AUSTRALIAN
Medicine
The national news publication of the Australian Medical Association

Change course

Government faces ballot box pain on health, p7

INSIDE

ISSUE 28.01 FEBRUARY 15 2016

AMA

AUSTRALIAN
Medicine

Managing Editor: John Flannery
Editor: Adrian Rollins
Production Coordinator: Kirsty Waterford
Contributors: Sanja Novakovic
Odette Visser
Graphic Design: Streamline Creative, Canberra

Australian Medicine is the national news publication of the Australian Medical Association Limited. (ACN 008426793)

42 Macquarie St, Barton ACT 2600
Telephone: (02) 6270 5400
Facsimile: (02) 6270 5499
Web: www.ama.com.au
Email: ausmed@ama.com.au

AMA LEADERSHIP TEAM

President
Professor Brian Owler

Vice President
Dr Stephen Parnis

In this issue

Freeze just the tip of the iceberg

BY AMA PRESIDENT PROFESSOR BRIAN OWLER

Parliament has resumed in Canberra and, despite hollow threats of a possible double dissolution election, the expectation is that the Federal election will be in August or September – a timeframe repeatedly endorsed by Prime Minister Malcolm Turnbull.

With the Budget in May, there is not a lot of time for the Government – and the Opposition – to put together compelling election policy platforms.

The early days of debate in Canberra were dominated by tax, specifically the prospect of raising the rate of the GST to 15 per cent, with some states backing this move as the only way to rescue their Budgets from the growing burden of funding health and education.

While the tax arguments will carry through until the election, other policy battles will be fought to win votes, with health and education near the top of the list.

After more than two years in power, the Government is yet to stake a strong claim for votes with its health agenda.

The 2014 Health Budget, with the co-payment at its core, set the scene for the Government on health. It was an ugly scene, and it has not changed.

The co-payment may be gone, but the damaging effects of that ill-fated policy linger, primarily in the shape of the Medicare patient rebate freeze.

Health Minister Sussan Ley has often said publicly that the freeze was only a short term measure, but it is highly unlikely to be gone before the election as the Government continues to hunt for savings across all portfolios.

Meanwhile, the freeze builds resentment in GP ranks and penalises patients.

But the freeze – as bad as it is – is only the tip of a very damaging health policy iceberg that threatens our health system.

The Government's strategy to turn around the co-payment damage has been to introduce a range of reviews, with the promise of new policy to come out of these reviews.

The big problem is that, despite denials, the reviews seem geared to put further Budget savings ahead of better patient services and outcomes.

This is not the time to take money out of health.

The MBS Review has to date come forward with fairly predictable item numbers to be scrapped, but they are the sort of things that would come through the MSAC process.

The more substantial work of this Review still lies ahead, and will most likely go beyond the election cycle. However, we may see some hints in the May Budget.

The Primary Health Care Advisory Group delivered its report to Government in December, and this work is expected to be reflected in Health Budget decisions in May.

The Private Health Insurance sector review may also play into Budget and election considerations.

The Government's raft of reviews has left very little of the health landscape untouched. How the Government responds to these reviews – in Budget and policy responses – may well have a significant electoral impact, especially if key health stakeholders are not properly engaged in any reform processes.

The recent AMA Public Hospital Report Card shines a very strong spotlight on what the AMA sees as major concerns about the Government's approach to the health portfolio – a preoccupation with funding cuts ahead of good health policy, and an apparent strategy for the Federal Government to retreat from its traditional key roles in providing health funding and services.

The latest Report Card provided a snapshot of the building public hospital crisis that has its origins in the 2014 Budget, most notably the abolition of National Partnership Agreement funding to the States, which Treasury estimated to total $57 billion between 2017 and 2025.

That is a significant funding cut, which comes on top of overall reductions in funding growth in subsequent Budgets.

The public hospital funding cuts shift all the responsibility on to the states and territories, which are already struggling with their own Budget situations.

The broader cuts shift a greater burden on to doctors and other health professionals to do more with less.

And the accumulated cuts to rebates and services shift costs on to patients, and will make it harder for many to access the care that they need.

This is not a health policy platform to take to a Federal election.

The AMA will be working hard to ensure that all the major parties take more positive policies to the election – policies that heed the advice of the medical profession, and respond to the needs of patients and the community.

Grasping insurers endanger clinical autonomy

BY **AMA VICE PRESIDENT DR STEPHEN PARNIS**

> "In our submission to the Government's review of private health insurance, we argued for the continuation of community rating, as it is essential to maintain the delicate balance between the public and private hospital sectors in the Australian health system"

Private health insurance is a hot topic at the moment. The big insurers are using aggressive tactics to reduce their benefit outlays (and increase their profits for their shareholders). New clauses in hospital contracts for non-payment for hospital acquired complications and readmissions within 28 days, and adding more exclusions to existing policies, will have a detrimental impact on our ability to care for our privately insured patients.

In Australia, the public and private systems work together as a part of a health system that provides universal access for patients to affordable health care. A strong private sector is essential to support the public hospital sector in meeting the needs of the uninsured.

In our submission to the Government's review of private health insurance, we argued for the continuation of community rating, as it is essential to maintain the delicate balance between the public and private hospital sectors in the Australian health system.

We called for the elimination of "junk" policies - those that meet the requirements to avoid the Medicare Levy Surcharge, but only cover treatment in public hospitals.

Finally, we pointed out that insurers themselves have been undermining the private health insurance product in several ways, including by:

- Insisting on hospital contracts that interfere with the established safety and quality system achieved by accreditation arrangements;
- adding more exclusions to existing policies;
- removing services from schedules of medical benefits;
- selling inappropriate policies to people who are likely to need treatment not covered by the policy;
- encouraging policy holders to downgrade their cover;
- requiring detailed clinical information and justifications to be submitted at the time of booking hospital treatment; and
- rejecting claims unless and until they are disputed by the patient or their doctor .

The AMA has and will continue to seek regulatory changes to contain these behaviours.

On the issue of interfering with the established safety and quality system, the Australian Commission on Safety and Quality in Health Care has published its list of Hospital Acquired Complications, noting its role in monitoring and improving safety, and underlining its unsuitability as a mechanism for non payment.

However, Medibank has managed to convince more than 120 (or 70 per cent) of Australia's private hospitals to sign contracts with non-payment clauses.

The clauses have significant consequences for medical practitioners. The patient's insurer will decide if the patient's care was in accordance with clinical guidelines. If a departure from the guidelines isn't sufficiently explained by the hospital or the doctor, the hospital will incur the cost of the difference between an episode with no complications and the actual episode.

The AMA cannot accept that these decisions are the remit of the private health insurers – the consequences for clinical autonomy are obvious. The additional medico-legal exposure is yet to be explored.

The AMA President has written to the CEO of Medibank Private seeking transparency of these audit arrangements so that:

- it is clear to patients how their clinical information will be used by Medibank;
- the health care sector can quantify the additional administration that Medibank's process will add to the delivery of health care in Australia; and
- it is clear to the sector how Medibank's process interferes with, or enhances, the existing risk management framework to identify, minimise and manage clinical risks that are required under the accreditation arrangements.

In a recent meeting with Medibank officials, the AMA was advised that doctors should approach their hospital administrators for details of the audit arrangements.

I urge you to do that, and to let me know if you believe there is undue interference in the clinical care of your patients.

In the meantime, the AMA will pursue appropriate transparency and scrutiny of the Medibank arrangements, which are no doubt being closely watched by other insurers.

Private health insurers should not be introducing safety and quality measures that are in isolation to the work that is being done by the Australian Commission on Safety and Quality in Healthcare, nor in a punitive way against all the literature that acknowledges that continuous improvement in safety and quality in healthcare is a shared responsibility that must be embedded within organisations at every level.

To deal with member concerns around patients finding out that they are not covered at the time of a procedure, or having higher out-of-pocket costs than expected, the Medical Practice Committee of the AMA is producing a Private Health Insurance Report Card. Further details are contained in the Medical Practice Committee report in this edition.

INFORMATION FOR MEMBERS

Road Safety

The 2016 Australasian Road Safety Conference 2016 (ARSC2016), the premier road safety conference for Australia, New Zealand and the Asia Pacific, will be held in Canberra from 6 to 8 September this year.

Hosted by the Australasian College of Road Safety (ACRS), Austroads, and The George Institute for Global Health, the theme for 2016 is "Agility, Innovation, IMPACT".

The Conference will have a special focus on harnessing the latest research, technology and policy innovations to produce the best road trauma reduction outcomes possible

The AMA continues to make an important contribution to the ongoing national campaign to reduce road fatalities and road trauma.

As a neurosurgeon, AMA President Professor Brian Owler frequently witnesses the tragic consequences of speeding, and has a strong personal commitment to improving road safety.

Professor Owler has been the face of New South Wales' Don't Rush campaign since 2010. This prominent advertising campaign has contributed to a reduction in speed and fatigue-related injury and death in that state.

But speeding, fatigue and risk-taking behaviours continue to contribute to too many lives being lost and harmed on Australian roads.

The annual economic cost of road crashes in Australia is enormous — estimated at $27 billion — and the social impacts are devastating.

Doctors play an important role in terms of assessing whether patients are fit to drive. Illness and disease may impair someone's ability to drive, temporarily or permanently.

The AMA website has a link to the National Transport Commission publication *Assessing Fitness to Drive: medical standards for licensing and clinical management guidelines. A resource for health professional in Australia (March 2012 as amended up to 30 June 2014)*, which can be used by doctors to help assess the fitness of a patient to drive.

Election time at the AMA

BY **AMA SECRETARY GENERAL ANNE TRIMMER**

> "I encourage members with an interest in participating in shaping the AMA's medico-political policies and positions to consider nominating for election to Federal Council, particularly those members who have policy experience within a State AMA or within their specialist College, association or society"

A happy new year to readers of *Australian Medicine*.

While the start of 2016 has been somewhat quieter on the medico-political front than last year, there is still a lot happening. Various reviews announced in 2015 (including of the Medicare Benefits Schedule and private health insurance) are part-way through, and some significant changes to funding for pathology tests and diagnostic imaging were announced in the Government's Mid Year Economic and Fiscal Outlook released in December.

The year will bring a Federal election. While timing is not confirmed, the Prime Minister and other senior Ministers seem committed to an election during the September-October period.

Prior to the election, the major parties will be releasing their health policies, which the AMA will consider with interest.

In its pre-Budget submission released this month, the AMA has outlined its position on the major issues likely to be considered in the lead-up to the election.

In 2016, the AMA has its own elections – for the President and Vice President, who will be elected by delegates at National Conference, and for elected positions on Federal Council. The positions on Federal Council up for election are Area Nominees (for each of five geographic areas – Queensland, NSW/ACT, Victoria, Tasmania, SA/NT, WA), Specialty Groups, and Special Interest Groups (Public Hospital Doctors, formerly called Salaried Doctors, Doctors in Training, Rural Doctors, Private Specialist Practice Doctors).

I encourage members with an interest in participating in shaping the AMA's medico-political policies and positions to consider nominating for election to Federal Council, particularly those members who have policy experience within a State AMA or within their specialist College, association or society.

Federal Council should reflect the diversity of medical practitioners and the wider AMA membership to ensure a breadth of views is contributing to policy development.

A nomination form can be downloaded via the advertisement calling for nominations, which can be found in this edition of Australian Medicine.

