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The national news publication of the Australian Medical Association

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AMA

ISSUE 28.04 MAY 16 2016

AUSTRALIAN
Medicine

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

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Don't Shoot The Messenger

BY AMA PRESIDENT PROFESSOR BRIAN OWLER

> "Doctors, pharmacists, nurses, Aboriginal health services, and even medical receptionists, have in the past week been blamed for rorts and waste in the system, with incorrect and inaccurate statistics being used to push these mischievous claims"

The Turnbull Government, led by Health Minister Sussan Ley, has recently made a habit of launching attacks on health professionals to justify its health policy decisions, especially the cuts to funding and services and the cost shifting.

It has not just been doctors in the firing line, although the Government has made a habit of demonising GPs, surgeons, radiologists, pathologists, and anaesthetists on a regular basis.

If not through direct attack, it has been via friendly journalists on the drip, or under cover of disenchanted private health insurers desperate to avoid the spotlight as their own sector is under forensic review.

Dentists have been copping it lately, joining the growing queue of health professionals being blamed for the Government's health policy mistakes and misadventures. Pharmacists and nurses have also come under attack, and they are not amused, and do not take these attacks lightly.

None of the health professions appreciate being criticised publicly in the media, especially when these attacks do not reflect what is discussed in private meetings.

The public – voters – do not like it, either.

Every poll of the professions in living memory has doctors, nurses, and pharmacists rated as the most trusted professions in the community. People trust their doctors and other health professionals. They do not like the ugly spectacle of politicians and some in the media attacking the integrity of health professionals. Needless to say, politicians rate very low on the trusted profession scale.

So, what is behind the misguided strategy of demonising doctors and other health professionals so close to an election? There can't be any votes in it.

You would think that an incumbent Government would want to win the hearts and minds of health sector leaders in the months ahead of a Federal Election, and on the eve of the Federal Budget, which will shape the direction of the Coalition's election health policies.

But this is not the case.

Doctors, pharmacists, nurses, Aboriginal health services, and even medical receptionists, have in the past week been blamed for rorts and waste in the system, with incorrect and inaccurate statistics being used to push these mischievous claims.

This is all subterfuge to keep the public focus off the main game – the fact that the Government's health policies, in the main, are all about making savings to the Budget, not improving access to quality affordable health care for all Australians.

The Government's ongoing justification for its extreme health savings measures, including cuts to public hospital funding, has been that Australia's health spending is unsustainable. This is simply not true.

The most recent comparative figures reported by the OECD show Australia's health expenditure as a proportion of GDP was below the OECD average and lower than 18 other OECD countries.

Australia's health costs (8.8 per cent), as assessed by the OECD, were just over half the corresponding proportion for the USA (16.4 per cent). Australia achieves better health outcomes for

Don't Shoot The Messenger

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its significantly lower proportional spend than the USA and many other countries, with the second highest life expectancy in the world, with the exception of Indigenous Australians.

Moreover, the Commonwealth Government's total health expenditure is reducing as a percentage of the total Commonwealth Budget. In the 2014-15 Commonwealth Budget, health was 16.13 per cent of the total, down from 18.09 per cent in 2006-07. It reduced further in the 2015-16 Budget, representing only 15.97 per cent of the total Commonwealth Budget.

Clearly, total health spending is not out of control. Nor is spending on medical services.

The reality is that today we are not spending any more on medical services as a proportion of total health spending than we were a decade ago.

The proportion today is 18.2 per cent, compared with 18.5 per cent a decade ago. While we are spending more on health in total, we are spending less on medical services.

Today, 86 per cent of privately insured medical services are charged at no gap by the doctor - which means that the doctor accepts the fee level set by the patient's private health insurer.

A further 6.4 per cent are charged under 'known' gap arrangements. This means that less than 8 per cent of privately insured patients may be charged fees exceeding private health insurance levels, including known gap amounts.

The number of doctors charging 'excessive' fees is in the absolute minority, and the AMA continues to work with the relevant specialist colleges, associations and societies to address this.

Nor are doctors' fees contributing to Budget woes, with specialist fees in many cases not being indexed for up to a decade.

Contrary to the line being pushed by the Government and the private health insurers, medical services are not an issue for the insurers or for patients.

Some insurers have been only too eager to vilify doctors even though the publicly listed PHIs have posted record profits, their executives are paid multimillion dollar salaries, and when doctors charge above the PHI schedule, i.e. a gap, the PHI contribution falls to 25 per cent of the scheduled fee.

