AUSTRALIAN
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Healthy new year!

From tracking epidemics and backing e-health to tighter gun control and prison needle programs – ideas to keep Australians safe and well in 2017, p3

INSIDE

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In this issue

From the editor

Changes at *Australian Medicine*

The AMA has a well-deserved reputation as one of the nation's most influential lobby groups. When it talks, governments listen and often act, whether it be scrapping GP co-payments or joining the international effort to combat Ebola.

This is not surprising. The AMA speaks with authority because of the hard-earned reputation of doctors to stand up for the interests of their patients, and of the broader community. Whether it be the cost of access to care, the dangers of antibiotic resistance and climate change or the high cost of alcohol, obesity and domestic violence, the AMA makes its case based on evidence and experience.

As editor of *Australian Medicine* for the past five years, it has been a privilege to observe and report on the passion and commitment doctors bring to their work of caring for those around them.

I have pleasure in announcing that Walkey Award-winning journalist Chris Johnson, most recently at the Canberra Press Gallery, has joined *Australian Medicine* as my replacement.

ADRIAN ROLLINS

Ideas for a healthier Australia

Tighter gun controls, improved disease surveillance, regulation of e-cigarettes and prison needle programs have been put on the national agenda by the AMA as part of a concerted effort to improve public health and safety.

As Prime Minister Malcolm Turnbull mulls over a permanent replacement for Sussan Ley as Health Minister, the AMA has put the spotlight on a range of issues directly affecting the well-being of Australians.

The Association has already sought a meeting with acting Health Minister Senator Arthur Sinodinos to press for an immediate end to the Medicare rebate freeze and to discuss concerns regarding the Government's review of the Medicare Benefits Schedule, implementation of the Health Care Homes model of care, the introduction of the My Health Record e-health system and the regulation of pathology collection centre rents.

The AMA will also sharpen the Government's focus on future of public hospital funding and the behaviour of private health funds when it releases its latest Public Hospital and Private Health Insurance report cards in coming weeks.

But, as AMA President Dr Michael Gannon flagged in his speech to the National Press Club last year, the nation also needs to invest much more in public and preventive health activities.

"Investing in prevention delivers twin benefits – one is the improved health and wellbeing of the individual, and the other is the reduced costs to the health system," Dr Gannon said in his speech. "The burden of health costs in Australia is largely being driven by people being hospitalised for health problems that can be prevented. Health prevention alone cannot stave off all disease and illness. But the OECD has estimated that about half of all premature deaths are attributable to preventable behaviours."

Acting on this, the AMA has directed the Government's attention toward a range of pressing public health concerns, and has proposed actions to ameliorate the risk.

A spate of transnational epidemics of serious and potentially deadly communicable diseases including Ebola and the Zika virus, together with the threat posed by rising antibiotic resistance, have underlined the importance of national and international coordination of disease surveillance and control efforts, and the AMA has intensified its calls for the establishment of an Australian Centre of Disease Control to ensure the country is well placed to respond to infectious disease outbreaks and contribute to global efforts.

The AMA has also called for tighter restrictions on gun ownership and use, including the establishment of a national firearms register, in an effort to reduce the alarming toll of death and injury stemming from the accidental and deliberate use of firearms. In 2014 alone, 253 died from gunshot wounds.

The AMA has proposed the introduction of prison needle and syringe programs as a practical, evidence-based step to curb the incidence and spread of serious blood-borne illnesses, particularly hepatitis.

Dr Gannon said that not only were such programs shown to be effective in protecting the health of inmates and prison staff, but had a potentially big pay-off in reducing the risk of prisoners spreading illness in the community upon their release.

As part of its work to improve public health and safety, the AMA has also drawn attention to the need for people to drive more carefully; to be safe around water including closely supervising young children; keeping button batteries out of the reach of infants and toddlers; covering up when outdoors, including making sure children wear sunglasses; to take care at music festivals and other outdoor events, including drinking plenty of water and avoiding risky behaviour; and to use the new year as an occasion for smokers to quit their deadly habit and for people to register as organ donors and inform their family of their intentions.

Dr Gannon said public and preventive health initiatives such as these were not about instituting a 'nanny state' or taking away people's choices.

But he said people needed to be made aware of the risks and consequences of their behaviour.

"Sadly, we are a country where levels of health literacy are surprisingly low – Australians make bad choices about the foods they eat, the fluids they drink, and their level of physical activity every day," the AMA President said last year. "There are not enough public health campaigns and we continue to fund, at tremendous expense, the consequences of failures to prevent chronic health conditions.

"The benefits of investment in preventive health can take years, even generations, to be felt. But now is the time to act. This is an investment we all have to make."

ADRIAN ROLLINS

Nation under-prepared for disease threat

Australia needs a national centre to track deadly diseases and help coordinate the public health response across domestic and international borders, the AMA has said.

As the Federal Government frames its forthcoming Budget, the country's peak medical association has called for resources to be allocated for the establishment of an Australian Centre for Disease Control (CDC) to enable the country to contribute to global efforts to combat and control infectious disease outbreaks.

AMA President Dr Michael Gannon said recent outbreaks of deadly diseases such as Ebola, SARS, MERS and the Zika virus had left thousands dead and caused enormous suffering, and Australia was not immune to the threat.

"Diseases and health threats do not respect borders," Dr Gannon said. "There are emerging problems of controlling communicable diseases within Australia's borders, and a CDC would provide a national focus on current and emerging communicable disease threats."

The need for nationally and internationally coordinated approaches to communicable diseases and health threats like antibiotic resistance has come into increasingly sharp focus with advances in travel and trade that facilitate the spread of pathogens.

In recognition of this, countries across the world have followed the US lead in establishing their own CDCs. Australia is now the only nation within the Organisation for Economic Cooperation and Development without its own CDC.

Dr Gannon said the country could no longer rely on ad hoc and patchwork arrangements to drive its response to outbreaks.

"We haven't yet faced fatal epidemics and infectious disease threats, but we do know that, when we face one, our current capabilities would be severely stretched," the AMA President said. "SARS, MERS, Ebola virus, and Zika virus are examples of the current known threats facing Australia, and these are threats that could result in widespread morbidity and mortality.

"If we are to be a serious force in combating disease in our region, we need a CDC," Dr Gannon said.

In a Position Statement released in early 2017, the AMA proposed an Australian CDC to:

- undertake surveillance of communicable diseases, nationally and internationally;
- coordinate the nation's response to epidemics, pandemics and other threats;
- provide expert advice;
- oversee the development of a national strategy on antimicrobial resistance;
- promote and track vaccination levels; and
- partn er with similar organisations internationally.

In the first instance, the AMA said the CDC would be staffed by Health Department disease surveillance personnel, and would operate under the supervision of a Governing Council comprising Federal, State and Territory officials.

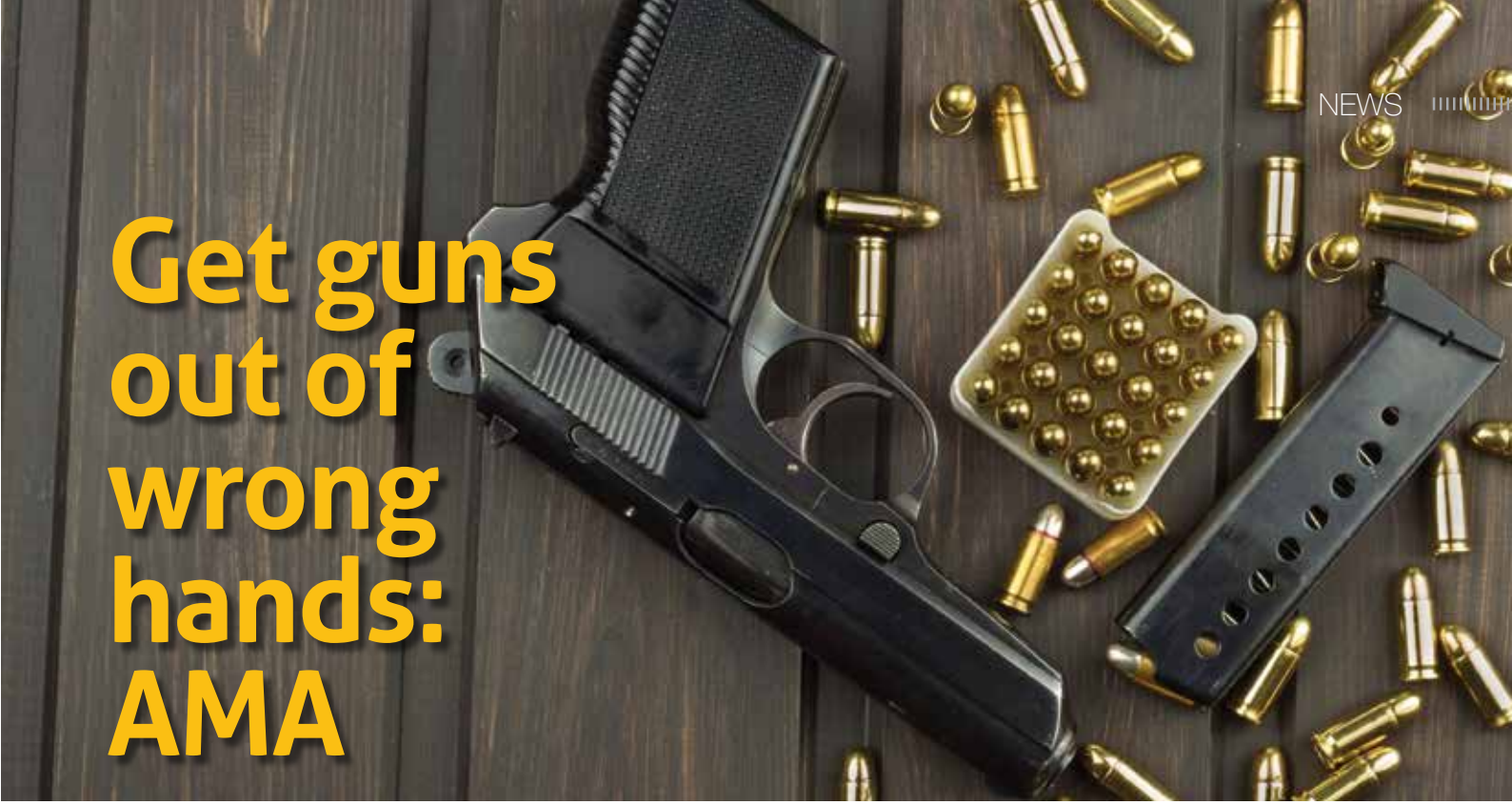
In addition to its monitoring and coordination role, the Centre would work with the National Health and Medical Research Council to establish research priorities, and improve the collection of disease data in coordination with the Australian Institute of Health and Welfare.

"The CDC would deliver effective communication of technical and surveillance information, and work with the States and Territories to manage the allocation of public health workforces and resources to tackle emerging and current threats," Dr Gannon said. "It would coordinate Australia's vital work with other countries to build international public health capacity through expanding and managing communicable disease surveillance, prevention and control, environmental health, and health awareness and promotion.

"The CDC's role would be to engage in global health surveillance, health security, epidemiology, and research."

The AMA *Position Statement on an Australian Centre for Disease Control* is at https://ama.com.au/position-statement/australian-national-centre-disease-control-cdc-2017

ADRIAN ROLLINS



Get guns out of wrong hands: AMA

The AMA has urged tighter restrictions on gun ownership and use, including the establishment of a national firearms register, in the face of attempts to water down and circumvent Australia's landmark gun control laws.

