ourselves, the evidence shows that gender colours the way we view our day-to-day interactions.

Some examples? In an election scenario, a recording of a lower-pitched voice is perceived as more competent, stronger and more trustworthy than the same recording digitally manipulated to reflect a higher pitch. As such, the lower-pitched candidate was more likely to be chosen as leader by study participants. Our view of women, who on average have higher-pitched voices than men, is being formed the moment we hear them speak.

There are studies to show that women speak less than men in meetings, but are perceived to speak more. Another study that analysed the talking behaviour of US Senators found that when women did speak more than their share of the conversation, they were rated 14 per cent less competent by observers. Men who spoke more than their share were instead perceived as being 10 per cent more competent. So our female leaders walk the double bind of having less opportunity to demonstrate competency by contributing to discussion and decision, or instead speaking more and being viewed as less competent as a result.

When it comes to nominating for and receiving positions, both men and women are more likely to offer a job to a male candidate than to a female candidate with an identical CV. Additionally, if a fictitious advertisement for a leadership role is given to equally qualified men and women, women perceive themselves to be less suitable for the job than the men perceive themselves to be. So, women are less likely to put themselves forward for a leadership position than men, and we're all less likely to believe a women who does put herself forward should be given the role.

However, many of these effects can be reversed where an effort is made to do so. For example, the same study that identified a gender disparity in the amount of time speaking at meetings also found that when a decision was being made by unanimous vote rather than majority rule the effect disappeared, and female voices were equally heard. Additionally, while research shows that the characteristics typically associated with leadership are stereotypically masculine, it also shows that this effect is decreasing over time, and suggests flatter organisational hierarchies which promote teamwork and interaction as the cause.

When we find ourselves forming an opinion about a male leader, or a female one, we owe it to them to think about why. To reflect on which judgements are valid, and which are instead the result of seeing a majority of leaders look a particular type of way. Only once we've understood our biases can we set about changing them.

All of us are responsible for the promotion and election of our leaders; within medical education, within hospital management, and as our professions' representatives. And we need to get those decisions right.

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Private insurers being brought to account

BY **DR ROBYN LANGHAM**

The AMA's activities over several years to shed light on the egregious behaviour of certain private health insurers is now bearing fruit.

The Australian Competition and Consumer Commission (ACCC), the Commonwealth Ombudsman and the Federal Government are now taking action to curb unacceptable practices and shift the focus onto consumer needs, informed by AMA advice and submissions.

As part of its work in this area, the AMA recently made a submission to the Government's review of private health insurance policy. Our submission called for the Government to abolish 'junk' policies; prevent insurers from arbitrarily introducing exclusions in policies and benefit payment schedules without prior advice; and prohibit insurers from encouraging consumers to purchase a product, or downgrade their cover to a level that is inappropriate to their health care needs.

In addition, the AMA's inaugural *AMA Private Health Insurance Report Card* issued in February this year sent a clear message that consumers could not take at face value information provided by their health insurer. We warned consumers to avoid 'junk policies' – those that provide cover only for treatment in public hospitals – and to ensure they clearly understood the level of benefits paid by their insurer and likely out-of-pocket costs.

In response, the Government has now announced that it will eliminate junk policies as a part of its program of private health insurance reforms.

The Government also intends to create a three-tiered system of policies that will allow consumers to more easily choose a product that is right for them. It will mandate minimum levels of cover for policies, and develop standardised terminology for medical procedures.

These proposals will require detailed consideration to ensure an appropriate balance between private and public health care is maintained. This work will keep the Medical Practice Committee busy this year.

The Government has also responded to our complaints that the operations of third party comparator sites for private health insurance are not transparent; 'comparisons of best value' exclude some policies and commissions are kept secret. The Government will require third party comparator sites to publish commissions they receive, similar to the requirements for other financial services.

The Commonwealth Ombudsman is also investigating those insurers who are insisting on seeking 'pre-approvals' for plastic and reconstructive procedures. Many of our surgeon members have been affected by this practice in which insurers require private hospitals to get surgeons to fill in and 'certify' a form providing clinical details of the procedure and the reasons why it is necessary.

While insurers continue to claim that this process is not compulsory and does not constitute a 'preapproval', we understand that patients, hospitals and medical practitioners are being told that if forms are not submitted, benefits will not be paid.