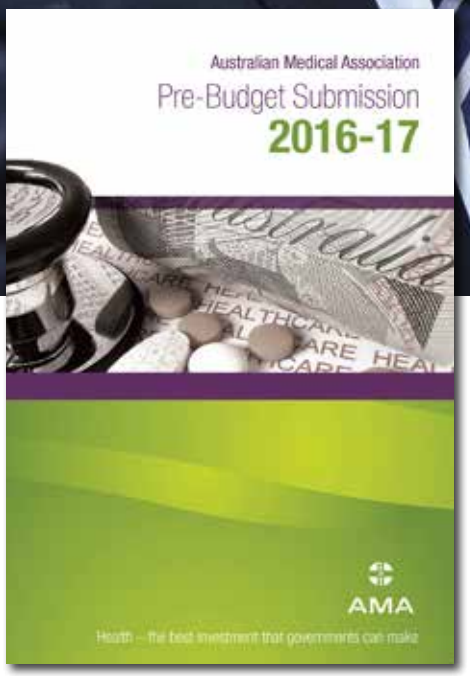
For the first time, in 2016 elections for members of Federal Council will be conducted electronically. Eligible members will receive an email with a one time token and link to a ballot paper. Some members will receive more than one ballot paper, depending on the groups they are associated with in the member database.

Most members routinely provide an email address, and this is becoming the primary means of contact with the AMA. The email address is used to identify members through the member-only section of the website, and in providing access to doctorportal. It will also become the means by which a ballot paper is delivered. If you do not have a personal email address registered with the AMA, I encourage you to log on to ama.com.au to update your details (which can be found on the profile page) in order to participate in the election process. Further information on the balloting process will be provided over the next month before the elections commence.

We always appreciate member feedback on AMA advocacy, policies, services, and membership offerings. The opportunity for direct member engagement in policy development will become a feature of your membership during 2016.

Again, I urge you to ensure that you have an up to date personal email address in your member record.

Government faces ballot box pain on health



The Federal Government could pay a hefty price at the ballot box unless it changes course on health policy, the AMA President Professor Brian Owler has warned.

As senior Ministers thrash out details of the all-important pre-election Budget behind closed doors, Professor Owler cautioned that how the Government responds to the many reviews it has commissioned across health, particularly regarding Medicare, primary health and private health insurance, “may well have a significant electoral impact, especially if key health stakeholders are not properly engaged”.

Government faces ballot box pain on health

... from p7

Professor Owler called for a fundamental shift away from the Government's current emphasis on cutting spending and offloading the funding burden onto patients and the states and territories.

"The Government is on a path of funding cuts and shifting costs to patients," the AMA President said. "This is not good for the Australian health system or the health of Australians.

He urged it to "change tack...before it is too late", warning the Government its current approach might m.

> "There is an urgent need to put the focus back on the strong foundations of the health system" – *Brian Owler*

Professor Owler's comments framed the AMA's *Pre-Budget Submission*, which includes detailed recommendations across 18 areas of health policy, from Medicare indexation and reform of hospital funding to GP infrastructure grants, palliative care, alcohol and tobacco policy and immunisation.

The AMA President said the submission gave the Government a guide on how to recalibrate its policy to end the current retreat from core responsibilities in funding and delivering health services.

"There is an urgent need to put the focus back on the strong foundations of the health system," Professor Owler said. "We need a strong balance between the public and private system, properly funded public hospitals, strong investment in general practice, and a priority put on prevention."

There are already signs that Government decisions are having an adverse effect on health services.

The AMA Public Hospital Report Card released in late January showed that improvements in hospital performance have stalled, and in some instances have gone backwards, since the Government's decision to 2014 to rip hundreds of millions of extra funding out of the system.

Professor Owler said the cuts, combined with a downshift in the indexation of Commonwealth hospital funding from next year, showed the Government's preoccupation with funding cuts came at the expense of good health policy.

The Government's response to the mental health review provided more worrying signs of how it might approach other areas of reform, he said.

Under the new approach, Primary Health Networks will be paid by the Commonwealth to provide tailored "integrated care packages" for patients with mental health problems.

Professor Owler said there was no commitment to a key role for GPs in providing care, and the Government had provided scant other detail.

"The worry is that the mental health approach may be a signal for what is to come with the Primary Health Review," he said, and added that a proposal for hospital funding to be replaced by a Medicare-style "hospital benefit payment" that would follow patients was also a worrying sign.

The AMA President said the Government had actively demonised doctors in its MBS review process, had encouraged private health funds to play a more active role in all areas of health despite concerns over inappropriate behaviour and poor value products, and showed signs of pursuing a US-style managed care system.

He warned that "this is not a health policy platform to take to a Federal election".

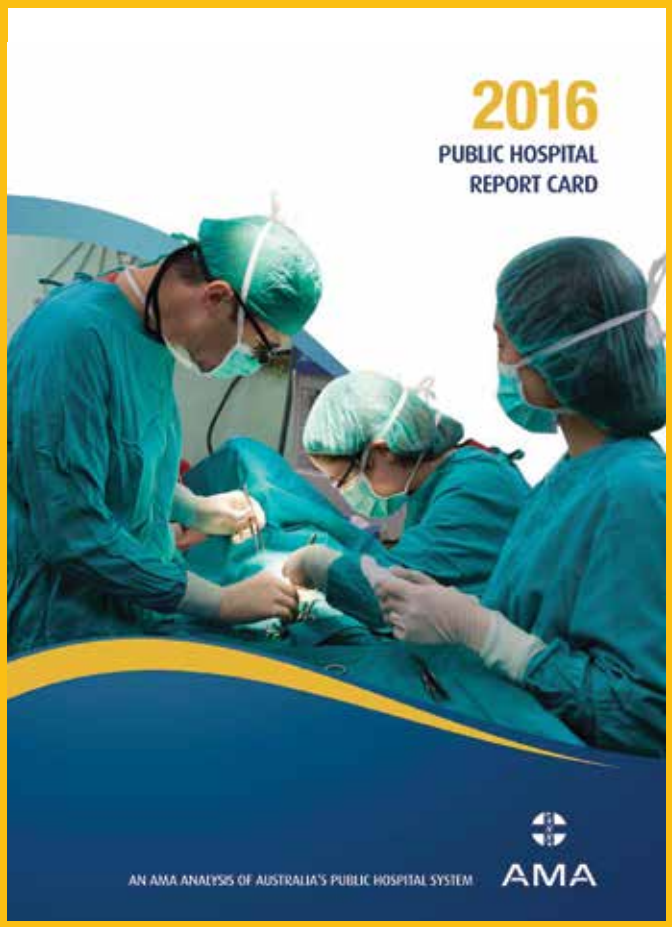
In its 27-page Budget submission, the AMA proposed the Government immediately reinstate indexation of Medicare rebates; increase indexation of public hospital funding to a rate that reflects growth in the cost of health goods and services; recognise the both the Commonwealth and the state and territories all have a role in funding and providing health services; explicitly address the role of the private sector in delivering care; and give patients the right to assign their Medicare benefit direct to the provider.

Professor Owler said the nation needed a health system built on "modern health policies, not outdated economic policies designed only to improve the bottom line".

ADRIAN ROLLINS

Hospitals struggle as Govt applies funding brakes

"The states and territories are facing a public hospital funding black hole from 2017 when growth in Federal funding slows to a trickle." – *Brian Owler*



Almost a third of Emergency Department patients in need of urgent treatment are being forced to wait more than 30 minutes to be seen, while thousands of others face months-long delays for elective surgery as under-resourced public hospitals struggle to cope with increasing demand.

The AMA's latest snapshot of the health of the nation's public hospital system shows that improvements in performance have stalled following a sharp slowdown in Federal Government funding, underlining doctor concerns that patients are paying a high price for Budget austerity.

"By any measure, we have reached a crisis point in public hospital funding," AMA President Professor Brian Owler said. "The states and territories are facing a public hospital funding black hole from 2017 when growth in Federal funding slows to a trickle."

The Federal Government will have slashed $454 million from hospital funding by 2017-18, and a downshift in the indexation of spending from mid-2018 will reduce its contribution by a further $57 billion by 2024-25.

Professor Owler said the consequences of Commonwealth cutbacks were already showing up in hospital performance, and the steep slowdown in funding growth in coming years will further exacerbate the situation.

"Public hospital funding is about to become the single biggest challenge facing State and Territory finances, and the dire consequences are already starting to show," the AMA President said. "Without sufficient funding to increase capacity, public hospitals will never meet the targets set by governments, and patients will wait longer for treatment."

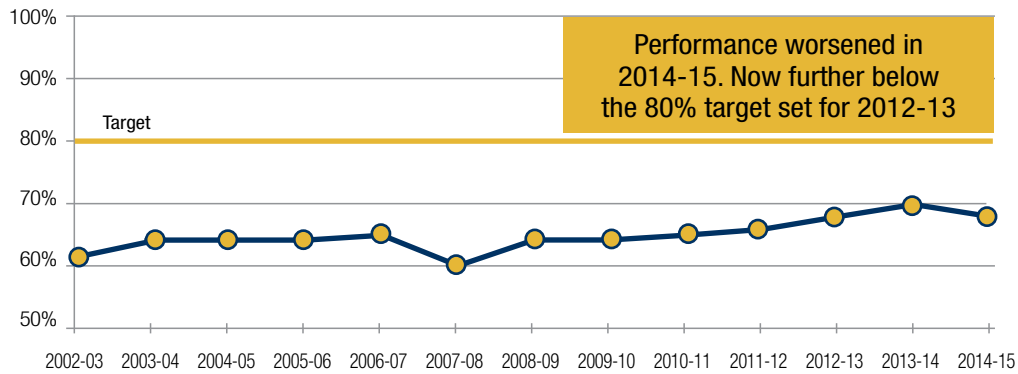
The AMA's Report Card, drawing on information from the Australian Institute of Health and Welfare, the Council of Australian Governments Reform Council and Treasury, shows the performance of public hospitals against several key indicators has plateaued and, by some measures, is declining.

In terms of hospital capacity, the long-term trend toward fewer beds per capita is continuing. The decline is even more marked when measured in terms of the number of beds for every 1000 people aged 65 years of older – a fast growing age group with the highest demand for hospital services.

Hospitals struggle as Govt applies funding brakes

... from p9

Percentage of Triage Category 3 (urgent) Emergency Department patients seen within recommended time (<30 minutes) – Australia



Sources: The State of our Public Hospitals (DoHA, 2004 – 2010); AIHW Australian Hospital Statistics: Emergency department care (2010-11 – 2014-15)

In 1993, there were almost 30 beds for every 1000 older people, but by 2013-14 that had virtually halved to around 17 beds.

Alongside a relative decline in capacity, there are signs the hospitals are struggling under the pressure of growing demand.

In emergency departments, often seen as the coalface of hospital care, the proportion of urgent Category 3 patients seen within the clinically recommended 30 minutes fell back to 68 per cent in 2014-15 – a two percentage point decline from the previous year, and a result that ended four years of unbroken improvement (see graph above).

The national goal that 80 per cent of all ED patients are seen within clinically recommended times appears increasingly unlikely, as does the COAG target that 90 per cent of all ED patients be admitted, referred or discharged within four hours. For the last two years, the ratio has been stuck at 73 per cent.

The outlook for patients needing elective surgery is similarly discouraging.

The AMA report found that, although there was slight reduction in waiting times for elective surgery in 2014-15, patients still faced a median delay of 35 days, compared with 29 days a decade earlier.

It appears very unlikely the goal that by 2016 all elective surgery patients be treated within clinically recommended times will be achieved. Less than 80 per cent of Category 2 elective surgery patients were admitted within 90 days in 2014-15 – a figure that has barely budged in 12 years.

The Commonwealth argues it has had to wind back hospital spending because of unsustainable growth in the health budget.

But Professor Owler said the evidence showed the opposite was the case.

The Government's own Budget Papers show total health expenditure grew 1.1 per cent in 2012-13 and 3.1 per cent the following year – well below long-term average annual growth of 5 per cent.

Furthermore, health is claiming a shrinking share of the total Budget. In 2015-16, it accounted for less than 16 per cent of the Budget, down from more than 18 per cent a decade ago.

"Clearly, total health spending is not out of control," Professor Owler said, and criticised what he described as a retreat by the Commonwealth Government from its responsibility for public hospital funding.