Following a concerted campaign by gun enthusiasts to overturn a ban on the importation of the Adler lever-action shotgun, the AMA has called for tighter controls and monitoring of who can own a gun in order to reduce gun deaths and improve public safety.

Launching the *AMA Position Statement on Firearms 2017*, AMA President Dr Michael Gannon said there was a legitimate role for guns in farming, sport, policing and the military, but access to firearms should be tightly controlled to reduce the number of deaths and injuries caused by shootings.

Since the introduction of the National Firearms Agreement in 1996 the number of gun deaths has halved, but hundreds are still fatally shot or badly injured each year. In 2014 alone, 253 people died from gunshot wounds, including 185 people who committed suicide.

Dr Gannon said the AMA did not want to take guns from responsible owners such as farmers and registered sporting shooters, but tighter controls were needed.

"We know that too many suicides, too many homicides, too many accidents happen because guns fall into the wrong hands," he told Sky News. "We know that people act impulsively. If they've got a lethal weapon at their fingertips it's far more likely they'll harm themselves or someone else, sometimes a loved one."

Under current laws, gun buyers must provide a 'genuine reason' for their purchase, but the AMA said the requirement was open to misuse and needed to be tightened.

It recommended that owning or carrying a firearm for the express purpose of self-defence should be banned and that only registered gun club members should be allowed to possess handguns.

In addition, the AMA said gun licenses should be refused for people subject to a current restraining order, or who have been convicted of an indictable offence involving violence or firearms in the previous five years.

Despite restrictions under the National Firearms Agreement, gun ownership remains relatively common. In 2012 there were 730,000 licensed owners and 2.75 million registered firearms in Australia, putting the national gun ownership rate at 3.32 per cent.

The number of illegal guns in the community may be even higher. More than 1.2 million firearms were surrendered in gun amnesties between 1988 and 2015, and estimates put the number of unlawfully held guns as high as six million.

Dr Gannon said such uncertainty made the AMA's call for all guns to be registered on a national database all the more urgent.

Proposals for a national registration system were first raised following the Port Arthur massacre in 1996, but were yet to be realised.

"Something that was called for at that time was a national register so that the State and Territory-based computer systems can talk to each other, so that we know exactly, where possible, where every firearm in the country is," Dr Gannon said. "This is 20 years overdue. It's time for the State and Territory governments to get their act together so that we can make sure, wherever possible, that lethal weapons aren't in the hands of people who shouldn't have them."

Get guns out of wrong hands: AMA

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In its Position Statement, the AMA has recommended the development of a real-time, readily accessible National Firearms Licensing Register that would incorporate all the information on firearms held by each State and Territory government.

In a promising sign for interstate co-operation on firearm control, Federal, State and Territory leaders meeting at the Council of Australian Governments late last year agreed to classify the lever-action Adler 110 shotgun as a category D weapon, putting it out of the reach of most gun owners.

The COAG decision has been regarded as a victory for gun control advocates, and was commended by Dr Gannon.

"The AMA supports a strengthening of current laws banning high-powered semi-automatic weapons and pump or lever action rifles, so that they cannot be circumvented by new or adapted models," the AMA President said. "We strongly oppose any campaigns or policies that seek to dilute or relax the restrictions on firearm purchase and ownership, such as winding back the mandatory 'cooling off' period between applying for and buying a gun."

The *AMA Position Statement on Firearms 2017* can be viewed at: https://ama.com.au/position-statement/firearms-2017

ADRIAN ROLLINS

Nation must do better on early autism diagnosis: AMA

Professor Brian Owler and AMA President Dr Michael Gannon at the ASD launch

AMA President Dr Michael Gannon has called on the Federal Government to help improve the early diagnosis of autism spectrum disorder and ensure children with the condition and their families get the best possible support.

Saying early diagnosis was essential to provide early intervention therapies for children with autism spectrum disorder (ASD), Dr Gannon insisted coordinated action and a national policy was necessary.

Governments at every level should work with medical colleges and professional bodies to boost the number and availability of clinicians able to provide timely diagnostic assessments of children suspected of having ASD.

The AMA President specifically called on the Federal Government to rule out any tightening of the eligibility requirements for people with ASD to access the National Disability Insurance Scheme.

And he said doctors were not the only important players in diagnosis and intervention, but that an integrated approach involving the health, education and disability sectors – working with families – was required.

"There is no specific biomedical test for ASD – it cannot be diagnosed with a blood test or a scan," he said.

"The number of paediatricians, child psychiatrists and clinical psychologists working specifically in ASD is limited, and the problem is magnified in rural and remote areas where few, if any, clinicians can make the diagnosis."

Dr Gannon said while ASD could be reliably detected at two years of age, Australian children were most commonly diagnosed just before their sixth birthday.

Children living in similar countries are commonly receiving diagnoses around three years of age.

The AMA put the focus on the early diagnosis of ASD in its *Position Statement on Autism Spectrum Disorder*, which was launched by Dr Gannon at a function attended by immediate-past AMA President Dr Brian Owler and Autism Awareness Australia Chief Executive Nicole Rogerson in Sydney in early December.

In launching the Position Statement, Dr Gannon referred to a survey by Autism Awareness Australia that found 34 per cent of families waited more than a year for a diagnosis, and close to 20 per cent waited more than two years.

"There are also no nationally consistent guidelines for GPs on what to look for and when, and how to refer a child who is suspected of having ASD," Dr Gannon said.

"But early detection is critical, as brain plasticity means early intervention can make a huge difference. The earlier ASD is diagnosed, the better the outcome."

Dr Gannon said the NDIS must remain accessible to families affected by ASD, noting that in many NDIS trial sites there was an unanticipated demand for support packages for children with ASD.

At one site, almost half of all participants had an ASD diagnosis.

He said that while the sustainability of the NDIS was not currently under threat, if demand consistently outstripped capacity it could eventually lead to a tightening of eligibility requirements.

Nation must do better on early autism diagnosis: AMA

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"This would threaten access to vital early intervention treatments," he said. "The AMA calls on the Government to guarantee ongoing access to the NDIS for people with ASD."

At the position statement launch, Dr Gannon also took aim at anti-vaccination activists for making wild claims about the cause of ASD.

He said assertions that autism was linked to vaccination were very misleading.

"We know that an increasing number of children in Australia are being diagnosed with ASD," Dr Gannon said.

"We don't know whether this is because our diagnosis processes are getting better or whether there is an actual increase in the number of children developing ASD – or a combination of both.

"But I am confident that, in time, we will fully understand the condition and be able to debunk the myths, misunderstandings and complete misinformation being spread about causes and cures.

"Parents of children with a potential ASD diagnosis have enough to deal with without being bombarded with ridiculous and misleading information."

Ms Nicole Rogerson welcomed the AMA position statement, saying that for too long autism had been put in the "disability basket" without proper recognition of the integral role doctors played in early detection.

"GPs are often the first point of call for parents who are concerned about their child's development, yet we are still seeing longer-than-necessary wait times for referrals and diagnosis," she said.

"What we know without a doubt is that early detection leads to early intervention, giving children the opportunity to have their best outcome."

The AMA *Position Statement on Autism Spectrum Disorder 2016* is available at https://ama.com.au/position-statement/autism-spectrum-disorder-2016.

CHRIS JOHNSON

Autism: What the AMA says should happen

Effective and evidence-based treatments should be instituted as soon as possible to maximise the effectiveness of such therapies.

- **Governments, the relevant medical colleges, and professional bodies should ensure there are a suitable number of clinicians and other professionals to enable timely access to diagnostic assessment for children who are suspected of having ASD.**
- **That medical practitioners work with families and teachers, who spend lengthy periods of time with a child, and seek their insights and observations.**
- **That comprehensive guidelines and/or minimum national standards for referral practices and diagnostic assessments be developed.**
- **That there be ongoing research into the effectiveness of current and novel therapies.**
- **That all health professionals who interact with children be encouraged to develop and maintain their understanding of early signs and symptoms of ASD.**
- **That the Government make a strong, ongoing commitment, that people who are affected by ASD will have ongoing access to support through the NDIS.**

CHRIS JOHNSON

Targets needed for women, Indigenous peoples in medical workforce

> "Doctors from diverse backgrounds bring skills and perspectives that enable the medical workforce to be more responsive and empathetic, not only to individual patients but to broader community needs" - *Dr Gannon*

Four of the nation's 15 medical colleges have never had an Indigenous trainee, and only in four medical schools has a female dean, Australia's peak doctors' body says.

The AMA has pointed to the figures to call for targets to increase the proportion of women in health leadership positions, and the number of Aboriginal and Torres Strait Islander people in the medical workforce.

The AMA's *Position Statement on Equal Opportunity in the Medical Workforce* recommends a range of policy actions for medical workplaces and training providers to provide all doctors and medical students with equal access to employment, education, and training opportunities.

"The medical workforce should reflect the diversity of the patients it cares for," AMA President, Dr Michael Gannon, said.

"Doctors from diverse backgrounds bring skills and perspectives that enable the medical workforce to be more responsive and empathetic, not only to individual patients but to broader community needs.

"There is an under-representation of women in leadership positions in the medical workforce, and an under-representation of Aboriginal and Torres Strait Islander people throughout the health care sector.

"The AMA supports targets to address this. Targets should be realistic, and must continue to be merit-based, but organisations should have a range of positive strategies and initiatives to attract doctors from diverse backgrounds."

The Position Statement says that medical workplaces and training providers should work to enact equal opportunity legislation to eliminate discrimination or harassment, and that organisations should employ staff whose behaviour actively promotes equal opportunity.

Currently, fewer than 12.5 per cent of hospitals with 1000 employees or more have a female chief executive, and only 28 per cent of medical schools have female deans.

Women make up one-third of State and Federal chief medical officers or chief health officers.

In 2012, there were 221 medical practitioners employed in Australia who identified as Aboriginal or Torres Strait Islander – representing 0.3 per cent of all employed medical practitioners who chose to provide their Indigenous status.

In 2015, a total of 265 Aboriginal and Torres Strait Islander students were enrolled in medical schools across Australia, according to the Medical Deans Australia and New Zealand.

Dr Gannon again encouraged Aboriginal and Torres Strait Islander students currently studying medicine to apply for the 2017 AMA Indigenous Peoples' Medical Scholarship.

Successful applicants will receive $10,000 each year for the duration of their course.

Applications close on 31 January. More information is available at https://ama.com.au/indigenous-peoples-medical-scholarship-2017.

The AMA Position Statement on Equal Opportunity in the Medical Workforce can be found at: https://ama.com.au/position-statement/equal-opportunity-medical-workforce-2016

MARIA HAWTHORNE

Prisons frontline in battle against deadly viruses

All prisoners should be given access to sterile needles and syringes as part of national efforts to curb the spread of dangerous blood-borne viruses like hepatitis and HIV, the AMA has said.

As the Federal Government pushes ahead with a $1 billion strategy to treat and eradicate hepatitis C, the AMA has recommended that prisons be equipped with needle and syringe programs to slow and prevent the transmission of blood-borne viruses among inmates and in the broader community.

> "... prisons provided a unique opportunity to intervene and protect not just those in custody, but those they might come into contact with upon release"

AMA President Dr Michael Gannon said the evidence showed that providing prisoners with clean needles and syringes, as well as access to condoms and disinfectants like bleach, not only protected inmates but reduced the risk of needle-stick injuries for staff.

Fears that such programs would promote illicit drug use were shown to be unfounded, Dr Gannon said, as were concerns they would undermine prison security.

The presence of blood-borne viruses (BBV) is a major health problem in the nation's prisons, which act as reservoirs for their spread to the broader community, and Dr Gannon said the introduction of needle and syringe programs was a "frontline approach" to preventing the transmission of such diseases.