In direct response to AMA concerns, the Department of Health wrote to all insurers in 2015 reminding them that, under law, they must pay benefits for a hospital treatment when an insured member undergoes a procedure for which a Medicare benefit is payable, and which is covered by their health insurance product.

Clearly this advice has been ignored, but the Ombudsman's investigation will hopefully put a stop to this practice.

Finally, the ACCC is taking legal action against Medibank Private for allegedly misleading consumers - specifically, failing to give notice to members on its decision to limit benefits paid for in-hospital pathology and radiology services.

As mentioned earlier, we raised the issue of arbitrary changes to policies and benefits in our submission to the Government's private health insurance review last year, but we also brought this to the attention of the ACCC in our 2016 submission concerning insurer activities designed to erode the value of private health insurance cover and maximise insurer profits.

Commenting on its legal action, the ACCC said: "Consumers are entitled to expect that they will be informed in advance of important changes to their private health insurance cover, as these changes can have significant financial consequences".

The AMA wholeheartedly agrees.

Govt must wise up after bruising election result

BY DR ROD McRAE, CHAIR, AMA COUNCIL OF PUBLIC HOSPITAL DOCTORS

" ... it is clear the Government had left the door wide open for the scare campaign, with several health-related faux-pas leading up to the election, including the proposal for co-payments, and some of its lingering health policies"

After a substantial delay, we now have a Government, and both major parties are in soul-searching mode.

What was clear from the election campaign was the significant focus on health. Prime Minister Malcolm Turnbull indicated that the so-called 'scare campaign' on the privatisation of Medicare had had some effect, and the Coalition needed to do more to reassure the electorate that his Government was committed to health, hospitals and Medicare funding.

This is all highly noble in hindsight, but it is clear the Government had left the door wide open for the scare campaign, with several health-related faux-pas leading up to the election, including the proposal for co-payments, and some of its lingering health policies. Australians value their health, but particularly the work of public hospital doctors. A scare campaign does little to instil confidence in a system buckling under the pressure of enormous budget cuts and ongoing high expectations for service delivery.

You will remember that there were two models of co-payment, and both of them were roundly rejected by the AMA. Neither model accounted for the neediest in our community, who frequent our public hospitals. Evidence suggests that some people, when faced with even nominal costs, will defer necessary visits to the doctor, and even potentially life-saving procedures or investigations such as blood tests, x-rays or ultrasounds. This just compounds problems down the track, with patients more likely to face emergency presentations.

We understand the Government's desire to constrain health spending, but sustained health care available to all Australians is the most economical model in the long run. We don't want to emulate highly-paid CEOs and their short-term financial goals.

Whatever model we develop, we must account for those in the community whose access to health care is constrained by factors such as location and/or social and economic circumstances.

The AMA needs to be part of an open, responsible debate about funding the national health system. There are elements of the health system that the Commonwealth pays for directly, but State Governments are struggling to fund the increasing demands on health and public hospitals, leading to the budget cuts we know too well.

It should not be forgotten that our health system represents great value for money by world standards, particularly in certain areas, but our public hospitals are now overtly overworked and underfunded. They are truly an investment in the health of our nation, our economic productivity and our future. Minister Ley must continue to make these arguments at the highest levels of Cabinet.

Having admitted that health worked against it in the election, the Government must now "wise up" and set a new health policy direction. Alongside issues such as the Medicare rebate freeze, the Government must, from the public hospital doctors' perspective, properly fund public hospitals and make a renewed commitment to investing in preventive health measures.

Most importantly, the Government must consult closely with the profession in the development of health policies to ensure better outcomes. They must recognise that the medical profession is best placed to advise on health policy.

I look forward to engaging with you through the Council of Public Hospital Doctors as we advocate on these and other important issues and brace for the journey ahead.

Government investment in doctors of the future still falling short

BY AMA VICE PRESIDENT DR TONY BARTONE

As the new Chair of the Medical Workforce Committee (MWC), I am looking forward to harnessing the committee to drive the AMA's response to the medical workforce crisis.