"There is no greater role for governments than protecting the health of the population," he said. "Public hospitals are the foundation of our health care system. Public hospital funding and improving hospital performance must be a priority for all governments."

The issue of hospital funding is set to loom large when the nation's leaders meet in March to discuss reform of the Federation.

Already, several premiers are pushing for an overhaul of taxation arrangements to provide the states with a better growth revenue stream than the Goods and Services Tax.

NSW Premier Mike Baird and South Australian Premier Jay Weatherill have proposed an increase in the GST with revenue raised used to help compensate low income families, cut direct taxes and increase health funding.

ADRIAN ROLLINS

WHO declares health emergency over Zika outbreak

The World Health Organisation has upgraded Latin America's Zika virus outbreak to a public health emergency as Australian health authorities have been put on high alert to prevent the mosquito-borne infection, linked to thousands of birth defects, getting a toehold in Australia.

At a special meeting on 1 February, the WHO's Emergency Committee considered that a "strong association" between Zika virus infections and serious congenital birth defects warranted declaring the rapidly spreading outbreak in South and Central America a Public Health Emergency of International Concern.

Acting on the recommendation, WHO Director-General Dr Margaret Chan said that although a causal relationship between Zika virus infection in pregnancy and microcephaly (small or under-developed brain) was not yet scientifically proven, it was "strongly suspected".

"After a review of the evidence, the Committee advised that the recent cluster of microcephaly cases and other neurological disorders reported in Brazil, following a similar cluster in French Polynesia in 2014, constitutes an 'extraordinary event' and a public health threat to other parts of the world," Dr Chan said.

In declaring a health emergency, the WHO has urged a coordinated international response to the virus threat, including improved surveillance of infections and the detection of congenital malformations, intensified mosquito control measures, and the expedited development of diagnostic tests and vaccines.

Though there is no evidence the Zika virus, which health experts suspect has infected millions in Brazil and surrounding countries in recent months, has been transmitted in Australia, authorities are concerned about the possibility someone infected with the disease overseas may travel to central and northern Queensland, where mosquitos capable of carrying the disease are found.

> "The level of alarm is extremely high … a causal relationship between Zika virus infection and birth malformations and neurological syndromes is strongly suspected" – *WHO Director General, Margaret Chan*

"There is very low risk of transmission of Zika virus in Australia, due to the absence of mosquito vectors in most parts of the country," the Health Department said, but added that "there is continuing risk of Zika virus being imported into Australia… with the risk of local transmission in areas of central and north Queensland where the mosquito vector is present".

Adding to concerns, the species of mosquito capable of carrying the virus have been detected at Australian airports from flights originating in south east Asia, most recently at Sydney International Airport on 26 and 28 January.

Border authorities undertook insecticide "fogging", and initial DNA testing showed that although the mosquitos originated in south east Asia, none were found to be carrying Zika or any other diseases of concern.

The Health Department said Chief Medical Officer, Professor Chris Baggoley, has briefed Government agencies on all aspects of the virus and the current outbreak.

Dr Chan said the virus was "spreading explosively" in South and Central America since being first detected in the region last year, and the prevalence of the mosquito capable of transmitting the virus, together with the fact that there is no vaccine or treatment,

WHO declares health emergency over Zika outbreak

... from p11

and no population immunity in newly-infected countries, were all causes for serious concern about the outbreak.

The virus, which is closely related to the dengue virus, was first detected in 1947, and there have only ever been 23 confirmed cases in Australia, all of them involving infection overseas.

So far this year, there have been just two confirmed cases – both in New South Wales and involving travellers from Haiti.

Only about 20 per cent of those infected with the Zika virus show symptoms, and the disease itself is considered to be relatively mild and only lasts a few days.

"The level of alarm is extremely high," Dr Chan said. "Arrival of the virus in some places has been associated with a steep increase in the birth of babies with abnormally small heads and in cases of Guillain-Barre syndrome."

"The possible links, only recently suspected, have rapidly changed the risk profile of Zika, from a mild threat to one of alarming proportions," Dr Chan said. "The increased incidence of microcephaly is particularly alarming, as it places a heart-breaking burden on families and communities."

Despite the threat, the WHO said there was no public health justification for restrictions on travel or trade.

Nonetheless, the Department of Foreign Affairs and Trade has issued a travel advisory recommending that pregnant women considering travelling to countries where the Zika virus is present to defer their plans.

The Brazil outbreak has drawn particular attention given that hundreds of thousands of athletes, government officials and tourists are expected to travel to the country later this year for the Olympic Games.

DFAT has issued similar travel advice for all 27 countries where ongoing transmission of the virus has been identified - almost all of them in Southern or Central America, except for the Pacific island nations of Samoa and Tonga, and Cape Verde, off the north-west African coast.

All other travellers are advised to take precautions to avoid being bitten by mosquitos, including wearing repellent, wearing long sleeves, and using buildings equipped with insect screens and air conditioning.

ADRIAN ROLLINS

High fail rate raises training doubts

Assessment standards for aspiring psychiatrists are under scrutiny after less than a quarter of trainees passed a new written test.

AMA Vice President Dr Stephen Parnis has written to the Royal Australian and New Zealand College of Psychiatrists urging it to review new training and assessment arrangements after just 23 per cent of psychiatry trainees undertaking the Modified Essay Question Written Exam in August last year were awarded a pass mark.

Dr Parnis told the College the AMA had been contacted by several trainees who were "very distressed", and had expressed significant concerns about very low pass rates for the first two groups of students sitting exams under the competency-based training program introduced in 2012.

"I understand this pass rate is much lower than experienced under the former training program," Dr Parnis wrote, noting widespread concern among trainees that they had received insufficient support in meeting the new assessment standards, and questioning whether the exams had been "appropriately calibrated".

"With any major overhaul of a training program, the AMA believes that it is very important for colleges to be sensitive to emerging issues, and seek to address them as a matter of urgency," the AMA Vice President said.

Trainees complained that supervisors and Directors of Training appeared unsure about the appropriate time to sit exams, what the newly-imposed standard of 'junior consultant' might mean in practice, and how they should prepare differently when re-sitting an exam.

Dr Parnis also expressed concern that the College had set tight limits on the number of times a trainee can sit the exams, with those who fail to meet these requirements being asked to show cause.

"This can be incredibly stressful in the best of circumstances, and it would be most unfair on the initial cohort of trainees if they were subject to these rules and it is [subsequently] shown that there are inherent problems in assessment processes," he said.

Dr Parnis said the AMA was generally supportive of the College's move toward a competency-based training framework, and had been reassured by the involvement of trainee representatives in monitoring and advising on the changes.

But the experience of the trainees showed the new arrangements needed to be reviewed, he said.

"While it is obviously early days for the new assessment arrangements, the low pass rates appear to warrant further consideration and potential remedial action."

ADRIAN ROLLINS

Anti-vax parents cannot dodge new laws

The Federal Government has confirmed that a form being circulated by anti-vaccination campaigners attempting to circumvent new 'No Jab, No Pay' laws has no legal standing, backing AMA advice that doctors are under no obligation to sign it.

Social Services Minister Christian Porter has written to AMA President Brian Owler confirming that medical practitioners were under no obligation to sign the form, which asks doctors to acknowledge the 'involuntary consent' of a parent to the vaccination of their children, and which is deemed to be ineffective in any case.

"I am able to advise you that under the No Jab, No Pay Act, immunisation providers are not obligated to sign such declarations," Mr Porter wrote. "This statutory declaration is not relevant evidence for the purposes of family assistance payments, [so that] even if such a form were signed by a doctor…it would not in any circumstances make the relevant parent eligible for payments that would otherwise be suspended."

The form has been circulated by anti-vaccination campaigners following Federal Government welfare changes aimed at denying certain welfare payments to parents who refuse to vaccinate their child.

Under the No Jab, No Pay laws, from 1 January this year parents of children whose vaccination is not up-to-date are no longer eligible for the Family Tax Benefit Part A end-of-year supplement, or for Child Care Benefit and Child Care Rebate payments. The only exemption will be for children who cannot be vaccinated for medical reasons.

The new laws were introduced amid mounting concern that vaccination rates in some areas were slipping to dangerously low levels, increasing the risk of a sustained outbreak of potentially deadly diseases such as measles.

The Australian Childhood Immunisation Register shows there has been a sharp increase in the proportion of parents registering a conscientious objection to the vaccination of their child, from just 0.23 per cent in late 1999 to 1.77 per cent by the end of 2014.

In all, around a fifth of all young children who are not fully immunised are that way because of the conscientious objection of their parents.

The form being circulated by anti-vaccination groups, headed "Acknowledgement of involuntary consent to vaccination", is intended to circumvent the No Jab, No Pay laws and allow conscientious objectors to receive Government benefits without allowing the vaccination of their children.

But Mr Porter said the aim of the new laws was to boost immunisation rates "by providing a level of encouragement and incentive for families to more thoroughly inform themselves about the importance of immunising their children".

The Minster said the Government recognised the right of parents to decide not to vaccinate their children, but the new laws meant there would be consequences.

"An individual is not prohibited in any way from maintaining their vaccination objection; it is simply the case they will not receive some of their family assistance," he said. "This is a relatively small financial cost, particularly when compared to the cost that the spread of crippling, debilitating and deadly diseases has on our health system and community."

"It is the Government's view that when an individual decides not to vaccinate their child, they are putting their child and the community at risk of infectious diseases."

Last month, the AMA's senior legal adviser John Alati advised that, where there was no medical reason for vaccination exemption, the doctor's job was to outline the relevant facts about immunisation and to provide vaccination where consent was given. Where it was withheld, "the doctor should not perform the procedure as it might constitute trespass to the person".

His advice was backed by Mr Porter, who said that "the appropriate path for a doctor or medical profession who may be requested to sign [the form being circulated by anti-vaccination campaigners] is simply to vaccinate where there is consent, and decline where consent is absent".

ADRIAN ROLLINS

GP guide could provide prostate relief

The number of men undergoing unnecessary prostate cancer tests and procedures is expected to drop following the development of evidence-based clinical guidelines.

In a major step toward resolving decades of confusion and uncertainty regarding the detection and treatment of prostate cancer – the second most common cancer in men – the National Health and Medical Research Council has approved a set of clinical guidelines that can be used by GPs and patients to inform decisions about whether to test for the condition.

The detection and management of prostate cancer has been dogged by controversy amid concerns that shortcomings in the widely-used prostate specific antigen (PSA) blood test has led to over-diagnosis and treatment, leaving many men with serious side-effects including impotence and incontinence.

To cut through the uncertainty and provide clear evidence-based advice to practitioners and patients, Cancer Council Australia and the Prostate Cancer Foundation of Australia (PCFA) undertook a three-year process in which they convened representatives from all the disciplines involved in testing, including urologists, pathologists, GPs, radiation and medical oncologists and epidemiologists, to develop consensus guidelines.

The result, *PSA Testing and Early Management of Test-detected Prostate Cancer: Guidelines for health professionals*, has been approved by the NHMRC as providing evidence-based recommendations for the use of PSA tests and managing patients following a positive reading.

The Cancer Council and PCFA said they hoped the guidelines would help doctors "navigate the daily professional dilemma of informing men about the risks and benefits of testing, and prevent scenarios where PSA tests are conducted without patient consent".

The test for PSA in the blood is considered an unreliable marker of prostate cancer and so is not considered appropriate for use in population screening.

But, in the absence of an effective alternative, many men choose to have it anyway.

The problem is that false-positives can lead to a patient having an invasive biopsy procedure, exposing them to the risk of serious side-effects.

The NHMRC estimates that for every 1000 men aged 60 (and who do not have an immediate relative with prostate cancer) who take the test annually for 10 years, two will avoid a prostate cancer death before 85 years.