"All the evidence shows that harm minimisation measures, such as access to condoms and lubricant, regulated needle and syringe programs, and access to disinfectants such as bleach, protects not just those in custody, but prison staff too," the AMA President said. "It also reduces the likelihood of someone being discharged from prison with an untreated BBV, and spreading it in the outside community."

The prison needle and syringe program is a key recommendation of the *AMA Position Statement on Blood Borne Viruses 2017*, which proposes a range of measures to reduce the incidence of infections, including ready access to voluntary BBV testing, vaccination of hepatitis C patients, sex worker health promotion and outreach services and the treatment of BBV as a health rather than legal issue.

While BBVs are present in the general community, they are particularly prevalent among prisoners, many of whom are injecting drug users, are already infected and use dirty needles and syringes while incarcerated.

Against this, the AMA said prisons provided a unique opportunity to intervene and protect not just those in custody, but those they might come into contact with upon release.

"The AMA supports NSPs [needle and syringe programs] as a frontline approach to prevention of BBVs, and other harms among people who inject drugs. The published evidence supporting the needle and syringe programs is very strong," the Position Statement said. "The well-being and health of people in custodial facilities has wider community health implications, as any detainee infected with a BBV may transmit that infection within the prison population or to the wider community if they are released with an untreated condition."

Dr Gannon warned against punitive approaches, such as making the transmission of BBVs a crime.

"Criminal sanctions should be used only as a last resort for people who intentionally put others at risk of BBV infection," Dr Gannon said, cautioning that criminalising it would deter people from getting tested, disclosing their illness or seeking treatment, increasing the risk of spread.

"There is no evidence that laws that criminalise BBV transmission either prevent or deter transmission," he said.

The AMA *Position Statement on Blood Borne Viruses 2017* is available at https://ama.com.au/position-statement/blood-borne-viruses-bbvs-2017.

ADRIAN ROLLINS

'TripAdvisor for doctors' a distraction from insurer woes

Private health funds have been accused of setting up doctor rating websites in an effort to deflect blame for rising insurance premiums onto the medical profession.

AMA President Dr Michael Gannon said that although the desire of patients for information and value for money was understandable, insurers were setting up doctor rating websites to serve their own purposes rather than provide a useful service for consumers.

"I would trust your GP to give you the accurate information on the best specialist for you, not the fund's self-determined list of which doctors agree to charge the fee that they're willing to pay," Dr Gannon told radio 6PR. "And I think there's a whole lot more to quality health care than whether or not someone feels aggrieved that the receptionist was rude or the magazines weren't that good."

The AMA President was commenting on plans by major insurers including BUPA, NIB and HBF to begin publishing data on gap fees charged by individual specialists on the Whitecoat website from early next year, along with assessments of the quality of care.

The health insurance industry has been attempting to put the spotlight on high gap fees being charged by some specialists in what Dr Gannon considers to be an exercise in "doctor bashing".

He admitted that a small number of doctors were charging excessive fees, which was reflecting poorly on the rest of the profession.

"I think they diminish us doing the right thing, charging what we would regard as reasonable gaps," the AMA President said. "I will never stand up and try and defend significant gaps; we realise that they're a barrier to people getting the best possible care."

But he said the data showed that the vast majority of doctors were doing the right thing by their patients. Government figures show 86 per cent of all private insured medical services are being provided by doctors at no gap to the patient, and a further 6.4 are being provided with a known gap. Furthermore, the average bill for out-of-pocket expenses fell more than 5 per cent in the September 2016 to $128.99.

Dr Gannon sheeted the blame for doctor gap fees to the decisions by successive governments, and by insurers, not to index their rebates and benefits to reflect increases in the cost of providing medical services, leaving doctors with little option but to increase charges to their patients.

Nonetheless, Dr Gannon said, the fact that the doctor's share of private hospital care costs had remained at 15 per cent since 2007 showed that medical fees were not out of control.

Instead, he said, insurers should look to their own operations.

"It's the insurers that need to look within at the carve-outs, the exclusions, the caveats in their health insurance policies. The for-profit industry, and to a lesser extent the not-for-profit health funds, are creating a system that is making their policy-holders unhappy. Unfortunately they're deflecting blame onto the doctors."

The sector is finding itself under increasing scrutiny.

Private health funds are grappling with mounting consumer dissatisfaction over the quality, value and affordability of their products, and former Health Minister Sussan Ley appointed a committee to advise on reforms to the industry, including a ban on junk policies and a move to more simplified product offerings, with far fewer exclusions and reduced excess levels.

Ms Ley had put insurers on notice that the Government expected them to do "everything possible" to limit the size of 2017 premium increases, with speculation they will rise by an average of 5 per cent on 1 April.

Dr Gannon said he understood why "insurers are pushing back, but I would encourage them to look at their own products and look for reforms, not just go doctor bashing."

The AMA is due to release its second Private Health Insurance Report Card in early 2017.

ADRIAN ROLLINS

Measuring outcomes crucial to improved care: AMA

Measuring clinical outcomes in general practice is pivotal to improving patient health and quality of care, the AMA has said.

As private health insurers push for patients to rate the care they receive from individual doctors and the Medical Board assesses models for revalidating the competency of medical professionals, the AMA has issued a *Position Statement on Measuring Clinical Outcomes in General Practice – 2016* in which it makes the case for patient outcome measures.

Stressing that medical practitioners already intrinsically use outcome measures to assess appropriate treatment of patients, the AMA said its Position Statement aimed to guide the focus in order to minimise unintended consequences and prevent misuse of indicators.

"Unintended consequences might include unnecessary testing, inappropriate prescribing, cherry-picking of patients, reduced access to GP of choice, and a greater focus on the indicator being measured than the patient," the AMA said.

"These unintended consequences cost the health system more and undermine patients' trusts in their GP."

To avoid this, the AMA argues outcome measures should be voluntary, non-punitive, easy to measure and relevant.

They should also align the Medical Home model of care and Bodenheimer's Quadruple Aim – improved population health; reduced care cost; satisfied patients; and satisfied providers.

"Practical and well-designed outcome measures are fundamental to understanding the benefits and value of specific actions or interventions, and for self-directed learning for continuous improvement in the delivery and quality of care provided," the position statement reads.

"Health outcomes are affected by more than just the care provided by clinicians or the personal choices of patients, as social determinants and government policies can have a significant impact.

"To be meaningful, the right measure for the right purpose must be selected."

The AMA recommended the following steps be followed when developing and implementing outcome indicators:

1. Select relevant patient groups, care processes or clinical outcomes to be evaluated.
2. Organise a balanced consensus groups, measurement team.
3. Conduct a literature search for indicators already developed or data about optimal care available (evidence-based guidelines).
4. Select indicators and standards.
5. Define the measure specification.
6. Operationalise (Identify data sources, data collection procedures, implementation plan and pilot test).
7. Report (statistics, tabulations, data presentation).
8. Apply to the system of quality improvement.

The AMA said there was no single outcome measure perfectly suited for all purposes, and assessment of improvement toward a desired outcome would likely involve a suite of indicators for a particular purpose.

Factors determining which measure could be used to demonstrate progress toward a desired outcome included importance, relevance and meaningfulness.

Other factors to be considered were feasibility, accessibility, reliability, sensitivity to change, and validity.

The AMA insisted any formal outcome measures must be supported with funding to facilitate and implement the necessary processes, encourage ongoing participation and reward quality improvements.

They should also be subject to ongoing review and evaluation.

"Poorly designed or inappropriate measures can result in the dysfunctional behaviour of those being assessed and erroneous assessments," the AMA said.

The Position Statement warned against using outcome measures to identify poor or high performers, or to use them as the sole basis for pay-for-performance incentives.

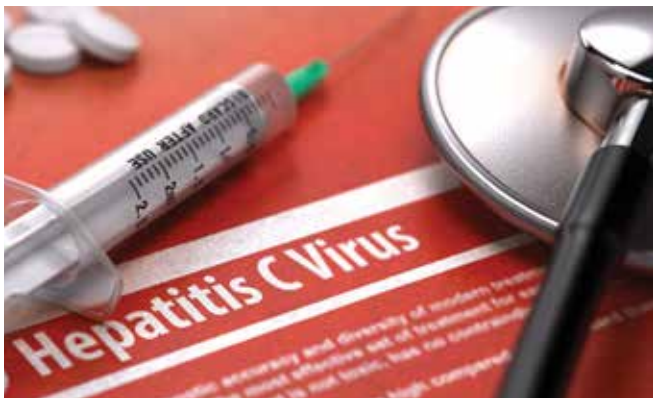
"In the quest for ongoing quality improvement, frameworks that are judgement-free and scientifically rigorous could enable GPs and general practices to monitor their own performance [and] compare themselves with their peers or against past performance," the AMA said.

"[And] take whatever action seems necessary to improve the quality of care provided and health outcomes for patients."

The AMA *Position Statement on Measuring Clinical Outcomes in General Practice – 2016* is available at: https://ama.com.au/position-statement/measuring-clinical-outcomes-general-practice-2016

CHRIS JOHNSON

Hep C cure's $1bn price tag



The Federal Government has spent almost $1 billion on drugs in the first four months of its campaign to eliminate hepatitis C, reinforcing estimates that it will ultimately cost taxpayers $3 billion to cure chronic sufferers.

Figures compiled by *Australian Prescriber* show that since the hepatitis C treatments sofosbuvir and ledipasvir were listed on the Pharmaceutical Benefits Schedule in March, the Government has paid out $942.8 million on 43,900 prescriptions for the drugs, at an average cost of almost $21,500 per script.

Sofosbuvir has been hailed as a "game-changing" medicine that can cure hepatitis C in as little as 12 weeks, but the cost for most individuals is prohibitive - $110,000 for a course of treatment.

But following its listing on the PBS, chronic hepatitis C sufferers can get for as little as $6.20 a prescription.

Former Health Minister Sussan Ley linked the subsidisation of the hepatitis C treatments to $650 million in savings from the controversial axing of bulk billing incentives for pathology and diagnostic imaging services.

"These two new hepatitis C medicines have come on to the market and rocketed into the number one position on the list of top drugs by cost to the Government," *Australian Prescriber* medical editor Dr John Dowden said. "They were only approved in March, and in the four months to June have cost the Government almost $1 billion for 43,000 prescriptions."

While hepatitis C treatments grabbed the crown as the most costly drugs for 2015-16, the most common medicines prescribed were statins and proton pump inhibitors.

Altogether, more than 14 million prescriptions where issued for the statins atorvastatin and rosuvastatin last financial year, while almost 6.9 million were written for the proton pump inhibitor esomeprazole.

The next most commonly prescribed drug was the painkiller paracetamol (5.05 million prescriptions), followed by the reflux medication pantoprazole (4.7 million), the blood pressure drug perindopril (4.05 million) and the diabetes medicine metformin (3.57 million).

While hepatitis C treatments have grabbed a big slice of the Commonwealth's medicine's budget, other expensive treatments for leukaemia, multiple sclerosis, arthritis and eye disease are also taking a hefty share.

The anti-inflammatory biologic adalimunab, a drug used to treat rheumatic and psoriatic arthritis, Crohn's disease and chronic psoriasis, has been supplanted at the top of the expenditure table by ledipasvir and sofosbuvir, but still cost the taxpayer almost $334 million last financial year.

Top 10 drugs by cost

MEDICINE	COST ($M)
Sofosbuvir and ledipasvir	570,730
Sofosbuvir	372,094
Adalimunab	335,857
Ranibizumab	241,256
Aflibercept	231,194
Esomeprazole	170,554
Etanercept	166,538
Trastuzumab	157,134
Fluticasone & Salmeterol	148,878
Insulin Glargine	146,202

Source: Australian Prescriber

ADRIAN ROLLINS

Record-long wait for elective surgery

Elective surgery waiting times have jumped to a record high as growing numbers of patients stretch public hospital resources and finances.