I would like to acknowledge Dr Stephen Parnis for his stewardship of the MWC as inaugural Chair. Like Stephen, I have a long-standing interest in medical workforce issues, and believe that ensuring Australia has the medical workforce to meet community needs is a critical challenge for governments and health policymakers.

Over the last 15 years the number of medical school places has increased substantially in response to past workforce shortages. But the need for more medical schools is over, as we know from successive sets of workforce data that Australia now has sufficient numbers of medical students. We must now focus on improving the distribution of the medical workforce, and providing enough postgraduate medical training places, particularly in rural and remote areas and the under-supplied specialty areas.

At the recent Federal Election, the AMA offered four important policy proposals to help achieve this outcome:

- expanding the National Medical Training Advisory Network's (NMTAN) workforce modelling program;
- establishing a Community Residency Program;
- increasing the GP training program intake; and
- expanding the Specialist Training Program.

NMTAN is the Commonwealth's main medical workforce training advisory body, and focuses on planning and coordination. It has representatives from the main stakeholder groups in medical education, training and employment.

NMTAN's report on the psychiatry workforce was released in March. This is the first specialty report to be finalised by NMTAN since Health Workforce Australia was axed in 2014. It contains valuable data and analysis, including a projected undersupply of 125 practitioners by 2030 for the psychiatry workforce, despite a likely increase in the number of Australian-trained psychiatrists.

NMTAN is intending to beef up its work program. The AMA has argued consistently for complete workforce modelling and reporting across all medical specialties by the end of 2018; it is vital to have data sooner rather than later on imbalances across the specialties to enable effective workforce planning.

We will continue to engage with the Government of this issue. In the meantime, we await with interest the expected release of the reports on the anaesthesia and general practice workforces later this year.

An important piece of work undertaken by the MWC last year was developing the Community Residency Program for Junior Medical Officers (CRP). This is the AMA's proposal to establish and fund a program for high-quality prevocational placements in general practice for junior doctors as a replacement for the valuable Prevocational General Practice Placements Program abolished by the Government in 2014.

We continue to lobby for our CRP. The Government's announcement late last year that it will fund 240 rotations in general practice settings for rural-based interns is a partial replacement for the PGPPP, and was an admission by the Government that its decision to abolish the program was a backward step, especially for rural health.

As a practising GP, I am keenly aware that more resources are needed to build and maintain a sustainable GP workforce.

The AMA's call to increase the GP training program intake to 1700 places a year by 2018 is worthy of the Government's consideration. This must be backed with solid measures to support GP training, including incentives for supervisors and investment in training infrastructure. Rural general practices need grants to help them expand their facilities and provide more teaching opportunities for medicals students and GP registrars, and to enhance the range of services they provide.

The Commonwealth's Specialist Training Program (STP) is a valuable workforce program that is giving specialist trainees the opportunity to train in settings outside traditional metropolitan teaching hospitals. Though the Government has committed to provide 1000 placements by 2018, the AMA strongly believes that the STP must be expanded to 1400 places a year, with the focus on encouraging specialist training in rural settings and specialties that are under-supplied.

Other areas of focus for the MWC will be promoting generalism in the medical workforce, encouraging greater gender diversity in medical leadership, and increasing clinical supervision capacity.

Progress, but much more to do.

Care for yourself, and each other

World Suicide Prevention Day, 10 September

BY DR HIROWATARI, CHAIR, AMA COUNCIL OF RURAL DOCTORS

In our small town in Queensland, we are reeling from the recent suicide of a colleague. Tragically, every year too many doctors die at their own hand.

What is it about our profession that makes suicide a particular risk? Is it the paradox of a "healing" profession harmed by the very nature of their work?

Below are what I think are some of the contributing factors.

Overwork and exhaustion. This is coupled with burnout, sleep deprivation, trying to valiantly do handle an impossible workload with insufficient time, resources, and support. It is a form of external and self-abuse. We are working longer hours and are on call longer and more frequently than our urban colleagues. Cut yourself some slack, do not strive for perfectionism.

Stress. Conflict at work, depth of responsibilities, financial worries, relationships, loss of autonomy - there are multiple sources of stress. With every morbid outcome we witness we are at risk of post-traumatic stress. And we feel alone. We are discouraged from showing stress. Do not convert this stress into cynicism; remember the high ideals that brought you to this career.