During the December 2015 quarter, insurers paid $3,542 million in hospital treatment benefits. This was broken down into 70 per cent on hospital services such as accommodation and nursing, approximately 15 per cent on medical services, and 14 per cent on prostheses.

General practice, too, has demonstrated a real willingness to work with the Government to deliver high quality reforms, particularly in relation to the treatment of patients with complex and chronic disease.

The 2016 Budget provided the Government with a real opportunity to steer a new course and a new strategy of health policy and health sector engagement, but they passed on this opportunity. We can only hope the Government is saving some health largesse to be announced ahead of the election.

Doctors and the other health professions are restless and demanding better health policy, better consultation, and greater respect in public conversations and pronouncements. We need a mature and honest exchanges of views, not sneaky media leaks and cheap attacks on our integrity and professionalism.

Doctors see millions of Australians face-to-face every day. Multiply that number when you count radiology and pathology centres, pharmacies, and other health professionals.

Some groups have already commenced campaigns against Government health policies. More will join them if there is not a change in policy direction and a change in the Government's public relationship with the health sector.

* An edited version of this column first appeared in the *Australian Financial Review* on 4 May 2016.

Alcohol-related violence

BY AMA VICE PRESIDENT DR STEPHEN PARNIS

Doctors are at the front line in dealing with the devastating effects of excessive alcohol consumption.

We deal with the fractured jaws, the facial lacerations, and the eye and head injuries that can occur as a result of excessive drinking. We see the deaths and life-long injuries sustained from road trauma and violence.

Many of the people who are injured are not the ones who consume alcohol. They are innocent victims.

But, despite our best efforts, the news stories about alcohol-related violence continue. The apparently random violent attacks and domestic assaults continue. They are utterly unacceptable.

Every time a young person loses their life in alcohol-related violence, we talk about the tragedy of a life cut short, and vow to ensure that it hasn't happened in vain, that it won't happen again.

The real risk is that we are now perceiving these incidents as normal and we, as a community, are becoming desensitised to the horrific consequences of excessive alcohol consumption.

Two years ago, the AMA hosted a National Alcohol Summit that brought together political, medical, public health and community leaders, policy makers, the families of victims, and other stakeholders in order to identify practical solutions to the problem. The message from the Summit was clear and concise – governments need to act.

The Alcohol Summit concluded that tolerating, and even glorifying, binge drinking must stop. Governments must do everything within their power to change the prevailing attitude towards alcohol, and protect the innocent from harm.

Yet the scourge of excessive alcohol consumption and alcohol-related violence is still being felt throughout the community, and more often by our most vulnerable, including children and young people.

Two years on, and we are still waiting for action at the Commonwealth level.

The AMA was hopeful that the National Alcohol Strategy would be finalised this year (the previous Strategy expired in 2011), but that looks doubtful. With an election set for 2 July, we are not sure what will happen to the Strategy. Regrettably, many NGOs who engage in advocacy around reducing alcohol-related harms have seen their funding cut, or significantly reduced.

Alcohol is not the only problematic substance we face.

In 2015, the Government took quick and decisive action to reduce the impact of crystal methamphetamine (Ice). The National Ice Taskforce undertook extensive consultations and formulated the National Ice Action Strategy. The Government accepted and funded the Strategy to the extent of $300 million. While the AMA is genuinely supportive of the Government's action on Ice, we are disappointed that alcohol has not received the same amount of attention.

One in three people presenting to Emergency Departments are alcohol affected. Ninety-two per cent of the doctors and nurses in EDs have experienced assaults or physical threats from drunk patients.

Alcohol causes far more injury, harm, and loss of life across the whole community than any drug.

Some progressive State governments understand this and have implemented measures to reduce alcohol-related violence. NSW and Queensland have introduced lockouts, last drinks regulations, and restrictions on the sale of takeaway alcohol. While these measures will not completely solve all of the alcohol-related problems, they are a proven and effective place to start.

The disturbing truth is that most Australians drink at levels that put themselves and others at risk of harm.

Fifteen per cent of Australians (over the age of 12) report consuming more than 11 standard drinks on one occasion. We have more than 70,000 alcohol-related assaults in the community every year. Five million Australians report being a victim of an alcohol related incident (including verbal and physical abuse).

Alcohol-related violence is not a small or isolated problem. It permeates every city and town and every community. It will not be solved by simply hoping that Australians become more responsible with their drinking habits.

Governments must recognise that broad measures are needed to reduce the impact of alcohol-related violence. The AMA will continue to make that case with clarity and determination.