More than half of patients had to wait at least 37 days to be admitted for elective surgery last financial year – the longest delay recorded in figures going back to the start of the century, and a blow-out of 10 days from the wait facing elective surgery patients in 2001-02.

The jump in the median waiting time from 35 days in 2014-15 and 36 days the previous four years has occurred amid a relentless 1.7 per cent a year increase the volume of patients needing elective surgery.

The pressure on hospitals has been underlined by figures in the AMA *2016 Public Hospital Report Card* showing they are falling well short of performance targets agreed upon by the Council of Australian Governments.

In 2011, COAG set a target for 100 per cent of all urgency category patients awaiting surgery to be treated within clinically recommended times by 2016.

But the AMA Report Card showed that, after briefly reaching above 80 per cent in 2011-12, the percentage has since fallen back and was around 78 per cent in 2014-15.

The AMA warned that the actual waiting time facing patients was even longer than reported by the Australian Institute of Health and Welfare, because its figures only recorded patients as awaiting elective surgery once they seen a specialist.

"The time that patients wait, from when they are referred by their general practitioner to actually seeing a specialist for assessment, is not counted," the AMA said. "This means that the publicly available elective surgery waiting list data actually understate the real time people wait for surgery. Some people wait longer for assessment by a specialist than they do for surgery."

In its *Elective surgery waiting times 2015-16* report, the AIHW found patients in need of eye, ear, nose and throat surgery faced the longest delays, with a median waiting time of between 74 and 78 days (and including a median waiting time of 209 days for those in need of repair for a deviated septum). By contrast, the shortest median waiting time was 13 days for patients needing a coronary artery bypass graft.

All up, 2 per cent of patients had to wait for more than a year for their elective surgery, including 15.5 per cent of Tasmanians on elective surgery waiting lists.

The deterioration in elective surgery waiting times highlights AMA concerns about increasingly inadequate Commonwealth funding for public hospitals.

In 2016, the Federal Government committed an extra $2.9 billion to fund public hospitals, but cut its contribution to growth funding from 50 to 45 per cent, capped at 6.5 per cent a year.

At the time, Chair of the AMA Council of Public Hospital Doctors, Dr Rod McRae, said such a contribution was "nowhere near enough to adequately fund public hospitals".

In addition, the funding agreement only extends to mid-2020, and Dr McRae said public hospitals needed longer term funding certainty.

ADRIAN ROLLINS

Report unfit drivers, coroner says

A coroner has recommended that doctors be required to report patients who are not medically fit to drive following an inquest into the death of a motorcyclist just hours after he became a father.

Victorian Coroner Audrey Jamieson said the death of Nicholas Barry Carr, 36, from Heywood, in a motorbike accident in August 2015 showed the shortcomings of relying on motorists to self-report to licensing authorities when their ability to operate a vehicle is impaired.

Mr Carr died after the motorbike he was riding along the Princes Highway in western Victoria left the road and struck a roadside barrier, flinging him almost 80 metres down the road.

The accident happened soon after he had left Portland District Hospital, where his partner was staying following the birth of their baby girl.

At the time, Mr Carr was on medication to control seizures caused by arteriovenous malformation in his medial right temporal lobe, and had been advised by his doctor not to drive.

The coronial inquest was told that, while the drug Tegretol had helped control the frequency and severity of his seizures, Mr Carr still experienced "zone outs" once every three days that would last for between two and three minutes, and on the day of his accident he had not taken the medication.

During a consultation just three weeks before the accident, Mr Carr's doctor told him he should not drive a vehicle until he was seizure-free for six months, but under Victoria's self-reporting regime, it was up to Mr Carr to notify the licensing authority – something he failed to do. He held a full licence at the time of the accident.

Ms Jamieson said the circumstances of Mr Carr's death highlighted the shortcomings of Victorian arrangements.

While South Australia and the Northern Territory both require health practitioners to notify authorities if a patient has a medical condition that might affect their ability to drive, the coroner said that in Victoria VicRoads had argued against a similar approach, claiming it could reduce the trust between a doctor and their patient. The roads authority said there was no evidence that mandatory reporting had improved road safety, and self-reporting requirements were "appropriate".

But Ms Jamieson said Mr Carr's death showed the self-reporting model was "not entirely effective".

"The Victorian coronial cases identify significant limitations in a self-reporting framework, most obviously being that an individual would be reluctant to inform VicRoads of something that could affect their right to drive," the coroner said, adding that the situation put both the individuals themselves, as well as other road users, at risk.

"Mr Carr's death, so proximate to his daughter's birth, is a tragic reminder of the inherent dangers of operating a motor vehicle contrary to both road laws and medical advice," she said.

Ms Jamieson recommended that it be mandatory that medical practitioners report a patient who they believe is not medically fit to drive.

"Treating medical practitioners are best placed to determine whether their patient is or is not fit to drive," she said. "The community is entitled to expect that if a medical practitioner is alert to such a risk, it should be mandatory that they make a report to VicRoads.".

ADRIAN ROLLINS

Macquarie medical school plan panned

The AMA has urged the Federal Government to reject Macquarie University's "ill-conceived" plan to open a medical school for full-fee paying students.

Just days after Rural Health Minister Dr David Gillespie announced a shift in the Government's policy focus away from expanding the number of medical school places to encouraging more doctors to practice in rural and regional training areas, the AMA has sounded the alarm over Macquarie's medical school plans.

Federal AMA President Dr Michael Gannon and NSW AMA President Dr Brad Frankum have written to Dr Gillespie condemning the idea.

"We wish to express our complete opposition to Macquarie University's plan to establish a full-fee paying medical school," the AMA leaders said. "This is an ill-conceived [idea] that will simply waste precious health system resources for the benefit of a privileged few who will be able to afford entry."

Dr Gannon and Dr Frankum said medical workforce modelling showed the country was producing sufficient medical graduates and was struggling to provide enough training positions for aspiring doctors. They warned that without extra investment in training there would be a shortfall of 569 first-year advanced training places by 2018, rising to a shortage of 1011 places in 2030.

Rather than allowing more medical schools, the leaders encouraged the Government to stick to its revised policy focus and make improvements in the distribution of the medical workforce its priority.

So far details of Macquarie University's plans remain limited, but the AMA understands they include a proposal to establish an offshore medical program for domestic and international full-fee paying students – a model heavily criticised by Dr Gannon and Dr Frankum because it will narrow the pool of aspiring doctors by excluding those from lower income backgrounds, to the detriment of the profession.

"The AMA firmly believes that entry to medical school should be based on merit, as opposed to financial capacity," they said, adding that evidence showed high fees and the prospect of significant debt deterred those from less wealthy families from entering university.

Furthermore, they warned that students loaded with big would tend to choose specialties based on potential earnings, which meant few Macquarie graduates were likely choose to work in lower-remuneration specialties like general practice, or in less wealthy communities.

Dr Gannon and Dr Frankum urged Dr Gillespie to ensure the review he has commissioned of medical workforce distribution includes an assessment of Macquarie's plans.

"The University has failed to consult with the profession and we feel that it is driven largely by financial considerations, and for reasons of prestige as opposed to addressing genuine medical workforce needs," they said.

ADRIAN ROLLINS

Breast implant lymphoma risk upgraded

The risk of women with breast implants developing a rare form of lymphoma has been revised sharply upward by the medicines watchdog following a review of evidence.

The Therapeutic Goods Administration has revealed that there have been 46 confirmed cases of breast implant-associated large cell lymphoma (BIA-ALCL) in Australia since 2007, including three fatalities, and estimates that the chance of a woman with breast implants developing the disease within 14 years of surgery is between 1 in 1000 and 1 in 10,000. Previously, it had put the risk at between 1 in 50,000 and 1 in 3 million.

But, despite the upgrade in risk, the TGA said the condition remains rare, and continues to recommend against implant removal, instead urging recipients to monitor their breasts for any changes.

The regulator said no cases of BIA-ALCL had yet been detected in women with smooth implants, and advised those who notice enlargement, swelling or a lump in one of both breasts to seek medical advice "as soon as possible".

"Most cases of breast implant-associated ALCL are cured by removal of the implant and the capsule surrounding the implant, however a small number are more aggressive," it said.

A joint taskforce of plastic surgeons formed in 2015 to investigate the association between BIA-ALCL and textured and polyurethane breast implants said it was working closely with the TGA on the issue, including sharing information about the research identifying the increased lymphoma risk.

Taskforce Chair and Australasian Society of Aesthetic Plastic Surgeons President Dr Mark Magnusson said the link between breast implants and BIA-ALCL had been known for "some years".

"While the cause of BIA-ALCL remains unproven, the importance of stringent standards and infection control is critical in light of a growing body of evidence that suggests a link between the growth of bacteria on the surface of breast implants leading to the development of BIA-ALCL over time," Dr Magnusson said.

Australian Society of Plastic Surgeons President Dr James Savundra the risk of BIA-ALCL was low, and the vast majority of women who notice swelling of the breast do not have the condition.

But Dr Savundra advised that any such swelling should be investigated, and said the issuer underlined the importance of the Australian Breast Device Registry.

He advised all women undergoing breast implant surgery to ensure they are included on the registry.

ADRIAN ROLLINS

INFORMATION FOR MEMBERS

Medicare compliance debts transferred to Health Department

The Medicare compliance debt function has moved from the Department of Human Services to the Department of Health.

The change took place October 2016 and contact has begun to inform all providers that have a debt owing to the Commonwealth that has been transferred to Health.

Letters and new invoices have been and are being sent to providers with outstanding debts.

New invoice numbers and new payment methods are being provided, along with requests to pay outstanding debts immediately.

Doctors on payment plans will be contacted about new arrangements, but until that happens they should continue paying their debts in line with their agreed payment plans.

Any payment made to the Department of Human Services during the transition period will still be attributed to the payment of any Medicare compliance debt.

Questions and enquiries about the debt transition can be made by contacting the Health Provider Compliance Division at the Department of Health on (02) 6289 9390 or email hpcd.debt.recovery@health.gov.au

Govts lashed over omission of specialists from maternity review

AMA President Dr Michael Gannon has slammed the nation's governments over their "astonishing" decision not to include obstetricians or other medical specialists in working group formed to advise on maternity care policy.

Federal, State and Territory health ministers are developing a National Framework for Maternity Services (NFMS), and the Queensland Government has taken the lead in convening a Maternity Care Policy Working Group to provide expert advice.

But Dr Gannon, a Perth-based obstetrician and gynaecologist, was incredulous that no obstetrician or other relevant medical specialist had be included on the working group.

"It is inconceivable to the AMA that a working group charged with the development of such critical national guidance has neither GP nor obstetrician representation," he wrote in a letter to Queensland Health Minister Cameron Dick and the-then Federal Health Minister Sussan Ley late last year. "Improving the quality of care and outcomes for mothers and babies via the development of a new NFMS cannot occur if there are no obstetricians and other medical specialties on the [working group]."

Dr Gannon said obstetricians, anaesthetists, paediatricians, psychiatrists, GPs, pathologists, physicians, haematologists and midwives all played critical roles in delivering the best care for mothers and babies, and their input was vital.

"Without these perspectives, the NFMS cannot possibly reflect the complexity and breadth of the services required, or indicate to governments the necessary funding required to adequately support maternity services in Australia," he said.

Dr Gannon said the development of the national framework was occurring in an environment in which obstetricians were increasingly being sidelined.

"We have already seen a move towards midwife-led care in public hospital maternity services.