But a further 87 will, as a result of a false-positive test, have an unnecessary biopsy. As a result of the biopsy, 28 will experience side-effects including impotence and incontinence, and one will be hospitalised.

The risk of a false-positive and the attendant unnecessary yet serious complications means that the decision to have a PSA test is not a straightforward one, and PCFA Chief Executive Officer Associate Professor Anthony Lowe said the new guidelines were intended to help doctors and patients navigate the decision to maximise the benefits of the test and minimise the harms.

"Contention about the PSA test has made it difficult for health professionals to take a consistent, evidence-based approach to the test," A/Professor Lowe said. "While the debate has played out, thousands of men have continued to take the test, as it's the only available biomarker to assist doctors in assessing a man's prostate cancer risk."

Cancer Council Chief Executive Officer Professor Sanchia Aranda said use of the guidelines should result in less over-treatment associated with PSA testing.

"The PSA test is an imprecise test, and has the potential harms as well as benefits," Professor Aranda said. "Use of the guidelines will hopefully reduce the level of over-treatment and guide improved management of men with early stage prostate cancer until we have a better biomarker."

Among other advice, the guidelines recommend:

- an end to rectal examination of asymptomatic men by GPs;
- no PSA test for men unlikely to live another seven years because of other health complaints;
- harms of PSA tests may outweigh potential benefits for men older than 70 years; and
- for men aged 50 to 69 years who decided to have PSA testing, tests should be conducted every two years, not annually.

The guidelines can be downloaded from: www.pcfa.org.au and wiki.cancer.org.au/PSAguidelines

ADRIAN ROLLINS

MJA chief embraces latest career twist

When the position as Editor in Chief for the *Medical Journal of Australia* became vacant last year, Nick Talley's wife told him, "You should take that role".

At the time, Professor Talley was well ensconced in his position as the University of Newcastle's Pro Vice Chancellor (Health) and, with much already on the go, let the idea slide.

But, as has happened at other times in his life, a call out of the blue set Professor Talley's career on a new path.

The Board of AMPCo, which publishes the *MJA*, approached him about becoming its Editor in Chief – an offer he happily accepted.

"My wife was right, that I would enjoy the role," he told *Australian Medicine.*

Becoming the *MJA* Editor in Chief is not, on the face of it, an obvious move for Professor Talley, a gastroenterologist who has enjoyed a stellar career as a medical researcher and administrator, with more than 1000 publications to his name.

It is not the first time he has been head-hunted for a position that has taken his career – and life – in an unexpected direction.

In the early 1990s, while working at the Mayo Clinic in the United States, he was approached to become Foundation Professor of Medicine at Nepean Hospital in Western Sydney.

As he himself describes it, it was a significant challenge.

"I was 37 years old, had virtually no administrative experience, and was charged with the daunting task of developing teaching and research plus new clinical departments in a hospital that didn't even yet have a physician's training program," he recalls.

After nine years in the position he was lured back to research and the Mayo Clinic Rochester in 2001.

Five years later, he was "tapped on the shoulder" to transform the Department of Medicine at Mayo's Florida centre into "a cohesive academic entity".

It was, Professor Tally says, an exhilarating experience: "I learnt more about the science of leading and management than at any other time in my career".

This knowledge was to stand him in good stead when he was poached in 2010 to become Newcastle University's Pro Vice Chancellor (Health), a post he has held ever since.

But, while overseeing the University's research and education programs, Professor Talley is excited about the opportunities and demands of guiding the *MJA* in coming years.

It is a testing time to be assuming the helm of such a publication.

The rise of the internet has changed the way people access information leading many to question whether the days of *MJA*-style publications, particularly in their hard-copy format, are numbered.

Professor Nick Talley

Questions are also being asked whether then process of peer review, used by the *MJA* to help verify the quality of the research that it publishes, is any longer suitable.

But Professor Talley looks on the task ahead of him with enthusiasm.

"We are in the middle of a digital revolution," he says. "The way people obtain and use information is rapidly changing and evolving. It's a very challenging and interesting time to be in the field of publishing."

Armed with years of experience as a researcher and educator, Professor Talley has clear ideas about what the *MJA* needs to do.

"To provide important information and updates to clinicians at the coalface; to be a publication for first-class research of relevance to Australia; and to make clinicians aware of developments that will impact on what they do," he says. "That is an enormously important role."

Some believe the proliferation of open-access online journals in recent years may marginalise, if not kill off, publications like the *MJA*, but Professor Talley doubts this.

Though welcoming the idea that study data and results be open to all, he questions whether many such publications will survive, particularly because concerns about quality will have many doubting their usefulness.

While he is not sure that, in 10 years' time, the journal will still be a print publication, he has no doubt that the *MJA* in some form has a strong future.

"There is a very important place for peer reviewed journals of high quality that act as gatekeepers for advances in science and scientific knowledge," Professor Talley says. "There will still be a critical role for journals like the *MJA*."

ADRIAN ROLLINS

Rural health fix doubts

The Federal Government has rebuffed calls for an increase in the quota of medical students who come from rural backgrounds despite concerns initiatives to boost medical services in country areas will continue to fall short.

The Government has been accused of sending mixed messages on its rural medical workforce policy after using some of the funds freed up from cutting almost $600 million from health and aged care workforce spending to fund new programs intended to improve rural training opportunities.

It used its 2015-16 Mid Year Economic and Fiscal Outlook (MYEFO) to unveil a $93.8 million Integrated Rural Training Pipeline intended to improve the retention of postgraduate prevocational doctors in country areas.

The Pipeline includes the establishment of 30 regional training hubs (which will receive $14 million a year); at least $10 million a year for a Rural Junior Doctor Training Innovation Fund to foster new training approaches; and $16 million a year to fund up to an extra 100 places in the Specialist Training Program through to 2018.

Minister for Rural Health Fiona Nash said the funds for the initiative had been obtained by improving the targeting of existing health workforce programs and activities.

"The Australian Government invests more than $1 billion a year in programs to build the health workforce," Senator Nash said, citing as an example the fact that, in 2014, almost 80 per cent of clinical placements were in metropolitan areas.

A further $130 million of health workforce spending is to be redirected into an expansion of the Rural Health Multidisciplinary Training program, with particular focus on addressing workforce shortages and increasing support for training in nursing, midwifery and allied health.

"Our objective is to provide the most effective support for health students to train in areas of need," Senator Nash said.

But the impact of the announcement has been tempered by concerns that the overall effect of the changes is a net loss of funding for health workforce programs.

Health Minister Sussan Ley admitted as much when, in a statement released on 15 December, she confirmed that only a proportion of the $461.3 million the Government expects to save by "rationalising" existing workforce programs would go to fund the new initiatives, with the rest "being sensibly invested into Budget repair".

Prior to the release of MYEFO, the AMA had urged the Government to make it mandatory that one in every three medical students be recruited from a rural background, and that the proportion required to undertake at last a year of clinical training in a rural area be increased from 25 to 33 per cent.

The AMA has welcomed the expansion of the Specialist Training Program, but President Professor Brian Owler said that country areas were still struggling to attract and retain sufficient locally-trained doctors despite record numbers of medical graduates.

"The 'trickle down' approach to solving workforce maldistribution is not working," he said. "Australia has enough medical students, and the focus must now shift to how to better distribute the medical workforce."

The AMA President said there was good evidence that medical students from a rural background, or those who undertook extended training in rural areas, were more likely to take up practice in the country upon graduation.

The AMA said less than 28 per cent of commencing domestic medical students came from a rural background, and recommended that the Government increase the current intake target from 25 to 33 per cent.

Professor Owler said significant action was needed, with a recent survey showing less than a quarter of domestic medical graduates lived outside the nation's capital cities.

"The implementation of more ambitious targets may prove challenging in the short term, but there is evidence that this approach would be more successful in getting more young doctors living and working in rural Australia," he said.

But the Government has so far resisted the suggestion.

Instead of increasing the rural medical student quota, universities have been directed to set their own targets for rural background students.

A Health Department spokesperson told *Medical Observer* that, even without a higher quota, a third of medical students in 2014 were of rural origin.

ADRIAN ROLLINS

Medical practices to be hit in under-pay crackdown

Medical practices have been put on notice to expect a visit from Fair Work inspectors in the coming months to ensure staff are receiving appropriate pay and allowances.

The workplace watchdog has announced it will be carrying out spot checks to examine conditions for receptionists, managers and other staff at 600 health and residential care workplaces around the country, including medical practices.

Fair Work Ombudsman Natalie James said on average more than 3000 people a month from the health care and social assistance sector contacted her organisation concerned about pay and work arrangements, and the forthcoming campaign of inspections had been developed with "intelligence and advice from key stakeholders".

Ms James said Fair Work inspectors will be checking to make sure employers are paying correct minimum hourly rates, penalty rates, allowances and loadings and providing appropriate meal breaks. They will also be ensuring compliance with record-keeping and pay-slip obligations.

The blitz reflects ongoing concern about the behaviour of some employers in the sector, which includes not only medical practices but allied health services and residential care operators.

Since 2010, the watchdog has recovered more than $7 million on behalf of 5300 underpaid workers in the industry, which employees more than 1.4 million, almost 80 per cent of them women, and includes around 10,000 457 visa holders.

In the past three financial years, the Ombudsman has taken seven matters concerning employers in the sector before the courts, and a further 43 have been issued formal Letters of Caution about their workplace practices, putting them on notice that further contraventions may result in enforcement action. Eight received on-the-spot fines for technical infringements.

Ms James said one of the campaign's aims was to ensure employers were aware of their responsibilities.

For medical practices, the Ombudsman will focus on employees covered by the Health Professionals and Support Services Award.

The AMA has advised practice owners unsure of their obligations under the award or their record keeping requirements to contact their local State or Territory AMA for advice.

ADRIAN ROLLINS

INFORMATION FOR MEMBERS

Searching for a hero

The Integrated Family and Youth Service (IFYS) are looking for a superhero. More precisely, a doctor who spent time in foster care as a child who would be willing to share their story.

Drawing on the fact that many superheroes depicted in popular literature, most notably Superman, were raised by foster parents, IFYS has developed a campaign called (with tongue firmly planted in cheek) 'Raise the next Superhero', to recruit foster families for the hundreds of children who enter care every month.

If you are a doctor who spent time in foster care while growing up, and would be willing to share your story, please contact Letitia at communications@ifys.com.au

Look no further than GPs for Medical Home

> "Evidence suggest patients with a usual GP or Medical Home have better health outcomes, and 93 per cent of Australians have a usual general practice, and 66 per cent have a family doctor"

GPs already perform many of the functions of a Medical Home, and should be at the centre of any move to formalise such an arrangement in Australia, the AMA has said.

As Health Minister Sussan Ley contemplates the findings and recommendations of the primary health review led by former AMA President Dr Steve Hambleton, the AMA has issued a Position Statement advising that any proposal to adopt a Medical Home approach in Australia must have GPs at its core.

Internationally, the term Medical Home is used to refer to a model of primary care that is patient-centred, comprehensive, team-based, coordinated, accessible and focused on quality and safety.

AMA Vice President Dr Stephen Parnis said in Australia these attributes were already embodied in general practice.

"The concept of the Medical Home already exists in Australia, to some extent, in the form of a patient's usual GP," Dr Parnis said. "If there is to be a formalised Medical Home concept in Australia, it must be general practice. GPs are the only primary health practitioners with the skills and training to provide holistic care for patients."

Evidence suggest patients with a usual GP or Medical Home have better health outcomes, and 93 per cent of Australians have a usual general practice, and 66 per cent have a family doctor.

Dr Parnis said the Medical Home concept had the potential to deliver improved support for GPs in providing well-coordinated and integrated multi-disciplinary care for patients with chronic and complex disease, and it made sense for this to be the focus of Government thinking on adopting the Medical Home idea in Australia.

"You can't just transplant models of health care from other countries without acknowledgement of local conditions and what is already working well," he said.