Big issues loom at National Conference

BY AMA SECRETARY GENERAL ANNE TRIMMER

> "On the political front, several senior politicians have confirmed their participation, notwithstanding that a Federal election will be in full flight by the time of the Conference"

The arrival of May brings with it not just a Federal Budget but also National Conference, a key event in the AMA annual calendar.

Preparation for the AMA National Conference is well underway. I have written in an earlier column about the facilitated debate which has been scheduled on the review of the AMA's position statement on assisted dying. On the political front, several senior politicians have confirmed their participation, notwithstanding that a Federal election will be in full flight by the time of the Conference. There will also be a panel discussion with some of Australia's leading political journalists analysing likely health policy issues in the Federal election.

A policy session of considerable relevance focuses on the role of private health insurance in the Australian health care system. With private health insurance premiums continuing to rise and some insurers looking at novel ways to tackle safety and quality issues in the private health sector, the session will explore issues affecting medical practitioners, health insurers and private hospitals. Panel participants include Dr Linda Swan, Medibank Private's Chief Medical Officer and Prof John Horvath AO, Strategic Medical Advisor at Ramsay Health Care.

Another policy session of interest looks at the challenges of medical self-regulation, exploring the balance between regulation and individual responsibility for maintaining professional standards and behaviours, and the opportunities to provide greater transparency and accountability to the public. The participants in this session include Dr Joanna Flynn, Chair of the Medical Board of Australia, and Associate Professor Matthew Thomas, a leading scientist in the field of human factors and safety management in high-risk work environments.

On the final morning of the National Conference, delegates will elect a new President and Vice President of the AMA for a two-year term.

Voting for the contested positions on the AMA Federal Council has now closed. Members who used the online voting tool found it easy to use. The full list of incoming Federal Council members will be published in the next edition of *Australian Medicine*.

At the Annual General Meeting, members will consider amendments to the Constitution to reflect a decision of Federal Council to create practice groups in place of special interest groups. Members will be able to belong to as many practice groups as are relevant to their medical practice. The practice groups will form the basis of future delegate groups to National Conference, in addition to State delegates and members of Federal Council.

I received a good response to my call for expressions of interest to fill the two positions on Federal Council for which no nomination was received.

After an exhaustive process, the Policy Executive of Federal Council has appointed Associate Professor Julian Rait to represent private specialist practice and to chair the Council of Private Specialist Practice, and Dr Sandra Hirowatari to represent rural doctors and chair the Council of Rural Doctors. A sincere thank you to all those members who expressed interest in the positions.

Budget hit on households

Main points

- **Medicare rebate freeze extended to 2020**
- **Indexation delays cost households $370m**
- **Bulk billing set to fall**
- **$2.9 billion for public hospitals**
- **$60 million for new drugs**

The Federal Government is increasingly pushing the cost of care onto patients and households as it screws down on health spending, undermining Medicare and putting the poorest and sickest at risk, AMA President Professor Brian Owler has warned.

As the Federal Government prepares for a 2 July election, it has raided Medicare for almost $1 billion in savings by extending the rebate freeze, pushing the system to the point where GPs will be forced to cut back on bulk billing and begin charging patients, Professor Owler said.

At the same time, it has taken an axe to aged care, public dentistry and community health program funding, is targeting the Medicare Benefits Schedule for multi-million dollar savings, and has further delayed indexation of the Medicare Levy Surcharge and the Private Health Insurance Rebate thresholds, costing families an extra $370.9 million between 2018-19 and 2019-20.

Professor Owler said the Budget continued the Government's "stranglehold" on the Medicare system, constituted "another hit to household budgets, and represent extra disincentives to people accessing health care when they need it".

The Government's decision to extend the freeze on Medicare rebates to 202 would be the "tipping point" for many medical practices, the AMA President warned, forcing many to wind back bulk billing and begin charging patients.

The Budget confirmed Prime Minister Malcolm Turnbull's pledge to provide an extra $2.9 billion for public hospitals, and included more than $57 million for new drugs, almost $10 million to help protect the nation against the overuse of antibiotics, more than $33 million for Indigenous eye tests and $21 million for a trial of Health Care homes.

Health Minister Sussan Ley said the Budget showed the Government would lift its spending on health, aged care and sport to $89.5 billion next financial year – a 4.1 per cent increase from 2015-16.

"Our reforms are targeted to meet the growing needs and expectations of the modern consumer and are bold and broad, but also affordable, achievable and, most importantly, fair," Ms Ley said.

The Minister said the Government had a "clear focus" on integration and innovation, and she pledged that it would "eliminate waste, inefficiency and duplication wherever we find it".