"Many women do not see an obstetrician in the antenatal and intra-partum period. This absence of a highly trained obstetrician can lead to, and is leading to, inferior outcomes for mothers and their babies."

The AMA President said midwives worked closely with obstetricians on a daily basis in providing care, and welcomed the fact that they were "heartily represented" in the review.

But the absence of obstetricians and other medical specialists was gobsmacking.

"To convene a working group on this issue without adequate representation from the highest trained specialists in this field is a serious oversight that requires immediate attention," he wrote to Mr Dick and Ms Ley, adding that it was a "genuinely breathtaking and abject omission and failure".

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

Economy suffers too if nation's poor mental health not properly addressed

Poor mental health costs Australia more than $60 billion a year and should be treated as a serious economic issue requiring immediate action.

That is the view of the National Mental Health Commission, which says the nation's mental health system needs improvement through an appropriate allocation of resources.

Commission chair Professor Allan Fels said evidence suggested a focus on prevention and early intervention aimed at reducing the need for more complex and costly interventions was necessary.

"Our current focus is on treating mental illness once it hits crisis point, whereas preventative interventions can improve peoples' lives and are cost effective," Professor Fels said.

"These interventions can involve improving health treatments as well as areas such as disability, housing and employment services."

Government modelling has revealed more than half a million people in Australia between the ages of 18 and 64 suffer from severe mental illness.

The modelling also shows that more than 100,000 of them who currently receive government support will not be included in the National Disability Insurance Scheme.

With population growth accounted for, the $22 billion NDIS will cater for only 64,000 places allowed by the Productivity Commission under the full rollout.

Figures (reached by the National Mental Health Service Planning Framework) suggest 290,000 mentally ill patients need community help each year, but the official modelling points to 100,000 of them missing out as programs change or are cancelled.

The National Mental Health Commission insists it is time to treat the impact of poor mental health as an economic issue.

The commission has hosted Professor Martin Kemp from the London School of Economics to help brief Federal Government policy makers on his work.

He uses economic arguments and evidence to help inform policy discussion.

"I've found the question is, can we afford not to fund early intervention mental health practices?" Professor Knapp said.

"For example, there are huge costs to society and individuals if early intervention isn't provided when children experience bullying.

"Its consequences were revealed when I examined the lives of victims 40 years later when they were 50. They were less likely to be employed, own their own home and less likely to marry. And they used more mental health services.

"Another example is if hospitals allocate funding towards treating people who self-harm by offering psychological intervention in emergency departments, it aids mental and physical recovery and has substantial societal and economic benefits."

The estimated cost of mental ill-health to Australia is about 4 per cent of GDP – or about $4000 per tax paper.

Better mental health would increase the national mental wealth, according to the commission, through greater workforce participation, productivity and economic competitiveness.

But this requires wise allocation of funding and services across the mental health and related sectors.

CHRIS JOHNSON

NBN seeks meeting with AMA about internet access in the bush

NBN Co has sought a meeting with the AMA after the peak doctors' group warned that unreliable, slow and expensive internet access was putting health services in rural, regional, and remote Australia in danger of falling even further behind city services.

The AMA's *Position Statement on Better Access to High Speed Broadband for Rural and Remote Health Care* calls on the Government to act urgently to improve internet access across the nation.

AMA Vice President, Dr Tony Bartone, said that technology had the potential to deliver better health outcomes at lower cost outside major cities and towns through telemedicine and eHealth, but the lack of reliable broadband was hindering progress.

"Regional and rural communities already face a high range of disadvantages when compared to their city counterparts," Dr Bartone said.

"They have more difficulty accessing health services close to home, are more likely to put off visiting their GP due to distance and cost, and have higher rates of potentially preventable hospitalisations.

"It is essential that these Australians have access to the same standard of health care as those living in the major cities.

"However, many regional and remote areas have very poor internet connections, with relatively small download allowances, and at a much higher cost and slower speed than the services available in our cities."

Last year, the *AMA Rural Health Issues Survey 2016* identified access to high speed broadband for medical practices as the top priority for rural GPs, with doctors raising serious concerns about slow and unreliable internet access, not only for conducting day-to-day business, but also for caring for patients via eHealth and telemedicine.

The AMA has called for action from NBN Co, including for it to effectively overbuild areas covered by its Sky Muster satellite service by pushing fibre and fixed wireless deeper into rural Australia.

For rural and remote areas left on NBN satellite, the AMA wants "measures to prioritise or optimise the broadband capacity available by satellite for hospitals and medical practices, such as exempting or allocating higher data allowance quotas, or providing a separate data allowance".

"At the moment the [satellite] allowances are quite ridiculously small and costly," Dr Bartone told iTNEws.

"When it comes to telehealth, the quality of the infrastructure determines a number of the outcomes.

"If you look at remote hospitals where radiology is being provided, they may not have an on-call radiologist to read the films. These films have to be transmitted to a central facility, and each film is several hundred MBs of data or more.

"Just from the volume of patients and number of tests performed, even the clinical information being ferried around is enormous. We need to give priority and extra dispensation to hospitals and practices in areas where access is an issue."

The AMA's criticism of the NBN was echoed by talkback callers to ABC Radio NSW.

John, from Narromine, described the service as "really disappointing". Complaints to NBN Co were dismissed as the fault of the service provider, while the service provider in turn referred complaints to NBN Co, he said.

Sarah, from Bomaderry, said she and her husband initially thought they were lucky to get the higher standard fibre-to-the-premises connection, rather than fibre-to-the-node.

Instead, it was just the same – "it's as slow as a wet dog".

The AMA's Position Statement was released a week after NBN Co released its own research, which claimed the network was "linking regional Australians to eHealth, bridging the digital divide between country and city".

The AMA *Position Statement on Better Access to High Speed Broadband for Rural and Remote Health Care* can be accessed at: https://ama.com.au/position-statement/better-access-high-speed-broadband-rural-and-remote-health-care-2016

MARIA HAWTHORNE

INFORMATION FOR MEMBERS

AMA Indigenous Peoples Medical Scholarship 2017

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

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

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

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

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

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

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

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

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

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

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

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

Applications close 31 January 2017.

The Application Form can be downloaded at:

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

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

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

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

INFORMATION FOR MEMBERS

Specialty Training Pathways Guide – AMA Career Advice Service

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

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

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

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

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

Information on the new website includes:

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

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

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

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

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

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

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

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

Women student leaders of today could be the medical leaders of tomorrow

BY ERIKA STRAZDINS AND JESSE A ENDE, MEDICINE VI, UNIVERSITY OF NEW SOUTH WALES

The Australian medical profession has made great strides towards gender equity, and from a once male dominated profession we are now seeing promising change at many levels.

Female medical graduates have equalled or exceeded their male counterparts since the turn of the century. Reflecting this, women are making up a greater proportion of the medical workforce, with a 40 per cent representation among doctors in 2015.

The next step for the Australian medical profession is to tackle the under-representation of women in leadership positions.

Women make up the minority of leaders across a broad range of areas in medicine. In education, only 29 per cent of deans are female; in academia 32 per cent of lead authors are women and women comprise a small proportion of speakers across specialty annual scientific meetings; of AMA state and territory presidents only 22 per cent are female; and a third of specialist positions were filled by women in 2011.

Leadership is a quality which is entwined throughout our medical practice, with doctors expected to lead medical teams, educate and research, and in so doing contribute to the profession.

Leadership, like medical practice, begins in medical schools. We created a snapshot of medical student society leadership in 2016. Twenty Australian medical student societies were analysed to determine gender representation in their executive committees in the president, vice president, secretary, and treasurer positions.

It was encouraging that almost 50 per cent of these roles are filled by female medical students, with some representation across all of the individual roles (president 37 per cent female, vice president 50 per cent, secretary 80 per cent, treasurer 37 per cent), as illustrated in Figure 1. However, while almost half of all leadership positions were filled by women, it is interesting to note that these positions were still skewed towards 'traditional' female roles of being an 'assistant' to their male counterparts, such as secretary (80 per cent) or vice president (50 per cent). Male medical students still seem to occupy the ultimate leadership role as the president or control the all-important finances as the treasurer.

It is clear that a discrepancy exists between current leadership by students in medical school executive positions and by doctors in the medical profession. There are a number of current leaders in medicine in Australia who believe this is due to factors such as women not having been in the profession long enough to reach leadership positions, not seeking such positions because of family or other commitments, or that they do not possess inherent leadership characteristics.

Dr Danika Thiemt, immediate-past Chair of the AMA Council of Doctors in Training, argues against this latter point, believing that all doctors possess the skills to become a leader.

We too believe that women possess inherent leadership characteristics, with our findings showing that female medical students are interested in, and actively involved in, leadership at their universities. The high proportion of female medical student leaders is strongly suggestive that women do in fact possess the inherent qualities and ambition necessary of a leader.

Additionally, these ambitious female medical students have been encouraged by the more recent cultural shift in attitudes towards women in leadership. In particular, many Australian medical schools have formalised their support for women's equity through designated representative roles and societies, as well as specific programs and events.

Admittedly, times have changed since the beginning of medical practice; now there are more women in medicine, with females comprising 55 per cent of medical graduates, and they have also been empowered to take on leadership roles. This makes it difficult to compare these data to the present day medical leadership, which is a product of the past 20 years of cultural and professional influences. Despite this, these trends at the university level are an encouraging sign for gender equity

Women student leaders of today could be the medical leaders of tomorrow

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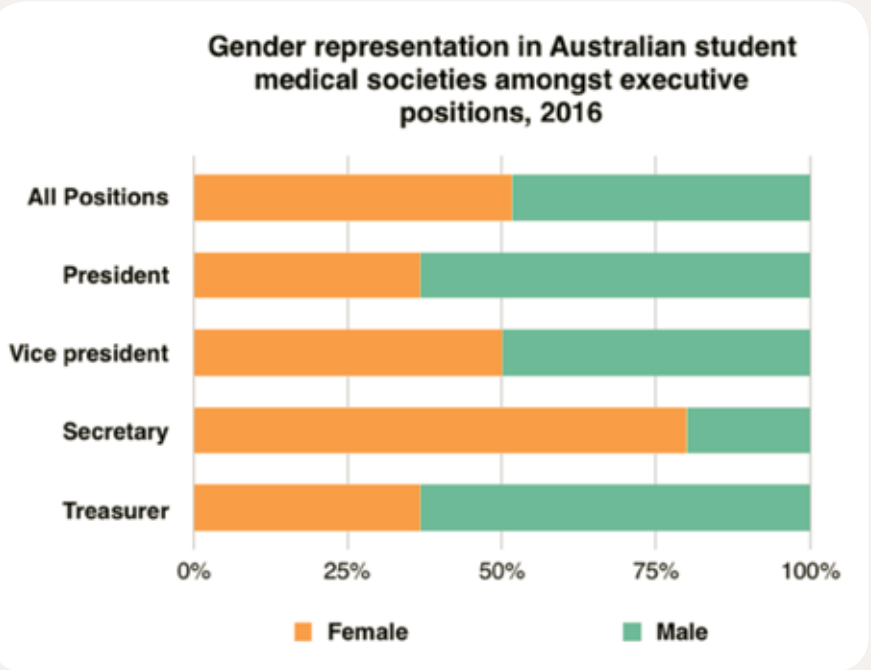

in future leadership in the medical profession in Australia.

We must acknowledge the important challenge of nurturing the passions and ambitions of these medical students as they move into the professional workforce. It will be interesting to compare current statistics regarding the gender balance in leadership positions to those in 20 years time, with the hope that today's leaders in university do in fact become tomorrow's leaders in the profession.