"Australia needs to build on what works, and ensure that a local version of the Medical Home is well-designed and relevant."

The AMA said this should involve additional funding to enable GPs to deliver comprehensive and ongoing care, including patient education, improved coordination and targeting of services, and activity that does not require face-to-face contact.

Establishing a Medical Home arrangement in Australia was likely to involve formally linking a patient with their nominated GP or medical practice through registration, and the AMA said this should be voluntary for both patients and doctors.

In addition, the peak medical group said fee-for-service must remain the predominant funding mechanism for doctors, though it acknowledged that the Medical Home could also involve a blended funding model that rewarded the delivery of services over a period of time.

The AMA Position Statement on the Medical Home can be viewed at: https://ama.com.au/position-statement/ama-position-statement-medical-home

ADRIAN ROLLINS

Govt wants 'friendly rivalry' in organ donation

Hospitals will come under pressure to disclose organ donation rates and ensure more staff are trained in discussing the issue with distressed families, as part of changes to organ donor arrangements announced by the Federal Government.

In its long-awaited response to an independent review of the Government-funded Organ Tissue and Donor Authority (OTDA), the Government did not adopt suggestions the country move to an opt-out system for donors.

Instead, Rural Health Minister Fiona Nash announced the establishment of a one-step online registration process for organ donors, the publication of hospital by hospital and State by State donor data, and the automation of a nationwide organ-matching system.

"Almost all Australians would like to be able to receive a donated organ themselves to save their life, or for their child or parent...yet the vast majority are not registered as organ donors," Senator Nash said. "If we increase the number of registered organ donors, we will save more lives. I look forward to fostering a friendly rivalry between states and hospitals as to who has the better organ donation rate."

The Government aims to achieve a deceased organ donor rate of 25 per million by 2018, a major jump from the current rate of 16 per million.

Senator Nash commissioned the review last year amid dissatisfaction with the rate of progress in boosting the donor rate.

But the decision was heavily criticised by television personality David Koch, who quit his position as Chair of the OTDA's Advisory Council live on air in protest at not being consulted over the decision.

The Ernst and Young review partially vindicated the Authority, finding that its strategy to boost donor rates was "sound". But it added there was "significant room for improvement" if there was effective national implementation and monitoring.

The review found that the OTDA lacked effective oversight, and recommended the appointment of a new Board of Governance to strengthen accountability – advice the Government has adopted.

Senator Nash said that, combined with easier online registration, targeted hospital improvement, better donor and recipient matching and greater transparency over donation rates by hospital and State, would boost donation rates.

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

Incentive payments – good marketing, bad medicine

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

What a muddle we and several incarnations of the Federal Government have landed ourselves in over incentive payments for doctors to bulk bill patients for pathology and diagnostic imaging services.

But when you confuse payment for medical services (treating patients) with payment for doing things (bulk billing) this is what you get.

When marketing behaviour to doctors, in this case bulk billing, you are doing something quite different to paying them for medical care. Marketing has its own rules and ethics, and they are not the same as those applying to the provision of medical care. Mix them up and you have a wreck, not a recipe.

Evidence that incentive payments have much influence on medical behaviour is scant. There is even less evidence that they have an effect on outcomes for patients.

Those professionally concerned with arranging payment for health services will complain that I have made nonsense of a sophisticated policy. I agree that the context determines somewhat whether incentive payments make sense or not. But the environment of Australian health care is not likely to be healthy for incentives.

Look at the experience.

At one end of a spectrum are payments made to doctors within managed care environments, where stipulated behaviour – sticking to a set of practice guidelines, getting 80 per cent of your post-op patients out of hospital on day three – is rewarded with a bonus payment above an agreed salary baseline.

We do not have managed care in Australia, save for a pale shadow of it the Veterans Affairs system, and many doctors view it with great alarm. But it is a way of doing business, if business is what you want.

In that context, I can imagine how incentive payments would function.

McKinsey and Company, a consultancy, has made case studies of systems of integrated care they have established in the US, the United Kingdom and Europe. There, they have used incentives and sanctions to encourage doctors to follow guidelines for the care of patients with complex problems. In a managed care system, achievement of specified performance criteria may also influence the doctor's future employment, so financial rewards are really just the reverse side of a coin that carries penalties on the other side.

But I am not aware of the successful use of incentive payments outside the closed environment of managed care.

Further along the spectrum, incentive payments have been used to encourage GPs in Australia to immunise children, or to prepare plans for the care of patients with chronic and complex disorders. What are we to make of these efforts?

In a thoughtful review of incentive payments in the UK, published in *The Australian Family Physician*, GP and researcher Michael Wright found that while "pay-for-performance programs are attractive to funders ... there is little evidence that [they] ... improve health outcomes or health care system quality. In addition, these programs may lead to undesired consequences."

Practitioners have been known to yield to temptation to game the system by shoehorning patients into categories of illness that attract incentive payments, and fast-tracking those patients who are not marked for incentive payments.

Dr Wright concluded that there was "evidence of financial incentives affecting the behaviour of health care providers, [but] no evidence that they improve health outcomes".

Because the environments into which incentive payments are introduced are often themselves changing in ways that improvement performance, it can very difficult to disentangle their effect.

And even when, as in the UK, positive effects like weight loss in the obese are achieved in the short term, two years after a good start the effects have usually vanished.

I have full sympathy for doctors who find incentive payments an attractive option, especially given the pathetic non-policy of not indexing Medicare payments to the cost of service provision.

I am saying nothing critical here about the search for savings because of increased productivity. We all know of places in medicine where remarkably cheap technology has replaced horse-and-buggy investigations and therapies, and clearly the fee that should be paid for these services should reflect that progress.

Of politicians and rectal probes

BY DR DAVID RIVETT, CHAIR, AMA RURAL MEDICAL COMMITTEE

Despite it being summer and the mercury hitting the 40s in many rural areas, Medicare rebates remain frozen.

It is time all practitioners got active in stirring their electorates up to resolve this bloody-minded impasse. Please talk to your colleges, and get them to get down and get their hands dirty doing some political pushing in this election year.

See your local MP, put up signs in your place of practice informing patients that bulk billing is going to have to end if the freeze continues, and ask patients to get involved to save Medicare as we know it. Universal access for all is under severe threat.

It is well and truly time the people sought honest answers from their politicians as to what the Government's real plans are for Medicare. It cannot be left to slowly and sneakily strangle it by shrinking patient rebates. As the election draws closer, ramp up your actions.

The Australian Competition and Consumer Commission has a strict embargo on collusion and price fixing so act independently and, if you have any doubts, check your planned actions with the Federal AMA.

You will shortly receive a Rural Medicine Issues Rating Survey, the result of which will be used to guide the AMA in its lobbying on your behalf. Please devote a few minutes to filling it out and telling us what most needs fixing.

The Rural Classification Working Group meets on 25 February, so if you have concerns regarding the Modified Monash formula as it affects you, please let me know now.

I am about to purchase a basic ultrasound with a 40 centimetre rectal probe for the farm to let me know which cows have failed to conceive. I only continue to feed the productive members of the herd.

It is a pity a similar device cannot be used to scientifically sort our politicians into the "keepers" and the "oxygen thieves".

The annual revelation of the small number of doctors rorting the Medicare system by the Professional Services Review should be accompanied by a similar release of data on politicians rorting the taxpayer, billing us for useless overseas junkets, trips to sporting events and family travel, with the odd helicopter flight and over-the-top entertainment expenses tossed in.

Before the political pot calls the medical kettle black, it needs to get its own house in order.

Thoughtless largesse by our political masters does not engender a culture of thrift in the community, let alone encourage respect.

Incentive payments – good marketing, bad medicine

... from page 21

But it is simply asking for trouble not to reward medical consultations at a rate today that applied yesterday, for no defensible reason.

To simultaneously offer incentive payments for behaviours that have not been shown to improve patient outcomes is simply playing ducks and drakes.

Nothing should be done until the current Medicare Benefits Schedule review has published its findings.

When those are in, payments for services that produce health outcomes should be speedily approved, and at a level that enables doctors and others to concentrate on care rather than their own survival.

The vast majority of doctors already possess the incentive to provide optimal and efficient care to their patients.

Incentive payment systems – an inappropriate and misplaced light-bulb idea for the most part – should be sold on e-bay to the commercial and marketing sector where they belong.

Uncertain times ahead for general practice

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

A new year should be full of promise, but for general practice this is far from the case.

These are uncertain times, with GPs facing an ongoing rebate freeze and potential reforms arising from the Primary Health Care Advisory Group Review.

> "We will need to recognise and unite against changes that will compromise patient care, while remaining open to those changes that will enhance care and deliver better patient outcomes"

The Government's policy intent appears to be Budget-driven and focused on pulling back on its core responsibilities in funding the delivering of health services. It is trying to shift more of the costs of health care to the individual, while seeking to cut costs under the banner of increased efficiency and effectiveness.

The challenge for us as a profession this year will be two-fold. We will need to recognise and unite against changes that will compromise patient care, while remaining open to those changes that will enhance care and deliver better patient outcomes.

2016 is also an election year, and we know that the public is very wary of the Government's health agenda – as evidenced in the response to attempts to reform Medicare.

The Government continues to push the line that health spending is out of control, when we know that the evidence suggests otherwise. Poorly thought-out reforms may turn into election issues, and the AMA will need to make sure that health is front and centre of voter's minds when it is time to cast their ballot.

While the findings and recommendations of the Primary Health Care Advisory Group are now with the Health Minister, there is no clear timetable for its public release or the Government's response. There is the hint of bold reforms, but there is no sense that the Government is willing or able to fund these. Simply shifting money around and creative accounting will not deliver the type of investment and support that general practice needs – a message that the AMA has consistently emphasised.

We know the areas where the Government will focus if it decides to move ahead with a reform agenda: the introduction of the Medical Home for patients with complex and chronic disease, new payment models, a significant role for Primary Health Networks in commissioning allied health care services, and the collection and sharing of clinical data.

In relation to the latter, data is fundamental for assessing quality improvement, and is something we as health professionals should be making greater use of in our practice for this purpose.

While the data we collect could undoubtedly prove the value of the care provided in general practice, we must guard against its disingenuous use. The challenge will be to ensure that patient privacy is protected, and that the clinical indicators against which data is collected are relevant, evidence-based and easily measured.

While the AMA will need to remain vigilant in responding to the Government's agenda, it is also important for us to present our own positive agenda for general practice. The AMA has outlined sensible changes to support patients with chronic disease, has emphasised the need to invest in and build general practice, has detailed proposals for a Community Residency Program and a role for pharmacists in general practice, and has developed a Vision for General Practice Training.

The uncertain policy environment is having a measurable impact on general practice - the lack of interest in the last round of GP infrastructure grants is strong evidence of this. The challenge for the Government will be to outline a cohesive policy agenda for general practice that ensures its sustainability and supports improved patient care. This will require a whole new approach compared to that we have seen in the past, and one can only hope that an election year will see a more constructive policy agenda emerge.

Dead tired, or just plain dead?

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

Medicine has come a long way over the years. We've swapped barber shops and razors for sterile theatres and harmonic scalpels. We've changed our plague masks for hand hygiene. We've traded leeches for phlebotomy.

But there's one thing we haven't managed to change, and that is the body's need for a good night's rest.

Like an old Nintendo that had played just a touch too much Super Mario Bros., we still need to hit the reset switch and start again, clear and refreshed.

And, like an old Nintendo, there are no shortcuts. You can pull out the cartridge and blow on it in a vain attempt to get things going again, but there's just no substitute for rest.

We work ourselves harder and harder to supposedly get more and more.

And if medicine does ever crack the puzzle that is fatigue, we'll almost certainly destroy ourselves.

Our need for sleep is that last bastion of defence against taking these sub-par shortcuts. Our biology is clear on this: a mandatory period of unconsciousness is required every 24 hours.