Substance Use. In a 2013 beyond blue survey, doctors in rural and remote areas reported higher levels of risky alcohol use than their metropolitan colleagues, and those who said they were under significant stress reported even heavier use. In dry communities, this behaviour is literally under the table – people have to hide their drinking and often feel shame. Just for today, say, no.

Lack of balance. Do we spend our downtime working? Go to the toilet when you need to, eat meals, sleep, exercise - the rest of the world does. Get away from your rural isolation, make a trip to the big city or do some four-wheel driving away from the community. Bushwalk. Take a swag. Fishing? Stargazing? No mobile signal? The flip side of no ADSL is the ability to get out of mobile telephone range. Milk this. The outback has much to offer.

Mental health issues. A quarter of doctors surveyed by *beyond blue* say they have considered suicide, and 2 per cent have actually attempted it. As a profession, we are clinically depressed at a rate higher than the general population. Also, as a profession, we need to totally remove the stigma surrounding mental health issues affecting ourselves and our colleagues. They are illnesses that require looking at. Like any other illness, there are preventable risk factors, causes, diagnoses and management. We must support and look out for each other. We do it for our patients and families. We need to do it for each other.

Our resilience is high, but so are the barriers to seeking help, like issues of privacy, AHPRA's mandatory reporting regime, embarrassment, and career development fears. Take the time to see a consultant who does not reside in your own head. Do not self-medicate. Consider meditation, mindfulness or explore spirituality. Five telephone counselling sessions are provided free by your College, and video specialist visits are available not just for your patients, but also to you. Every State now has a confidential doctor's support program.

Medical error or near error. The shame, the hiding of uncertainty, the fear of incompetency. We in the outback are generally GPs, which means we are not specialists in a defined area of expertise. So yes, at times we are working out of our comfort zone. Find a mentor, it is scary here. To my urban colleagues, I ask that you develop a tolerance for a rural doctor who is not superhuman

Criticism. This comes from colleagues, patients, employers, even strangers. It can be demoralising. Journal the criticism. The bullying, the snide remarks, racist/sexist comments, even a simple unsupporting "hmph" cuts us. Report abuse, talk about it. The greatest of these criticisms is the dreaded letter from our medical governing body: a subpoena to appear in court to defend our medical actions. Can our governing bodies find it in their hearts to empathise? With every letter calling us to defend our actions to the Board, can there also be a list of doctors willing to mentor a distressed colleague? Show us a registry of good outcomes, not just the bad ones.

The doctors around me in this small town are slowly coming out of their state of disbelief regarding the loss of their friend. I see their eyes humbly looking at each other with a deeper look.

I wish them a path through their confusion. I feel privileged when they talk to me about their pain.

I hope we can continue to talk about the fatal act as a form of prevention, and to help with the healing.

This year, 10 September is World Suicide Prevention Day. Let this small article prevent even one suicide.

Research

Sweeteners sabotage weightwatchers

Millions of Australians regularly turn to artificial sweeteners to help them lose weight, but research has found that they might be doing more harm than good.

University of Sydney research has shown that artificial sweeteners could actually be making you feel hungry, eat more, and may cause hyperactivity, insomnia, and glucose intolerance.

Researchers examined the effects of artificial sweeteners on the brain in regulating appetite and in altering taste perceptions in both animals and humans.

Lead researcher, Associate Professor Greg Neely, was inspired to research the issue after he noticed his stomach growling with hunger after consuming a diet soft drink.

Associate Professor Neely said after chronic exposure to a diet that contained artificial sweetener sucralose (Splenda), animals began eating a lot more.

“Through systematic investigation, we found that inside the brain’s reward centres, sweet sensation is integrated with energy content. When sweetness versus energy is out of balance for a period of time, the brain recalibrates and increases total calories consumed,” A/Professor Neely said.

Essentially, if the reward centre measures sweetness coming in from food but does not find an increase in the energy coming in, it will demand more energy, Associate Professor Neely said.

In his study with fruit flies, it was found that they consumed 30 per cent more calories when fed on a diet including the artificial sweetener sucralose for more than five days compared with when they were given naturally sweetened food.

“When we investigated why animals were eating more even though they had enough calories, we found that chronic consumption of this artificial sweetener actually increases the sweet intensity of real nutritive sugar, and then this increases the animal’s overall motivation to eat more food,” A/Professor Neely said.