Health on the hill

POLITICAL NEWS FROM THE NATION'S CAPITAL

Ministers in the hunt for health

Speculation is mounting that Greg Hunt will be Australia's next Health Minister following the resignation of Sussan Ley over thousands of dollars in travel expense claims.

Mr Hunt, who was Environment Minister for three years before being appointed to the industry and science portfolio following last year's federal election, has been mooted to make the move as Prime Minister Macolm Turnbull tries to minimise the extent of reorganisation caused by Ms Ley's departure.

Others considered in the running include Communications Minister Mitch Fifield, Energy Minister Josh Frydenberg and Human Services Minister Alan Tudge.

Senator Arthur Sinodinos, who is acting Health Minster, is regarded as less likely to hang on to the portfolio he is in the upper house and was forced to step down from the frontbench in 2015 after being called before an anti-corruption probe in New South Wales. The last time a Senator was Health Minister was Kay Patterson in the early 2000s.

Mr Turnbull is expected to make an announcement this week.

Ms Ley initially stood down from her Cabinet position on 9 January over revelations that she had claimed travel expenses for a number of trips to the Gold Coast, including one in which she bought a $795,000 apartment.

The previous day the Albury-based MP admitted to an "error of judgement" in making the claim, which she admitted failed to meet ministerial standards, and stood aside without ministerial pay after Prime Minster Malcolm Turnbull directed that the Secretary of the Department of Prime Minister and Cabinet, Dr Martin Parkinson, investigate.

At the time, Ms Ley expressed confidence that Dr Parkinson's investigation would show that "no rules were broken whatsoever", leaving the way clear for her to return to the portfolio.

But subsequent revelations that she had billed taxpayers more than $40,000 for at least 17 visits to the Gold Coast over three years, and had also racked up thousands of dollars in travel expenses for charter flights she piloted between Canberra, Adelaide and Melbourne, made it increasingly unlikely she would be able to return to her Cabinet position, and Mr Turnbull confirmed that in a media conference at Parliament House on 13 January.

In a written statement announcing her resignation, Ms Ley continued to insist she had done nothing wrong.

"I have made a personal decision to resign as Minister for Health, Aged Care and Sport," she said. "I am confident that I have followed the rules, not just regarding entitlements but, most importantly, the ministerial code of conduct."

But the Coalition MP acknowledged her actions had provoked community anger.

"Whilst I have attempted at all times to be meticulous with rules and standards, I accept community annoyance, even anger, with politicians' entitlements demands a response. The team is always more important than the individual."

At a media conference at her Albury electorate office on Monday at which she announced she was standing down, Ms Ley gave a detailed account of her apartment-buying trip to the Gold Coast.

She said she flew to Brisbane on 9 May 2015 on parliamentary business and decided to stay at the Gold Coast that night.

Ms Ley said that while there her husband drew her attention to an auction being held at the De Ville Apartments, and she made a spur of the moment decision to attend.

"I want to be very clear – my decision late Friday to attend this auction was made after I had planned to travel to the Gold Coast from Brisbane," Ms Ley said. "I inspected this property for the first time maybe 10 minutes before the auction commenced and I registered to bid.

"I own a home here in Albury and I had gained pre-approval to purchase an investment property. I had an idea of what I wanted and this apartment fit the bill. So the purchase of this particular property was neither planned nor anticipated."

The furore, coming less than two years after former Speaker Bronwyn Bishop was forced to resign after chartering a $5000 helicopter flight from Melbourne to Geelong, has intensified the spotlight on politician allowances.

Several other politicians from both sides of politics have become embroiled in the scandal. Three ministers – Attorney-General George Brandis, Immigration Minister Peter Dutton and Communications Minister Mitch Fifield claimed expenses to attend a New Year's Eve party hosted by Mr Turnbull, and Opposition frontbenchers Chris Bowen and Brendan O'Connor both spent more than $10,000 each to take their families to

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Darwin in mid-2015. This follows accusations in 2015 that Manager of Opposition Business Tony Burke abused travel entitlements after records showed he charged taxpayers $12,000 for a trip to Uluru with his family in 2012.

The Government has accepted in principle 36 recommendations made by an independent review of MP entitlements commissioned after the Bishop affair, including a clearer definition of what is meant by "parliamentary business".

Mr Turnbull has announced that an independent authority will be appointed to oversee politician expenses and entitlements, and Acting Special Minister of State Kelly O'Dwyer has promised the changes will be implemented in the "first half" of 2017.

ADRIAN ROLLINS

Govt announces indemnity cuts

The Federal Government is cutting back its contribution to the cost of medical indemnity claims, prompting warnings doctors will face a hike in insurance premiums.

In its Budget update, the Government has flagged that the threshold at which its contribution to high cost claims kicks in will be raised from $300,000 to $500,000 from 1 July, 2018, in a move expected to save it $36.1 million over two years.

The High Cost Claims Scheme, under which the Government contributes 50 per cent of a claim in excess of the threshold amount, was among a number of measures introduced in 2002 and 2003 to resolve the medical indemnity crisis, in which soaring premiums threatened to drive doctors from practising in high-risk specialties such as obstetrics.

Insurer Avant Mutual Group has warned that doctors will face a hike in premiums as a result of the move.

Flagging that it is unwilling to absorb the Government's cutback and will instead pass it on to doctors and patients, Avant has estimated doctor insurance premiums will be increased by an average 5 per cent, raising the prospect of increased out-of-pocket costs for patients.

"Doctors face a range of cost pressures across the board, and this move by the Government will only add to the pressure," Avant Senior Medical Officer Dr Penny Browne said. "We believe that it will also mean higher out-of-pocket costs for patients."

In the early 2000s skyrocketing medical indemnity insurance premiums, rising by as much as 25 per cent a year, created a crisis as many doctors threatened to move out of high-risk areas or quit practising altogether.

The-then Health Minister Tony Abbott intervened to tighten regulation of the industry and introduce a system of subsidies, including for premiums paid by doctors and to help offset the cost of large payouts.

The Australian National Audit Office has reported that since then the financial position of insurers has improved and they are now making significant profits, prompting the Health Department to plan reviews of the Commonwealth's involvement in and support for the sector and the system of legislation and regulations.

ADRIAN ROLLINS

No more medical schools as Govt flags welcome policy shift

The Federal Government has signalled a shift in policy focus from expanding medical school places to addressing shortcomings in the distribution of training opportunities as part of efforts to boost the number of doctors working in rural and regional areas.

Following sustained AMA advocacy on the issue, the Government has accepted that the country does not need more medical schools, and has instead identified the need to improve the spread of training places to enable more medical students and graduates to undertake their studies in rural and regional locations.

Assistant Minister for Rural Health Dr David Gillespie said a massive expansion in medical schools in the past decade meant the country was now producing more than enough medical graduates, and the challenge now was to increase the number choosing to train and practice outside the major cities.

"We've expanded medical undergraduate places by over 100 per cent since 2001, because we had an absolute shortage, but now predictions are that we'll have 7,000 excess medical practitioners by 2030," Dr Gillespie told ABC Radio. "So we want

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to look at the distribution of undergraduate training, see what works best, with the aim of addressing the shortage of medical practitioners in rural and regional Australia."

The Health Department and the Department of Education and Training have been directed to undertake a joint assessment of the number and distribution of medical schools and medical student places.

"This assessment will be considered within the context of existing workforce modelling and data, two decades of workforce distribution policies, the expansion of higher education places, and the Government's priorities to address the maldistribution of medical professionals across regional, rural and remote Australia," Dr Gillespie said.

The move follows sustained pressure from the AMA, which has for several years argued that the nation does not need more medical school places, and should instead focus on boosting medical training opportunities in rural and regional Australia.

Delegates at the 2015 AMA National Conference unanimously passed a motion calling on the-then Abbott Government to reconsider its funding for the Curtin Medical School, and in mid-2015 the AMA presented the Government with a plan to increase prevocational training opportunities for junior doctors in rural and remote areas.

In its plan for improved rural health care launched in May 2016, the AMA detailed proposals to boost the country medical workforce by, among other measures, a Community Residency Program to provide prevocational GP placements and expanding the Specialist Training Program to 1400 places by 2018, with priority for rural and regional training places, as well as a greater rural focus for existing medical schools.

The AMA also jointly proposed with the Rural Doctors' Association of Australia a comprehensive rural workforce incentive package, Building a sustainable future for rural practice: the rural rescue package.

Against this backdrop, AMA President Dr Michael Gannon welcomed the policy shift outlined by Dr Gillespie.

"The last thing we need are more medical schools," the AMA President told ABC Radio. "What we need to see is an expansion of the investment in existing rural clinical schools and a serious look at the process of maybe reallocating numbers to those universities with rural clinical schools, or to schools that are in rural areas themselves."

Dr Gillespie admitted that the current training structure, which provided limited opportunities for rural-based students and graduates, militated against increasing the number of doctors working in non-metropolitan areas, undermining access to care for rural and regional Australians.

"At key points in their training and development, the structure of the training system and a lack of advanced regional, rural and remote positions tend to force new doctors back to the cities, where they often settle," he said. "The baggage one collects in one's life, partner, mortgages, houses, friends, schools, children, if you've been there six or seven years, that's where you more than likely stay.

"We must ensure access to high quality postgraduate training for the existing numbers of medical students and recent graduates in rural, regional and remote Australia."

ADRIAN ROLLINS

Fill-in minister faces big calls

Stand-in Health Minister Senator Arthur Sinodinos faces major challenges on health funding, private health insurance premium increases and the overhaul of the Medicare payments system as he takes over the reins from Sussan Ley.

Senator Sinodinos has been made acting Health Minister at a critical time for the big-spending portfolio as preparations for the 2017-18 Budget intensify.

In previous years health has been the target of major spending cuts, and is likely to come under pressure to deliver more savings after the Mid-Year Economic and Fiscal Outlook revealed a further deterioration in the Commonwealth's financial position.

Ms Ley was forced to stand down on 9 January, her first day back from her Christmas break, following revelations that she claimed travel expenses for a trip to the Gold Coast in which she bought a $795,000 apartment, and resigned four days later.

The acting Health Minister will come under pressure from the AMA and other health groups to scrap the freeze on Medicare rebates amid mounting evidence that the financial squeeze on medical practices is forcing doctors to cut back or abandon bulk billing of patients.

A big to-do item on Senator Sinodinos's list will be to review and approve private health fund premium increases. Last year Ms

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Ley withheld approval and asked funds to resubmit their plans amid widespread consumer discontent over big premium hikes and the quality of cover provided. Eventually she signed off on an average 5.59 per cent rise, but ordered a ban on "junk" policies and a review of the industry.

Senator Sinodinos faces challenges implementing the Government's election deal to clamp down on pathology collection centre rents in exchange for providers dropping their campaign against the scrapping of bulk bill incentives.

The senator will also have to keep an eye on several major reforms and processes underway, including the massive MBS Review being led by Professor Bruce Robinson, implementation of the Health Care Home model of care, negotiations over public hospital funding and possible cutbacks to funding for after hours home doctor visits.

At the height of the uncertainty surrounding Ms Ley's position, AMA Vice President Dr Tony Bartone called for the Government to act quickly to resolve the expenses scandal to relieve the uncertainty hanging over the health portfolio.

"We're anxious because of what this presents to the portfolio in terms of lack of direction and activity," Dr Bartone told the *Australian Financial Review.*

ADRIAN ROLLINS

Small business umpire investigates pathology rents as Govt defers plans (again)

The small business ombudsman is investigating AMA concerns that the Federal Government's plans to cap pathology collection centre rents could harm medical practices.

The revelation comes as the Mid-Year Economic and Fiscal Outlook shows the Federal Government will defer implementation of its plans to July 2017, at a cost of $208 million next financial year.