The problem is that health is a 24-hour game. We don't get to choose when our patients have their subarachnoid haemorrhages, their inflamed appendixes or their persistent nocturnal croup.

Illness happens around the clock, and we must work with this clock.

But pressures are increasing. This has led to doctors-in-training working increasingly unsociable and, oftentimes, plain dangerous shifts.

We're not talking about missing out on the odd social event here and there. We're talking about fatigue management, and this is no idle matter at all. Interstate truck drivers have strict schedules and relief patterns that are tracked via GPS to ensure compliance.

Pilots and their crews have rotations so strict that entire planes will be delayed to prevent fatigue from setting in, at the cost of hundreds of thousands to the airline.

The critics of fatigue management will often counter with the inadequacies of a 38-hour work week.

Let me be very clear on this: nobody is asking for hours to be restricted to 38 hours a week.

This isn't like alcohol control, where a beer is illegal at 17 years and 364 days of age, but feel free to get plastered the next day. Fatigue is cumulative. It's as much about the pattern of shifts as the duration of shifts, if not more so.

If fatigue management was as simple as an hour cut-off, we'd have it sorted already. Fatigue is more complicated than just your weekly hours.

The AMA has long been an advocate for safe working hours for doctors and, naturally, most of this work falls into the space of doctors-in-training rostered for shift work.

Since 1999, there has been a National Code of Practice in place to help both employees and employers best assess risk and manage fatigue in the workplace.

It is currently being reviewed by the Council of Doctors in Training, which is planning to a Safe Hours Audit later this year.

We have undertaken many such audits over the years to monitor working hours. Sadly, unsafe working hours are still all too common.

The literature is quite clear on fatigue. Fatigue kills, and it doesn't matter whether you are a driver, a pilot or a doctor. If you're a human, you're subject to the never-ending diurnal requirement for restful sleep.

It has taken a gargantuan culture shift to show that working safer hours isn't about laziness, it's about safety and necessity.

Our next battle will be with health services who try to provide the same or increased services with less doctors and no technological advancement or true efficiencies.

If fatigue management is not a core component of working hours, you can guarantee that there'll be a price to pay in blood, whether it be the doctor's life or the patient's life.

We are all human, and we're are all tired at points in our lives. Fatigue management isn't about being tired. It's the difference between being tired, being dead tired and being dead.

Change aplenty looms in 2016

BY DR ROD McRAE, CHAIR, AMA COUNCIL OF SALARIED DOCTORS

Last year was a busy one, with many issues arising that affected salaried doctors, including Rights of Private Practice, workplace wellbeing (such as bullying and harassment), personal safety and the implications of the Border Force Act.

Salaried doctors are always in the front line of public health matters, and the expectations placed on them continue to build, increasing the pressure on terms and conditions.

It is hard to know which issues we will need to focus on as the year progresses, but there are several key issues that are likely to take up much of our time in the year ahead.

Workplace wellbeing

Issues of harassment are of continuing significance. Late last year a report revealed that junior doctors at Canberra Hospital continued to experience bullying, harassment and sexist treatment, leading to concerns about patient care. Lessons for many there.

This comes as no surprise to those who have been following the results of junior doctor surveys around the country. In December, the AMA released its updated Position Statement on Workplace Bullying and Harassment, which outlines the AMA's commitment to work with the whole of the medical profession to banish bullying and harassment from all medical workplaces.

Salary packaging limits

In its 2015-16 Budget, the Government announced a $5000 cap for salary sacrificed meal entertainment allowances would come into effect from April this year. Currently, in addition to FBT exemptions, employees of public benevolent institutions and health promotion charities can salary sacrifice meal entertainment benefits with no FBT payable by the employer and without it being reported. The ensuing consultation saw many submissions received, including from the AMA. We expressed concern at the potential effect on attraction and retention of staff, especially in struggling rural hospitals.

Despite many voices raised in protest, from 1 April 2016, a separate single grossed up cap of $5000 will apply for salary sacrificed meal and venue hire benefits for employees. Meal entertainment benefits exceeding the separate grossed up cap of $5000 can also be counted in calculating whether an employee exceeds their existing fringe benefits tax (FBT) exemption or rebate cap. All use of meal entertainment benefits will become reportable.

This is yet another erosion of benefits for public hospital doctors and effectively equates to a pay cut by stealth. However, you must comply. Please ensure your affairs are in order for the new regime from 1 April this year.

Rights of Private practice (RoPP)

Our industrial colleagues within the AMA/ASMOF family are continuing their work on a national strategy for RoPP, to bring some consistency to policy in this area. The benefits of RoPP far outweigh any perceived disadvantages, and we hope to make this clear in the policy that is in development. Also in development is a handy information booklet that can be used as a reference for those considering entering into RoPP arrangements.

Medicare Benefits Schedule (MBS) reviews

The MBS Review Taskforce released its consultation papers last September, setting out the background and context for the MBS reviews, as well as the process for undertaking them.

While it is arguably true that the MBS is outdated in many respects, any suggestion by those in the political arena that doctors have been using it to perform unnecessary procedures for financial gain is a pure insult to the profession. AMA policy is that this must not end up being a mere cost-cutting exercise. Clinical input, including from salaried doctors, is absolutely vital to keeping it transparent and relevant.

The consultation process closed on 9 November and the final results are yet to be published. So far, 23 items have been announced for removal.

With a federal election coming up in 2016, we hope that the incoming Government, whatever its political colours, will value the work of public hospitals, their doctors and other staff. I wish you a successful year ahead and look forward to working with you on these and many other issues.

AMA acts to hold insurers to account

BY **DR ROBYN LANGHAM**

> "The Medical Practice Committee is developing the AMA's first annual report card on private health insurance, which will provide consumers with clear, simple information about how health insurance works and encourage them to examine their policy more carefully"

This time last year I wrote about the AMA's position on various private health insurance issues in response to increasingly aggressive activities by insurers that were affecting patient care.

In late 2014, the privatisation of Medibank Private saw the market share of for-profit health insurers rise from 34 per cent to more than 63 per cent of health fund members. This has been a game-changer. We now have an industry dominated by the interests of for-profit health insurers rather than not-for-profits, with a subsequent shift of focus from providing patient benefits to increasing profits for shareholders. Medibank announced higher than expected profits this year.

The effects of this are becoming clear. In the second half of 2015, the Australian Competition and Consumer Commission issued a damning report on the quality and accuracy of information provided by private health insurers about their products, and the impact this was having on the ability of consumers to make informed decisions about which policy best suited their needs, and to understand exactly what they were covered for.

The AMA is working to help address this problem. The Medical Practice Committee is developing the AMA's first annual report card on private health insurance, which will provide consumers with clear, simple information about how health insurance works and encourage them to examine their policy more carefully.

The report card will include a table of all primary products offered by private health insurers to highlight those that have exclusions or restrictions. Consumers can check whether a particular policy provides 'public hospital only' cover and should therefore be considered junk.

The report card will also provide information on the level of benefits paid by different insurers for a sample of common procedures. Insurers vary significantly in how much they pay for the same procedure, and therefore how likely it is consumers will face out-of-pocket costs. The report card will also help doctors identify which are the better paying insurers when considering gap arrangements. The cost of a product's premium is not necessarily a good indicator of how well it will cover health costs.

The regulation of premium increases is one of many regulatory controls over private health insurers that is currently being examined by a review of the industry commissioned by Health Minister Sussan Ley.

The review is examining all aspects of government regulation of private health insurance, including issues such as: expanding its scope to primary health care; relaxing community rating principles; and shifting government subsidies to private hospitals payments for patient care rather than via health insurance premium rebates.

In its submission to the review, which can be viewed at https://ama.com.au/submission/ama-submission-private-health-insurance-consultations-2015-16, the AMA reaffirmed its support for community rating principles, in order to maintain the balance between the public and private hospital sectors. We would strongly oppose any moves to set premiums according to an individual's risk of ill health.

The AMA also called for junk policies – those with significant exclusions or that provide cover only for treatment in public hospitals – to be banned. Private health insurance policies should meet consumer expectations by covering them for those procedures most likely to be needed, and by providing them with a level of choice about the timing of their care and their medical practitioner.

It will be interesting to see whether the Government will announce any new policies on private health insurance as a result of this review, prior to the election later this year.

I encourage you to email any views or suggestions regarding these issues to president@ama.com.au

Gender diversity matters

BY **AMA VICE PRESIDENT DR STEPHEN PARNIS**

> "A healthier gender balance is essential if the medical profession is to harness the potential of all its members, and reflect the realities of modern medicine in policy and practice"

2015 was perhaps a seminal year for the issue of gender inequity in the medical profession.

The year started with comments about sexual harassment in surgery.

To its credit, the Royal Australasian College of Surgeons resisted the urge to deny there was a problem, and instead commissioned an independent Expert Advisory Group (EAG) to investigate its extent. The Group's report gave a sobering picture of the high prevalence of bullying, discrimination, and sexual harassment in the surgical workforce. I have no doubt that there are implications for the wider medical profession.

It was pleasing that the EAG responded to a number of points put forward by the AMA in its submission, including recognising that commitment to change needs to come from the top, and the importance of increasing gender diversity in senior roles in the College.

A scan of the leadership across the colleges, societies and employers shows limited gender diversity. My own college, the Australasian College for Emergency Medicine, is a case in point – currently, there are no women on its board. This under-representation exists despite the dramatic increase in female participation in the medical workforce in recent decades, to the extent that women now outnumber men as graduates of Australian medical schools.

To be sure, the medical profession is not alone in having a small number of women in senior leadership and management roles. According to the Australian Government's Workplace Gender Equality Agency, last year only 9.2 per cent of ASX 500 company directors were women; they comprised 9.2 per cent of ASX 500 executive management personnel; and 23 per cent of Australian university vice-chancellors.

Why does this matter?

A healthier gender balance is essential if the medical profession is to harness the potential of all its members, and reflect the realities of modern medicine in policy and practice.

Like many, I believe that determined leadership is the key to accomplishing lasting change in the culture of our profession. This includes the upper tiers of the colleges and associations, the employers of doctors and, indeed, the AMA itself.

At times the pace of change may seem slow, and the task too difficult; however, the changes that have been demonstrated recently within the culture of the Australian Army show what can be achieved with a determined effort.

There has been considerable debate, and no consensus, as to whether an increase in gender diversity is best accomplished by using mandated targets or quotas. In our submission to the EAG, the AMA expressed support for a voluntary code of practice or a similar document, that includes voluntary targets and timeframes.

I believe this approach is worthy of consideration.

Our goal is clear – to achieve timely and substantial progress towards a leadership of the medical profession that reflects its composition. In turn, we are then more likely to realise the full potential of our abilities as doctors, and to promote a healthier professional culture.

Taking the edge off sugary drinks

BY PROFESSOR GEOFFREY DOBB, FORMER AMA VICE PRESIDENT AND HEAD OF INTENSIVE CARE, ROYAL PERTH HOSPITAL

For a Government pre-occupied with Budget deficits and 'unsustainable' health spending, a specific excise on sugar sweetened soft drinks should be a no-brainer.

Obesity and type 2 diabetes mellitus and its complications are major underlying drivers of health costs, so a measure that both reduces these and produces taxation income should be exactly what any Australian Government is looking for.

They would, of course, have to withstand the intense lobbying from the soft drink industry that would be mounted against additional taxation on their product.

The lobbying might focus on a lack of evidence that a tax on sugar decreases consumption.

But an observational study from Mexico published in the British Medical Journal (Colchero MA et al, 2016;352:h6704) shows there was a 6 per cent decline in per capita consumption after introduction of the tax, increasing to a 12 per cent decline by December 2014.

The decrease occurred across all socio-economic groups, but was greatest in households of low socio-economic status, where a 17 per cent decrease was observed by December 2014. Interestingly, there was an increase in the consumption of untaxed beverages, mainly bottled plain water.