The researchers also found artificial sweeteners promoted hyperactivity, insomnia and other behaviours consistent with a mild starvation or fasting state.

Worldwide, obesity has more than doubled in the last 30 years. While debate rages over precisely what is driving this, it is generally thought there is a mix of genetic and environmental causes at work.

Millions of people are consuming artificial sweeteners in an effort to control their weight, and they are prescribed as a tool to treat obesity, despite little being known about their full impact on the brain and in regulating hunger.

The study was published in *Cell Metabolism.*

KIRSTY WATERFORD

Under the Microscope

Hereditary blindness cured?

A Tasmanian-led research team has successfully altered eye tissue in a laboratory by replacing genes that cause blindness with normal genes.

The team used molecular gene shears deployed through a simple injection into the eye. The shears latched on to individual eye cells, chopped out DNA fragments containing rogue genes, and replaced them with normal genes.

Lead researcher Associate Professor Alex Hewitt, from the University of Tasmania’s Menzies Institute, said regulators would need to be satisfied that the technique was safe, and that the shears could be turned off once they had done their job before starting human trials.

Human medical trials are expected to commence in less than five years.

For more information visit http://www.menzies.utas.edu.au/home/nested-content/feature-large/our-research-is-leading-the-way-towards-prevention-and-better-treatment-of-inherited-eye-diseases

Malaria’s weakness exploited

Australian National University researchers have found that changes in the protein that enables a malaria parasite to evade several anti-malaria drugs also make the parasite hyper-sensitive to other therapies – a weakness that could be exploited to cure the deadly disease.

The researchers said the findings could prolong the use of several anti-malarial drugs to treat the disease which kills 600,000 people around the world each year.

Lead researcher Dr Rowena Martin said the interactions of the modified protein with certain drugs were so intense that it was unable to effectively perform its normal role, which was essential to the parasite’s survival.

Research

Quit sugar messages no help in obesity battle

Health messages demonising sugar, fat and other nutrients are too simplistic and are hampering efforts to tackle the obesity crisis and its related health problems, according to scientists urging an overhaul in the approach to human diets.

In what researchers from the University of Sydney are calling "a radical rethinking of human nutrition science", they have developed a 'nutrition geometry' model which considers how mixtures of nutrients and other dietary components together influence health and disease, rather than focusing on any one nutrient in isolation.

The researchers hope the new approach will assist health professionals, dieticians and researchers to better understand and manage the complexities of obesity.

Lead researcher, Professor Stephen Simpson, said that the framework challenges prevailing thinking in the field of human nutrition and proposes that an approach based on nutrient balance will be more helpful in understanding the causes of complex chronic conditions diseases than the current single nutrient focus.

The traditional approach is no longer useful in the face of modern nutrition-related diseases which are driven by an overabundance of food, an evolved fondness for foods containing particular blends of nutrients, and clever marketing by the food industry, the researchers said.

"Conventional thinking that demonises fat, carbohydrate, or sugar in isolation as causes of the obesity crisis, known as the single nutrient approach, has now run its course," Professor Simpson said.

"We've provided a framework for not only thinking about, but also experimentally testing, issues around dietary balance. "

The 'nutritional geometry' frameworks assists in plotting foods, diets, and dietary patterns together based on their nutritional composition. This helps observe otherwise overlooked patterns in the links between certain diets, health and disease.

The new model enables complex problems like obesity to be viewed from a variety of perspectives.

The researchers plotted data regarding the composition of 116 diets, compiled from previous published studies examining macronutrient ratios (carbohydrate, fats and protein) and energy intake.

"Although at face value more complex than the single nutrient model, our 'nutritional geometry' framework can simplify the study of human nutrition in the long run by helping to identify those subsets of factors and interactions that are driving negative health and environmental outcomes in our rapidly changing environments," Professor Simpson said.

The study was published in the *Annual Review of Nutrition.*

KIRSTY WATERFORD

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"Essentially, the parasite can't have its cake and eat it too. So if an anti-malaria drug is paired with a drug that is super-active against the modified protein, no matter what the parasite tries to do it's checkmate for malaria."