Australian Small Business and Family Enterprise Ombudsman Kate Carnell has revealed she has commenced "preliminary inquiries" into the proposed changes following a request from the AMA.

In a letter to AMA President Dr Michael Gannon, Ms Carnell advised that she would examine the issue as part of her brief to safeguard the interests of small businesses.

"This is a complex and multifaceted issue," the Ombudsman wrote, and asked the AMA to advise on how many practices might be affected by the Government's proposals, and the scale of the financial impact.

The AMA contacted the Ombudsman as part of efforts to have the Government reconsider its approach to regulating collection centre rents.

During the last Federal election the Government promised to re-examine rules regarding the definition of 'market value' applying to collection centre rents as part of a peace deal with the major pathology companies, who had been planning to campaign against Coalition over the scrapping of bulk billing incentive payments.

The Government has been accused of planning to cap collection centre rents, prompting concerns that practices which have already entered lease agreements and have made financial plans based on expected rent revenue, could be left at a significant disadvantage.

At a meeting in late 2016, the AMA Federal Council reiterated its support for prohibited practice laws and steps to identify and address sham leasing arrangements.

But the Council resolved to support the right of practices to negotiate collection centre leases freely, provided rents were not linked to referrals, and stipulated that any new definition of market value must not adversely affect practices acting ethically in entering into leasing arrangements.

The Government had planned to introduce its new rules from 1 January 2017, but deferred this following representations from the AMA and has now indicated they will not proceed until July 2017, reducing anticipated savings by $208 million.

Dr Gannon said the AMA was ready to work closely with the Health Department to come up with a "more balanced" policy that more genuinely targeted inappropriate rental arrangements and did not interfere with legitimate commercial deals.

Ms Carnell has flagged that she would like to meet with the AMA to further discuss its concerns.

ADRIAN ROLLINS

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Increased competition won't solve hospital funding shortfall

Public hospitals, palliative care services, public dental services and social housing are in need of reforms aimed at delivering greater choice, according to a Productivity Commission report.

Those reforms could include privatisation and outsourcing, the report suggests, setting the scene for potential heated political debate in a context of heightened community sensitivity.

When it comes to public hospitals, the AMA says the case has not been made as to how increased competition will solve the problems identified in the report of performance, access and patient outcomes.

Any attempts at public hospital reforms, the AMA says, must start with a focus on providing sufficient funding.

The Productivity Commission's report *Introducing Competition and Informed User Choice into Human Services: Identifying Sectors for Reform* highlights the areas of the public sector it considers are best suited for more competition.

But it cautions against foolhardy ventures into the open market such as the rorts and pitfalls encountered following liberalisation of vocational education and training arrangements.

In 2012, the Federal Government expanded the VET FEE-HELP scheme to allow students to access loans while undertaking courses from more private sector providers.

The number of approved providers doubled in the ensuing two years, but there were no safeguards in place requiring training providers to demonstrate they were delivering high-quality education.

Aggressive marketing subsequently resulted in thousands of students left with large debts for courses they either had slim hope of completing or which were of little help in securing employment.

The Productivity Commission warned against the human services sector going down a similar path.

"With governments' involvement in the provision of human services comes the expectation from the community that those services meet a minimum standard," the study report says.

"If governments do not adequately discharge their stewardship function, the effects can be damaging to service users, providers and governments.

"Australia's recent experience with the VET FEE-HELP scheme demonstrates what can happen when governments fail to discharge their role well."

The Commission pointed out that some recipients of human services can be vulnerable, with decisions often taken at a time of stress, but that competition between multiple service providers for the custom of users can drive innovation and efficiencies.

Competition between multiple service providers is not always possible or desirable, the report warned, cautioning that increasing competition and contestability was not an end in itself.

"One size does not fit all, and redesigning the provision of human services needs to account for a range of factors," the study report says.

"Further, reforms may raise or lower government expenditure on the provision of human services, and different design options will have different fiscal implications for governments."

The issue of government funding is where much of the political debate will centre.

The Federal Opposition has already called on the Government to rule out further attempts to privatise the nation's universal public health system.

Shadow Health Minister Catherine King said Prime Minister Malcolm Turnbull's plan for the health system was to shift costs onto increased payments and to slash government funding.

"We all know where this ends up," she said.

"Privatising essential services that middle and working class families rely on."

On the matter of public hospitals specifically, the AMA said it welcomed bona fide efforts to improve services, provided they were genuinely focused on supporting better care for patients and were not simply used as a cover for reduced funding.

"The Productivity Commission's study report does not make a totally convincing case for why and how increased competition

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will solve the problems it identifies in terms of equitable access, benchmarking for best practice, and better outcomes through user choice," the AMA said.

"Australians already have a good practical understanding of the distinction between public and private health and hospital care. Putting private elements into public hospital care will be a challenge to that understanding."

The AMA's Public Hospital Report Card has documented that public hospitals are not meeting targets for treatment and waiting times in emergency care and elective surgery.

What is needed, it says, is sufficient funding for the capacity required to meet public demand for hospital services.

"While there is always scope to intelligently consider other reforms that may assist in hospital performance, including increased competition, this should not divert attention from the main game, which is sufficient funding," the AMA said.

"It also should not be a theoretical exercise driven by economic concepts with no understanding of the reality of service provision in public hospitals.

"The Productivity Commission's study report itself acknowledges that competitive tendering is not a magic bullet, and must be accompanied by 'strong government stewardship' – not a concept in wide abundance."

The Productivity Commission's inquiry is being undertaken in two parts. The first is to identify services that are best suited to reforms to introduce greater competition, contestability or informed user choice.

For the services identified as best suited, the second part of the inquiry is to make reform recommendations that help to ensure all Australians have timely and affordable access to high quality services that are appropriate to their needs, and that those services are delivered in a cost effective manner.

The final inquiry report will be submitted to the Australian Government in October 2017, after which a government response is expected.

A total of six areas have been identified in this study where the commission considers outcomes could be improved both for people who use human services, and the community as a whole.

They are social housing, public hospitals, end-of-life care services, public dental services, services in remote Indigenous communities, and government-commissioned family and community services.

The Productivity Commission report is available at: http://www.pc.gov.au/inquiries/current/human-services/identifying-reform/preliminary-findings

CHRIS JOHNSON

Health Department reveals extent of bulk billing

Federal Government claims that bulk billing rates are at a record high have been undermined by the Health Department's admission that less than two-thirds of patients have all their GP visits bulk billed.

In an answer to a question on notice on 2 December, the Department confirmed that just 64.7 per cent of patients had all of their GP visits bulk billed in 2015-16 and almost 20 per cent were left out-of-pocket up to half the time they saw their family doctor.

The results, as first reported by *Medical Observer*, belie claims by former Health Minister Sussan Ley that bulk billing remains at record high levels.

In November, Ms Ley seized on official figures showing that 85.4 per cent of GP services were bulk billed in the September quarter, up almost 1 percentage point from a year earlier, as evidence of the Government's investment in Medicare.

But the figure is a measure of the number of services bulk billed, as opposed to the number of doctor visits, which many consider to be a more meaningful indicator of patient costs and access to care.

Ms Ley said that even on this measure, results in 2015-16 were stronger than they were a decade ago.

Whereas almost two-thirds of patient sin 2015-16 had all their GP visits bulk billed, in 2004-05 the proportion was just 50.8 per cent the Minister said, and it was 57.6 per cent in 2008-09.

Nonetheless, the Health Department said that to quote a bulk billing rate of 64.7 per cent would be "misleading. The headline bulk billing rate of 85.1 per cent for GP visits is the official bulk billing figure".

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Ms Ley said the proportion of patients not bulk billed at all had more than halved from 22.7 per cent in 2004-05 to 10.8 per cent in 2015-16.

But the AMA has warned that the Government's Medicare rebate freeze is putting medical practices under intense financial pressure, forcing them to cut back on bulk billing or abandon it all together, increasing costs for their patients and driving concerns that people who are ill will increasingly put off seeing their doctor, putting their health at risk and increasing the cost of treatment when they eventually seek care.

These concerns have been leant weight by a separate answer to a question on notice in which the Department confirmed the average patient contribution jumped 5.4 per cent in inflated-adjusted terms in 2015-16, the biggest increase in three years.

In the past decade, Government figures show, patient out-of-pocket costs have grown by an average 5.6 per cent a year in real terms, and AMA President Dr Michael Gannon said they were now above the average among advanced economies.

In the September quarter alone, out-of-pocket costs surged 4.5 per cent to reach an average of $34.61.

Dr Gannon said this showed that the Medicare rebate was falling increasingly behind the real cost of providing health care, and underlined the inadequacy of the Government's investment in primary health care.

The Government has frozen Medicare rebates until 2020, but is coming under mounting pressure from doctors and patients to scrap the measure and substantially boost its contribution to the cost of care.

ADRIAN ROLLINS

INFORMATION FOR MEMBERS

Pharmaceutical Benefits Advisory Committee – endocrinologist vacancies

AMA members with expertise in endocrinology are invited to submit an expression of interest for a medical specialist position on the Pharmaceutical Benefits Advisory Committee (PBAC).

PBAC has asked the AMA to nominate suitable members to be considered for vacancies that will arise in July 2017.

PBAC positions are challenging, stimulating and provide an opportunity to contribute directly to pharmaceutical benefits policy in Australia.

PBAC is an independent expert committee that advises the Minister for Health on medicines in relation to the Pharmaceutical Benefits Scheme. PBAC is required to consider the clinical effectiveness, safety and cost effectiveness of a medication compared with existing therapies.

AMA members who nominate must be able to interpret the comparative outcomes of therapy involving a medicine and critically appraise clinical evidence.

The AMA's executive will assess nominations prior to forwarding them to the Minister for potential appointment.

PBAC meets three time a year for three-day meetings and may hold up to three additional one-day meetings. PBAC members currently receive an annual salary of $41,780 and travel costs are reimbursed. Appointments are generally for four years.

Further information about PBAC can be found on the PBS website.

To nominate, please forward your contact details and a curriculum vitae no longer than 2 pages to gmorris@ama.com.au by **13 February 2017**. If you have any questions, please contact Georgia Morris on 02 6270 5466 or gmorris@ama.com.au.

PNG's radical plan to cut sky-high maternal and baby death rates

It will be compulsory for mothers to give birth in a hospital or clinical under radical plans announced by the Papua New Guinean Government to combat the Pacific nation's extremely high maternal and infant death rates.

PNG Prime Minister Peter O'Neill has outlined plans to pay pregnant mothers living in rural areas to travel to health facilities to have their babies.

"Our Government will fund mothers to come from villages and stay in urban areas so they can have the babies and then return," Mr O'Neill told the ABC. "There will be no excuses for mothers trying to give birth in remote areas. This way our infant mortality rate will immediately drop, our maternal mortality rate will immediately drop."

PNG's maternal mortality rate is the highest in the Asia Pacific region, at 215 deaths for every 100,000 live births, and 45 out of every 1000 babies die. By comparison, Australia's maternal mortality rate is 6 per 100,000, and among Indigenous Australians it is 14 per 100,000.

Much of the high death rate is attributed to the fact that around half of all babies are delivered at home in rural villages.

Mr O'Neill said doctors coming from Cuba under a new aid deal would be sent to rural areas to help provide the extra medical services needed to make the plan a reality.

But health and aid workers, while applauding the aim, are concerned about how the plan would work, and are sceptical regarding the PNG Government's ability to deliver on its ambitions.

Head of Obstetrics at the University of Papua New Guinea, Professor Glen Mola, told the ABC the principle problems confronting health workers and services was a lack of funds.