It will take time to determine if this change in purchasing patterns is followed by a reduction in obesity and associated chronic diseases. As pointed out in a commentary accompanying the BMJ study, designing taxes to engineer an improvement in people's diets is complex, and only one arm of what is ideally a multi-faceted approach to changing people's consumption.

In Australia, we have the still-voluntary Heath Star Rating system to improve the information available to consumers about their food purchases and what they are eating. But with reduced support and coordination of preventive health measures, public education around healthy eating and the value of exercise has diminished.

The key role of our general practitioners in counselling those at high risk of type 2 diabetes, or undergoing incremental weight gain is, arguably, undervalued, and no one in Government seems of a mind to support this work with the financial recognition it deserves.

In the meantime, there are few health measures that come with revenue (rather than acting as a cost) to Government. A tax on sugar sweetened beverages would be one.

The next Budget would be soon enough.

Health on the hill

POLITICAL NEWS FROM THE NATION'S CAPITAL

Minister takes on health funds as election looms

Health Minister Sussan Ley has stepped up her pressure on the private health insurance industry, demanding all 35 funds reduce planned premium increases or justify higher charges.

Positioning herself as a strong advocate for consumers ahead of the federal election due later this year, Ms Ley has written to all insurers asking them to re-submit their applications for premiums increases due to come into effect from 1 April.

"Consumers have strong concerns about the affordability of their premiums; hardly surprising given premiums have increased at a rate of around 6 per cent per year for the past five years," the Health Minister said. "It is important I am armed with the full picture before approving any premium increase, particularly as consumers are telling me they are finding it increasingly difficult to simply shop around for a better deal."

Under current arrangements, health insurers receive around $6 billion a year from the Federal Government each year and, in return, have to get proposed premium increases approved by the Health Minister.

For the last two years, premiums have increased by an average 6.2 per cent, even as a proliferation of policies with multiple exclusions and large excess has undermined the value of cover on offer.

Ms Ley said health funds would need to lower their planned premium increases or provide evidence as to why they cannot do it.

But there are suggestions that the Minister is grandstanding on the issue for short-term political gain rather than trying to achieve sustained reform.

The funds lodged their proposed premium increases with the Health Department late last year, but Ms Ley made her announcement just a week before the Government traditionally notifies insurers of its decision.

Peak industry body Private Healthcare Australia told *The Australian* health funds undertook months of research and taking actuarial advice in coming up with their premium proposals, and for the Minister to make her request so late in the process was "quite challenging for the funds to comply with".

Dr David told *The Australian* a "one-off discount on pricing is unlikely to address the fundamental problems".

Jumping the gun

But the nation's largest insurer, Medibank Private, pre-empted Ms Ley's move by a week when it announced it was re-submitting its proposed premium increases for 2016.

While Medibank has not disclosed what size of premium increase it is proposing, a financial update from the fund suggests it is likely to be below the industry-wide average rise of 6.2 per cent approved last year.

Medibank announced its move after releasing preliminary figures showing an operating profit in the first half of the financial year of $270 million and a $100 million boost to its full-year profit outlook from above $370 million to in excess of $470 million.

The improved financial performance has been underpinned by a crackdown on benefit payouts and a series of tough deals struck with private hospitals involving shifting the financial burden of medical complications away from the insurer onto providers.

Medibank's decision to resubmit its proposed premiums for 2016 was hailed by Ms Ley, who said any move to cut costs was welcome.

The price of war

But AMA President Professor Brian Owler warned patients could be the losers in any price war that breaks out between the major health funds.

Professor Owler told Channel Seven he was concerned that people lured into taking out a health insurance policy by cut-price premiums might later find it does not provide the cover they expected, leaving them out-of-pocket for important medical care.

Without accompanying regulatory measures to buttress the quality of health insurance cover, the AMA is worried any premium price war could result in even more policies riddled with multiple exclusions and hefty excess charges.

Health on the hill

POLITICAL NEWS FROM THE NATION'S CAPITAL

... from p29

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

Professor Owler said it had become virtually a daily occurrence for patients booked in for common treatments to discover upon arrival that they were not covered by their insurance.

He said all too often insurers made changes to a policy after it had been bought without informing policyholders, leaving many unexpectedly stranded.

ADRIAN ROLLINS

High Court rejects legal challenge to offshore detention

The Federal Government has incurred widespread condemnation over its intention to transfer more than 250 asylum seekers, including 72 children, from the Australian mainland to Nauru after the High Court ruled that offshore detention in another country was lawful.

In a landmark decision, the High Court rejected the claim by a Bangladeshi woman detained by immigration authorities that the Government's arrangement with Nauru breached the Constitution.

The nation's highest court ruled that the Commonwealth's memorandum of understanding with the Nauruan Government was authorised by section 61 of the Constitution, and its move to hire Transfield to operate the detention centre on the island was "a valid law".

The judgement deals a probably terminal blow to challenges to the legality of the Government's highly controversial offshore detention regime, and has dismayed doctors and other health workers deeply concerned by the trauma and distress detention causes, particularly children.

Paediatrician Dr Karen Zwi, who has been looking after children transferred from Nauru for medical treatment, told ABC Radio about a five-year-old boy who was allegedly raped on Nauru.

"Like many other children who are very distressed, he regressed, he began bed-wetting, he was anxious, he became very concerned about his mother's wellbeing," Dr Zwi said. "He actually began to self-harm, as I've seen several other children do as well, and eventually he was transferred over to the mainland for treatment. His greatest fear is returning to Nauru. That is this huge cloud hanging over him, that he will be returned to an absolutely traumatic and devastating environment for him."

That fate now appears increasingly likely.

On 13 January, Immigration Minister Peter Dutton announced that 72 children "off boats" who were being detained were due to return to Nauru.

The announcement has been condemned by lawyers and child advocates, and is at odds with AMA calls for all children to be immediately removed from detention.

Just before Christmas, AMA President Professor Brian Owler released a statement in which he reiterated the AMA's long-held view that all asylum seeker children should be moved out of immigration detention.

The AMA President acknowledged that the number of children being detained had fallen significantly under the Coalition Government, but added that "it is time for all the detained children to be moved to safer places".

"Some of the children have spent half their lives in detention, which is inhumane and totally unacceptable," he said. "These children are suffering extreme physical and mental health issues, including severe anxiety and depression."

Government figures indicate 68 children are currently being held in detention on Nauru, and a further 79 are on the mainland.

The *AMA Position Statement on the Health Care of Asylum Seekers and Refugees* can be viewed at: https://ama.com.au/position-statement/health-care-asylum-seekers-and-refugees-2011-revised-2015

ADRIAN ROLLINS

UK doctors strike a second time

"Early last month, around 45,000 junior doctors across England went on strike to protest against proposed changes to employment contracts they believed would lead to unsafe work hours that would compromise patient safety - the first such industrial action in more than 40 years"

Junior doctors in Britain have gone on strike for a second time after talks with the United Kingdom Government foundered over the issue of a pay cut for practitioners working on Saturdays.

The British Medical Association resolved to push ahead with a 24-hour strike planned for 10 February after negotiations with the National Health Service and the Health Department reached a stalemate over the Government's insistence that doctors working on Saturdays be paid the same rate as a normal weekday.

BMA Junior Doctors' Committee Chair Dr Johann Malawana said the Government's "entrenched position in refusing to recognise Saturday working as unsocial hours, together with its continued threat to impose a contract so fiercely resisted by junior doctors across England, leaves us with no alternative but to continue with industrial action".

Early last month, around 45,000 junior doctors across England went on strike to protest against proposed changes to employment contracts they believed would lead to unsafe work hours that would compromise patient safety - the first such industrial action in more than 40 years.

The strike caused 1279 inpatient operations and 2175 outpatient services to be cancelled, though the protesting doctors honoured a commitment to ensure accident and emergency departments were not affected by the protest.

Emergency care was also to be quarantined from disruption in the 10 February strike.

A planned follow-up strike on 26 January was called off to allow for the resumption of talks, chaired by Salford Royal NHS Foundation Trust Chief Executive Sir David Dalton, to resolve the dispute.

The BMA reported that "good progress" had been made on a number of outstanding issues, understood to include safeguards against unsafe rostering practices and excessive work hours.

But Dr Mulawana said it was "particularly frustrating that the Government is still digging in its heels" on remuneration for Saturday work.

Health Secretary Jeremy Hunt has been pushing for the introduction of contracts which he argues would make the NHS a truly seven-days-a-week service.

Mr Hunt said numerous studies had shown that people received lesser care on weekends than they did during the week, and "I can't, in all conscience as Health Secretary, sit and ignore those studies".

But Dr Mulwana accused the Minister of obfuscating the fact that NHS doctors already provided round-the-clock services.

"The Government misrepresents junior doctors as a block to a seven-day NHS, but they already work every day of the week," the BMA official said. "What we are asking is that this is reflected in fair and affordable recognition of unsocial hours."

"The BMA's aim has always been to deliver a safe, fair junior doctor contract through negotiated agreement," he added.

The World Medical Association had thrown its support behind the junior doctors.

WMA President Sir Michael Marmot said the peak international medical organisation recognised the right of doctors to take action to improve working conditions that may also affect patient care.

He urged the Government to "establish a new working relationship with junior doctors. It is essential that trust is restored on both sides, for the sake of patient care".

ADRIAN ROLLINS

Kidnapping leaves big hole in care

AMA President Professor Brian Owler has voiced concerns for the safety of an Australian couple kidnapped from a health clinic in Burkina Faso, and raised fears the incident will not only disadvantage the local community but could deter others from undertaking humanitarian work.

Dr Ken Elliot and his wife Jocelyn, who have worked as medical missionaries in the impoverished West African country for more than 40 years, were snatched by suspected Al Qaida-linked militants from their home in Baraboule, near Djibo, about 200 kilometres north of the capital Ouagadougou.

Reports suggest the couple, who are both in their 80s, were taken in the early hours of 16 January, and may have been taken hostage for ransom as part of a fierce struggle between rival militant factions.

They were very well known in the area, where they run a 120-bed hospital. Dr Elliot is the only surgeon, and the clinic they established in 1972 serves a population of two million.

In a video published recently for the Friends of Burkino Faso Medical Clinic by Global Business Solutions Institute, Dr Elliot talked of the "enormous need" for care in the area.

In the video, Dr Elliot said there was a great shortage of surgical care in the region, and their hospital treats everything from hernias and bladder stones to tumours.

"You name it, we do it, because there is nowhere else to do it," he said. "When you look around and see the need, the need is enormous, [but] the rewards are enormous."

President Owler told ABC Radio the Elliots were among hundreds of Australian doctors around the world performing humanitarian work, often in isolated areas.

"We sometimes hear their stories, but most of the time the stories are not told and they're really unsung heroes," the AMA President said. "We should be very proud of the sort of work that these people are doing. They do, clearly, put themselves in danger."

Professor Owler said that, in addition to fears for the welfare of the Elliots, he was also concerned about what effect their abduction would have on the local community.

"Clearly, he and his wife have been doing humanitarian work

in Africa for most of their lives, devoted their lives to heling the local people and, of course, when this sort of thing happens, it takes away a vital resource from these local people," he said.

In the wake of the kidnapping, Djibo locals have mobilised to demand the release of the Elliots, amid concern that without them local health services will deteriorate.

A local family friend, Seydou Dicko, told the BBC that "he is not only Australian but he is someone from Burkina Faso, someone from our community, because what he did for our community even the Government itself couldn't do more than that".

Professor Owler said the incident could also deter others from following in the path of the Elliots and other Australian doctors providing health services for disadvantaged communities in some of the world's poorest countries.

"I think it probably deters other people from taking up similar work in the future," he said.

The Department of Foreign Affairs has said it is working with local authorities to try and locate the couple.