The study was published in the *PLOS Pathogens* journal.

Low rates of cervical cancer screening

A report by the Australian Institute of Health and Welfare has found that only three in five eligible Australian women had a pap test in the past two years.

In 2013-2014, 3.8 million women aged 20 to 69 years (57 per cent) participated in cervical screening.

Despite the low participation rate, Australia's cervical cancer rates are considered low by international standards.

In 2012, there were 725 new cases of cervical cancer diagnosed and in 2013 there were 149 deaths. This is equivalent to between nine and ten new cases of cervical cancer diagnosed per 100,000 women and two deaths from cervical cancer per 100,000 women.

For more information the report, *Cervical screening in Australia 2013-2014*, can be found at http://www.aihw.gov.au/publication-detail/?id=60129554885

Pain leading cause of severe behaviour in dementia

Existing or undiagnosed pain has been linked to severe behavioural symptoms associated with dementia, according to Australian researchers.

Associate Professor Stephen Macfarlane, Head

Research

RNA may lead to heart disease cure

Researchers believe they are a step closer to finding a cure for heart disease following advances in understanding how the human genome effects the formation and operation of heart muscle cells.

Australian National University researchers have examined how the genome interacts with RNA-binding proteins – temporary copies of genetic information stored in DNA – to gain fresh insights into how to tackle heart disease.

All cellular life uses DNA to store genetic information and to pass it on through the generations. But the information is useless unless it is copied into chemically similar but more versatile nucleic acid molecules called RNA.

RNA carries the code for making proteins, but it also has non-coding regulatory roles that are particularly important in architecturally complex beings.

Lead researcher Professor Thomas Preiss said the finding opened new avenues of research into RNAs.

"In studying how RNA-protein interactions govern genome function in the heart, we saw potential for both the generation of knowledge and, ultimately, the development of new therapy," Professor Preiss said.

"So we endeavoured to establish a collection of RNA-binding proteins that are active in heart muscle cells."

The research team identified more than 1000 RNA-binding proteins by using innovative protein analysis methods. These enabled them to catch proteins in the act of binding RNA, and also identify what part of the protein was in contact with the nucleic acid. As a result, they identified new types of protein surfaces capable of interacting with RNA.

Heart disease is a leading cause of death. On average, one Australian dies from heart disease every 27 minutes.

Improvements in diet, lifestyle and treatment in recent years has seen the death rate decline, and the ANU researchers said work on the function of RNA-binding proteins had the potential to deliver further gains.

KIRSTY WATERFORD

Under the Microscope

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of the Clinical Governance for the Dementia Centre for HammondCare, and his research team identified that in 65 per cent of cases, pain was the main contributing factor to severe behaviours in dementia patients. Other leading factors included environment (60 per cent), limited carer knowledge (38 per cent), and depression (21 per cent).

Associate Professor Macfarlane said that it was common to find that, instances where pain contributed to behaviours involving aggression, agitation, and anxiety for dementia patients, that once it was alleviated the intensity of such behaviours was significantly reduced.

"Pain is an enormous issue for people living with dementia, and for older people generally, and is often undiagnosed as a contributing factor to behaviours," Associate Professor Macfarlane said.

For more information visit - http://www.hammond.com.au/news/pain-major-contributing-factor-for-severe-behaviours-in-dementia

Whole-genome testing now available

Australia has its first clinical whole-genome sequencing service which could triple the diagnosis rates for Australians living with rare and genetic conditions.

The service was launched by the Garvan Institute of Medical Research's Kinghorn Centre for Clinical Genomics. Director Professor John Mattick said the service marked a turning point in disease diagnosis and health care in Australia.

Patients seeking a diagnosis for a possible genetic condition will be referred to a clinical genetic service which will work with NSW Health Pathology to assess whether whole genome sequencing can provide an answer.

Those who may benefit will then be able to access the service, which will screen all 20,000 genes at one time.

The simple blood test costs $4300, and has the capacity to identify the biological cause of illnesses so rare only a handful of people have the condition worldwide.

For more information visit http://www.garvan.org.au/research/kinghorn-centre-for-clinical-genomics/clinical-genomics/sequencing-services

KIRSTY WATERFORD

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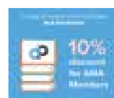

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