"If we've got the money, let's see it please... we desperately need it," Professor Mola said. "We don't even have gloves in the Port Moresby General Hospital National Referral Hospital, to put on to deliver women sometimes these days."

The PNG health system has been struggling under pressure from deep budget cuts. The health budget was slashed by 30 per cent in 2014 and 2015, and was reduced by a further 21 per cent in the 2017 Budget.

As a result, the number of fully functioning health facilities in the country has dwindled, according to Camilla Burkot of the Development Policy Centre, and the country now has just 0.5 nurses or midwives for every 1000 people, far below the WHO recommended level of 4.45 per 1000.

"Even in the face of a strong, evidence-based plan for improving the rates of supervised births in PNG, it's difficult to see how the Government will be in a position to implement it," Ms Burkot said, cautioning that while encouraging women to give birth in health facilities was key, it was not a 'magic bullet' solution to high mortality rates, particularly if the facilities were overcrowded and under-resourced.

Ms Burkot said, aside from the practical concerns, one of the most troubling aspects of Mr O'Neill's plan was its "vaguely punitive tone".

The policy would make it mandatory for pregnant women to give birth in a clinic or hospital, implying they would face some form of sanction if they did not – a prospect that troubles Ms Burkot.

The PNG Government is yet to provide details of its plan, and Ms Burkot said it was vital that women and health workers be consulted in its development and implementation.

"Implementation of the plan needs to be fully and realistically costed before it is presented to Parliament," she said. "PNG women themselves must be given an opportunity to express their views and experiences around childbirth, in order to craft a policy solution that responds to the real reasons why many either do not seek out, or do not have access to, skilled attendance at birth."

Mr O'Neill has promised to provide more detail in coming weeks, and the PNG Government is expected to introduce draft legislation in January.

ADRIAN ROLLINS

US health authorities urge e-cigarette crackdown

US health authorities have called for e-cigarettes to be subject to the same laws and regulations as other tobacco products amid "alarming" uptake of the technology among young Americans.

In a joint report issued in late 2016, the US Department of Health and Human Services, the US Surgeon General and the Centers for Disease Control and Prevention (CDC) said that although understanding of the health effects of e-cigarettes was still evolving, enough was known to warrant tight controls on the marketing and use of the devices.

There has been an explosion in their use among young people - US Surgeon General Dr Vivek Murthy reports e-cigarette use among US high school students soared by 900 per cent between 2011 and 2015 (though the proportion of users fell back in 2016) – and health experts warn the vapour they emit is potentially harmful and their use risks creating a new generation of nicotine addicts.

US Health Secretary Sylvia Burwell said the burgeoning use of e-cigarettes threatened to undo recent progress in cutting down on smoking.

"Important strides have been made over the past several decades in reducing conventional cigarette smoking among youth and young adults," Ms Burwell said. "As cigarette smoking among those under 18 has fallen, the use of other nicotine products, including e-cigarettes, has taken a drastic leap. All of this is creating a new generation of Americans who are at risk of nicotine addiction."

CDC Director Thomas Frieden said e-cigarettes had rapidly become the most common tobacco product used by young Americans and not only was their use "not safe", but could act as a gateway to smoking.

"E-cigarettes are tobacco products that deliver nicotine," Dr Frieden said. "Nicotine is a highly addictive substance, and many of today's youth who are using e-cigarettes could become tomorrow's cigarette smokers."

The CDC Director said e-cigarette companies were using the same marketing and advertising tactics as Big Tobacco had to promote their products to young people, and urged that they be subject to the same control and prevention measures, including sales restrictions, increased taxation, widespread 'smoke-free' laws and mass education campaigns.

Australian and international health authorities have adopted a similarly cautious approach to the use of e-cigarettes.

The National Health and Medical Research Council has recommended that health authorities act to "minimise harm" pending evidence about the safety and efficacy of e-cigarettes, and they have not been approved as an aid to quitting smoking by the Therapeutic Goods Administration.

The AMA, in a Position Statement issued in 2015, backed the precautionary approach, calling for a ban on e-cigarette sales to minors and marketing restrictions similar to those that apply to tobacco products.

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

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

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

But in the UK, the Royal College of Physicians has taken a different approach.

In April 2016 it recommended that smokers be encouraged to use e-cigarettes as an aid to quit their deadly habit, finding that there was no evidence they were a gateway to tobacco smoking.

"E-cigarette use is likely to lead to quit attempts that would not otherwise have happened, and in a proportion of these to successful cessation. In this way, e-cigarettes can act as a gateway from smoking," the College said.

However, American health authorities, echoing Australian concerns, warn that there is insufficient evidence as to the benefits and effects of e-cigarettes, and the "precautionary principle" of avoiding possible health risks should guide policymakers.

"Although we continue to learn more about e-cigarettes with each passing day, we currently know enough to take action to protect our nation's young people from being harmed by these products," US Surgeon General Dr Murthy said. "Previous reports of the Surgeon General have established that nearly all habitual tobacco use begins during youth and young adulthood."

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

(See also, *E-cigarettes not a smoking gateway*, To the Editor, p34)

ADRIAN ROLLINS

TO THE EDITOR

Cancer screening

Dear Editor,

Why reinvent the wheel ('National cancer screening register: update', *Australian Medicine*, 8 December 2016)?

Leave cancer screening in GP hands where it belongs. We have a very high uptake of FOBT, paps, mammography and prostate cancer screening and manage it well.

Dr Larry Light
GP, Melbourne

E-cigarettes not a smoking gateway

E-cigarettes not a smoking gateway

Dear Editor,

The article 'E-cigs a gateway to smoking for young: study' (*Australian Medicine*, 10 November 2016) misinterprets the finding of a recent study and incorrectly claims that e-cigarettes are leading young people to smoking. In fact, the evidence suggests that the opposite is likely to be true.

The study, published in *JAMA* (Leventhal AM et al), found that young people who use e-cigarettes are also more likely to smoke. This association tells us nothing about whether the vaping caused the smoking. A more likely explanation is that young people who are more attracted to experimentation are more likely to try both products, due to a shared underlying vulnerability.

In fact, it is likely that vaping is diverting young people away from smoking tobacco. In the US, between 2013 and 2015, as e-cigarette use in young people has been rising, the rate of smoking has declined faster than at any time in the last 40 years (Monitoring the Future study). It is obviously better for young people not to use e-cigarettes, but vaping is preferable to smoking tobacco, and is at least 95 per cent safer. Many studies have found that regular use of e-cigarettes is almost entirely concentrated in young people who already smoke.

The UK Royal College of Physicians recently completed a comprehensive review of e-cigarettes. It concluded that there was no evidence that e-cigarettes are acting as a gateway to smoking in young people. In fact, the RCP recommends that "in the interests of public health it is important to promote the use of e-cigarette ... as widely as possible as a substitute for smoking".

On the other hand, the draconian policy of the Australian Medical Association on e-cigarettes is potentially harmful to public health and should be urgently reviewed.

Conjoint Associate Professor Colin Mendelsohn
School of Public Health and Community Medicine
The University of New South Wales, Sydney Australia

Euthanasia – AMA position ambiguous

Dear Editor

I am concerned that the AMA position on voluntary euthanasia and physician assisted suicide, as outlined in *Australian Medicine* on 21 November 2016, and as reported in *The Australian*, 24 November, seems ambiguous.

In my view a strong statement is needed that euthanasia contravenes the AMA Code of Ethics and will not be supported.

It is my long-held view that Australian doctors should take no part in actively assisting patient suicides. It contravenes long-held codes of ethics, and threatens to disturb the trust patients have in their doctors.

Doctors and nurses have long practiced a form of passive euthanasia, where futile active treatments are withdrawn and terminal patients are given liberal doses of narcotic to sedate and relieve pain. The intent is the key. When the intent is to kill the patient we enter very dangerous ground, a point of no return.

If physician assisted suicide is sanctioned by the AMA then I will immediately resign my membership, held for 40 years.

Dr R S Williams FRACS FRCS
semi-retired surgeon

Euthanasia – the AMA got it right

Speaking on national television [ABC, *Q&A*] in November 2015, Andrew Denton strongly advocated a Belgian-style euthanasia system, with assisted suicide for the elderly, mentally ill and "anyone who is suffering", ie patients with chronic diseases or chronic pain. Nine months later, there is a complete policy reversal, and euthanasia will be limited to the "terminally ill".

TO THE EDITOR

... from page 34

Incredibly, the media have ignored Mr Denton's Q&A declaration and, furthermore, Mr Denton has not retracted his original views. The public and politicians have every reason to be sceptical. Dr Nitschke's Exit International is the largest pro-euthanasia movement, and their stated goal is to have free access to Nembutal for anyone wanting to end their lives . "Rational suicide" has replaced euthanasia.

I thus congratulate the AMA Ethics and Medico-legal Committee on re-affirming its opposition to euthanasia and assisted suicide. Every national medical association in the world (except The Netherlands) is opposed to Euthanasia, while in 2015 the World Medical Association re-affirmed its condemnation of euthanasia.

In the UK, a parliamentary Select Committee on Assisted Dying for the Terminally Ill was a virtual Royal Commission into euthanasia, and included several eminent Law Lords. The committee issued a stern warning to legislators regarding the wording of any euthanasia Bill, pointing out that in The Netherlands, 90 per cent of people euthanased were not terminally ill. The Select Committee recommended that people be "terminally ill", with only months to live. Wording such as "terminal illness or condition" and "unbearable suffering" are readily abused. The euthanasia Bill recently debated in the South Australian Parliament contained similar wording, and was described as "dangerous" by AMA President Dr Michael Gannon.

In debating euthanasia, politicians should take advice from experts in the field, rather than public opinion polls. Sadly, the recent Victorian parliamentary inquiry rejected submissions from the Palliative Care Physicians and Geriatricians opposing euthanasia.

Dr John Hayes FRACP
Consultant Physician

After the fax

Dear Editor,

I believe there is a small storm on the way for fax communications at medical centres around the country.

Now that the NBN has moved to a mixed technology to complete the country's internet, and the decommissioning of all but the last intervals of the old copper network is still going ahead, faxes will have to eventually be transmitted over internet protocol, or "VOIP".

NBN Co. have openly admitted that the compression used in fax protocol is not compatible with VDSL internet, and they cannot guarantee reliability.

At our pharmacy, we've been attempting faxes over VOIP for more than a year, and I can certainly vouch for it being a very 'black art'. I believe many surgeries across the country will get a shock when their old (or new) fax machines 'fail to proceed' over their new, virtual, phone lines.

In our discussions with medical centres who are having trouble getting faxes through to us, the suggestion of using plain, old email to get prescription images to us is mostly met with flat refusals. Excuses range from email being insecure (despite the public key infrastructure encrypting the entire internet since its inception) to just not being willing or able.

I think a recommendation from a society like yours for practices to equip themselves with common flatbed scanners and reception email accounts, well before it becomes a necessity, will prevent many future administrative problems and even some medical misadventures.

Stephen McPhee
Ettalong Pharmacy, NSW

RHD - not just the poor

Dear Editor

I am writing to comment on the [AMA] Indigenous Health Report Card (*Australian Medicine*, December 12, 2016). In the President's Message and elsewhere RHD, and presumably acute rheumatic fever (ARF), is described as "a disease of poverty".

In 1947, aged 17, I contracted ARF. I recovered and played contact sport for many years after. But recently my cardiologist reported that in a routine ultra-sound examination, there was evidence of valvular damage.

I grew up in a healthy environment and there was no hint of poverty. I report this in case your readers actually believe it only occurs where poverty exists.

Yours sincerely,

Colin M. Orr
Retired Anaesthetist

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