ADRIAN ROLLINS

Australian Medical Association Limited • ABN 37 008 426 793

Invitation for nominations for election to Federal Council

AREA NOMINEES

Invitation for nominations for election to Federal Council as Area Nominees

The Constitution of Australian Medical Association Limited (AMA) provides for the election, every two years, to the Federal Council of one Ordinary Member as a Nominee of each of the following Areas:

1. New South Wales and Australian Capital Territory Area • 2. Queensland Area • 3. South Australia and Northern Territory Area
4. Tasmania Area • 5. Victoria Area • 6. Western Australia Area

The current term of Area Nominee Councillors expires at the end of the AMA National Conference in May 2016.

Nominations are now invited for election as the Nominee for each of the Areas listed above.

1. Nominees elected to these positions will hold office until the conclusion of the May 2018 AMA National Conference. • **2.** The nominee must be an Ordinary Member of the AMA and a member in the relevant Area for which the nomination is made. • **3.** The nomination must include the name and address of the nominee and the date of nomination. It may also include details of academic qualifications, the nominee's career and details of membership of other relevant organisations. • **4.** Each nomination must be signed by the Ordinary Member nominated AND must be signed by two other Ordinary Members of the AMA resident in the Area for which the nomination is made. • **5.** Nominations must be **emailed** to the Secretary General (atrimmer@ama.com.au). To be valid nominations must be received no later than **1.00pm (AEDT) Friday 4 March 2016**. • **6.** A nomination may be accompanied by a statement by the nominee of not more than 250 words to be circulated to voters. • **7.** The ballot will by undertaken by electronic ballot.

The nomination form can be downloaded from: ama.com.au/system/files/AreaNomineeForm.pdf.

For enquiries please contact Lauren McDougall, Office of the Secretary General and President (email: lmcdougall@ama.com.au).

SPECIALTY GROUP NOMINEES

Invitation for nominations for election to Federal Council as Specialty Group Nominees

The Constitution of Australian Medical Association Limited (AMA) provides for the election, every two years, to the Federal Council of one Ordinary Member as a Nominee of each of the following Specialty Groups:

1. Anaesthetists • 2. Dermatologists • 3. Emergency Physicians • 4. General Practitioners • 5. Obstetricians and Gynaecologists
6. Ophthalmologists • 7. Orthopaedic Surgeons • 8. Paediatricians • 9. Pathologists
10. Physicians • 11. Psychiatrists • 12. Radiologists • 13. Surgeons

The current term of Specialty Group Councillors expires at the end of the AMA National Conference in May 2016.

Nominations are now invited for election as the Nominee for each of the Specialty Groups listed above.

1. Nominees elected to these positions will hold office until the conclusion of the May 2018 AMA National Conference. • **2.** The nominee must be an Ordinary Member of the AMA and a member of the relevant Specialty Group for which the nomination is made. • **3.** The nomination must include the name and address of the nominee and the date of nomination. It may also include details of academic qualifications, the nominee's career and details of membership of other relevant organisations. • **4.** Each nomination must be signed by the Ordinary Member nominated AND must be signed by two other Ordinary Members of the AMA Specialty Group for which the nomination is made. • **5.** Nominations must be **emailed** to the Secretary General (atrimmer@ama.com.au). To be valid nominations must be received no later than **1.00pm (AEDT) Friday 4 March 2016**. • **6.** A nomination may be accompanied by a statement by the nominee of not more than 250 words to be circulated to voters. • **7.** The ballot will by undertaken by electronic ballot.

The nomination form can be downloaded from: ama.com.au/system/files/SpecialtyGroupForm.pdf.

For enquiries please contact Lauren McDougall, Office of the Secretary General and President (email: lmcdougall@ama.com.au).

SPECIAL INTEREST GROUP NOMINEES

Invitation for nominations for election to Federal Council as Special Interest Group Nominees

The Constitution of Australian Medical Association Limited (AMA) provides for the election, every two years, to the Federal Council of one Ordinary Member as a Nominee of each of the following Special Interest Groups:

1. Public Hospital Practice (previously called Salaried Doctors)
2. Rural Doctors
3. Doctors in Training
4. Private Specialist Practice.

The term of Councillors expires at the end of the AMA National Conference in May 2016.

Nominations are now invited for election as the Nominee for each of the Special Interest Groups listed above.

1. Nominees elected to these positions will hold office until the conclusion of the May 2018 AMA National Conference. • **2.** The nominee must be an Ordinary Member of the AMA and a member of the relevant Special Interest Group for which the nomination is made. • **3.** The nomination must include the name and address of the nominee and the date of nomination. It may also include details of academic qualifications, the nominee's career and details of membership of other relevant organisations. • **4.** Each nomination must be signed by the Ordinary Member nominated AND must be signed by two other Ordinary Members of the AMA Special Interest Group for which the nomination is made. • **5.** Nominations must be **emailed** to the Secretary General (atrimmer@ama.com.au). To be valid nominations must be received no later than **1.00pm (AEDT) Friday 4 March 2016**. • **6.** A nomination may be accompanied by a statement by the nominee of not more than 250 words to be circulated to voters. • **7.** The ballot will by undertaken by electronic ballot.

The nomination form can be downloaded from: ama.com.au/system/files/SIGForm.pdf.

For enquiries please contact Lauren McDougall, Office of the Secretary General and President (email: lmcdougall@ama.com.au).

My Aged Care – "Wouldn't be without them"

BY DR CLIVE FRASER

After 19 years on the road, it was inevitable that my beloved Volvo V70 wagon would catch a cold and break down some time.

As these things happen, it halted right at the entry to the carpark for my rooms.

Unable to get it going again, for the first time ever, I called my Auto Club's breakdown service for help.

Their motto is, "Wouldn't be without them" and, true to their word, within 15 minutes their mechanic arrived.

He took a brief history, turned the ignition on a couple of times, primed the fuel pump, and then presto, I was back on the road.

It's very comforting to know that for $86 per year wherever you are, help is always at hand.

I estimate that a 19-year-old car is pushing the equivalent of 95 human years, so I treat the old girl with a lot of respect and tender loving care.

Just the way you might support an elderly member of the family still living at home.

But, with health problems surfacing for an elderly relative, I have some concerns about the complexity of accessing help for our beloved.

For starters, there's a thing called My Aged Care.

There was a 45 minute phone call to take the details, and a faxed copy of an Enduring Power of Attorney verified that I was authorized to act on behalf of the relative.

All's well and good, so far.

Then there was an appointment for an assessment lined up.

But the assessor was a no-show and it took four days to track her down, upon which she advised that the assessment was next week and not last week, even though that wasn't what she had said and verified in her text message.

Not wanting to bite the hand that feeds you, we met subsequently and from then on things went further astray.

There was a text message from her on a Saturday afternoon and a phone call on a Sunday morning.

Unfortunately, the assessor said she'd assessed the husband, when it was actually the wife.

Oh, by the way, she also failed to identify that there were cognitive problems, which were the original reason for the referral in the first place.

Easily sorted, but then you are asked to wait for a call from a care provider.

Days turned into weeks and, eventually, a call back to My Aged Care shed more light on the lack of progress as the assessor had not "issued" the request to any care providers.

All sorted again, and copious apologies from the call centre.

On track at last. But then came another phone call from someone else at My Aged Care, offering to assess the applicant.

I'm always happy to accept help, but hadn't that already happened?

Finally, after eight weeks of frustration, the care providers started to call.

But the advice was, "You'd be better off with a package".

Against the odds, I called ACAT directly, explained the situation and asked for help.

No hold-ups this time, and everything about their recommendations was put in writing.

Throughout all of this my elderly relative kept asking, "How do people cope who don't have any friends or family to help them?"

I would ask exactly the same question.

Friends and family, "Wouldn't be without them".

Safe motoring,

Doctor Clive Fraser

doctorclivefraser@hotmail.com

Forget Sake, let the Koshu pour

BY DR MICHAEL RYAN

Most people, if asked to name a Japanese alcohol, would reply 'sake', or perhaps Suntory whiskey or Asahi beer. It comes as a surprise to many to find that Japan is an emerging wine producer.

I have just returned from a conference in Japan, and while there I had the opportunity to sample local, fully domesticated, Japanese wine.

Wine can be labelled Japanese if bottled there. This allows for imported grape juice or must, or even bulk wine, to be called Japanese. One has to look for the fully domesticated label for the true home grown product.

The main regions include Yamanishi, near Mt Fuji, where there are more than 130 genuine wine producers; Nagano/Niigita; and Hokkaido in the north. Hokkaido is the biggest wine producer. Wine production in Hyogo in the Kobe region and Yamagata is a smaller affair, with areas of less than 200 hectares, but the product is superior.

The climate in Japan is extreme. Hot summers with battering typhoons rapidly turn to cold snowy winters courtesy of Mongolia's frozen steppe. Awesome for skiing, though.

The soil is often acidic and land is scarce. Japan is incredibly mountainous, (another feature that makes it great for skiing) but, combined with the pressure of habitation and competition from other forms of agriculture use, it means Japan is tough going for a vintner.

Persistent wet and cloudy conditions are conducive to the development of mould, and hamper the ripening process.

Interestingly, Japanese authorities allow for sugar to be added during the fermentation process, similar to France's Chapatal laws. Up to 260 grams per litre can be added. This makes sense when on the Baume scale, which equates sugar levels to expected alcohol when the wine is fully fermented, only reaches to between nine and 11 Baume. By comparison, a serious Barossa Shiraz can be 14 or 15 Baume. Incidentally, the addition of sugar is illegal in Australia.

A high trellised system enables good air flow and some horizontal trellising helps resist typhoon winds.

Japanese vintners sounds like they share some of the maladies and challenges those in the Hunter Valley have to overcome.

Cabernet Sauvignon, Pinot Noir and Merlot dominate the European red varieties, and Chardonnay and Riesling are the mainstays of the whites.

The overwhelming conclusion is that the wines have varietal characteristics.

The Koshu variety, found in 1186 growing in the wild in the middle of Honshu and considered to be Japan's only true native variety, is the most common used for table wine. The grape is pink in colour, with a thick skin that aids in mould and botrytis resistance. The wine is a pale light yellow colour.

I found delicate white peach and floral notes in some, while in others there were additional grassy aromas. The palate is forward and light, with little acidity.

The four or five I tasted were consistent in this light style, and all were devoid of flaws. Some wine makers are experimenting with barrel fermentation and lees contact for complexity. I thought it was an outstanding match for sashimi of any kind.

Merlot seems to be the most consistent red varietal. A Merlot by Domaine Echigo, from the Niigita region, was outstanding. For $A35, it would match most $A50 Merlot-driven Bordeaux wines. Nice red to purple colour. Restrained red current and spice bouquet, with enough fruit, acid and structure to match lightly seared wagyu.

I had a little wine separation anxiety while in Japan. Certainly, one can pay over the odds in a big hotel for what we consider BBQ wine.

But the bottom line is, "when in Rome..." So, don't be afraid to try the Japanese wines, but have an open mind, considering it is a fledgling industry.

AMA Member Benefits

AMA members can access a range of free and discounted products and services through their AMA membership. To access these benefits, log in at **www.ama.com.au/member-benefits**

AMA members requiring assistance can call AMA member services on
1300 133 655 or **memberservices@ama.com.au**

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

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

Careers Advisory Service: Your one-stop shop for information and resources to help you navigate through your medical career.

CPD Tracker: Record your continuing professional development (CPD) online with the AMA's CPD Tracker, a free service for members.

Amex: American Express is a major partner of the AMA and offers members special discounts and extra rewards on a range of credit cards, merchant services and offers for existing AMA cardholders.

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

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

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

OnePath: OnePath offers a range of exclusive insurance products for AMA members.

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

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

Not a member?

Join now to discover the representation, services, resources and benefits available to members:

www.join.ama.com.au/join