"The Turnbull Government will make sure every health dollar lands as close to the patient as possible," Ms Ley said.

But Professor Owler said the positive initiatives in the Budget had been overshadowed by the cuts, and the document was a missed opportunity for the Government to "steer a new course and a new strategy of health policy and health sector engagement".

Budget hit on households

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The AMA President said that instead, the Government's strategy had been to attack health professionals.

"Doctors, pharmacists, nurses, Aboriginal health services, and even medical receptionists, have in the past week been blamed for rorts and waste in the system, with incorrect and inaccurate statistics being used to push these mischievous claims," he said.

Professor Owler said the attacks were a subterfuge being used by the Government to distract public attention from "the main game – the fact that the Government's health policies, in the main, are all about making savings to the Budget, not improving access to quality affordable health care for all Australians".

The AMA President said it was a myth that health spending was out of control, as the Government has claimed – this financial year it comprised less than 16 per cent of the Commonwealth Budget, down from 18 per cent a decade ago.

He also took issue with health insurer complaints that doctors were driving up their costs, pointing out that in many cases specialist fees had not been indexed in a decade.

"Contrary to the line being pushed by the Government and the private health insurers, medical services are not an issue for the insurers or for patients," Professor Owler said. "Some insurers have been only too eager to vilify doctors even though the publicly listed PHIs have posted record profits, their executives are paid multimillion dollar salaries, and when doctors charge above the PHI schedule, ithe PHI contribution falls to 25 per cent of the scheduled fee."

The Government already faces a campaign from pathologists and diagnostic imaging providers over its decision to axe and reduce bulk billing incentives, and Professor Owler warned it ran the risk of more health groups joining them if it did not change policy direction and improve it public relationship with the health sector.

ADRIAN ROLLINS

Budget quotes

"Tonight we've seen an extension of the Medicare rebate freeze, and that means that the Government has extended its stranglehold on patients' rebates. That means 925 more million dollars out of the pockets of everyday Australians; it means that people are going to have to pay more out of their own pockets when they receive medical treatment"

– AMA President Professor Brian Owler

"This is a plan that will ensure our children and our grandchildren enjoy the great opportunities these times offer them. This is a responsible economic plan for growth and for jobs"

– Prime Minster Malcolm Turnbull

"If you earn less than $80,000, which is 75 per cent of all Australian workers, you will not get a cent out of this budget, but your schools will be cut, the hospitals will be cut and we will see precious little action on climate change"

– Opposition leader Bill Shorten

"Our reforms are targeted to meet the growing needs and expectations of the modern consumer and are bold and broad, but also affordable, achievable and, most importantly, fair"

– Health Minister Sussan Ley

"Mr Turnbull has again smashed Australia's health system, ripping another $2.1 billion out of health spending and keeping the GP tax in place for another two years – a measure that will cost Australian families $925 million"

– Shadow Health Minister Catherine King

"It [the Medicare rebate freeze] will very likely see consumers paying greater gap payments as the price the Government pays for Medicare services won't even keep up with inflation"

– CHOICE CEO Alan Kirkland

"The 2016 Federal Budget has done absolutely nothing to reverse the increasing pressure on Australia's world-class health care system"

- Royal Australian College of General Practitioners President Dr Frank Jones

Patients to pay for extended rebate freeze

Main points

- Medicare rebate freeze extended to 2020
- Health Care Homes trial gets $21.3 million
- $21.2 million cut to Practice Incentives Program

Bulk billing rates will tumble and patients will increasingly be charged to see their GP following the Federal Government's decision to extend its controversial Medicare rebate freeze through to 2020, AMA President Professor Brian Owler has warned.

Professor Owler said the move, which the Government estimates will save it $925.3 million over the next four years, undermined the value of Medicare and would increasingly push the burden of health care off the shoulders of Government and on to doctors and their patients.

The Medicare rebate was first frozen by the previous Labor Government in 2013, and the following year the Abbott Government extended it until 2018. The latest decision means that it will be almost seven years by the time there is an increase.

Professor Owler said GPs had so far absorbed the cost, holding up bulk billing rates, but he cautioned that this could not continue.

"The rent for the rooms, the costs of providing equipment, the costs of providing staff – all those costs rise year on year," he said. "GPs have absorbed it. They've absorbed the rebate freeze."

But, Professor Owler added, this was "just something that cannot continue".

He said the prospect of an additional two years without an increase would cause many doctors and medical practices to conclude that they could no longer afford to carry the cost.

"I think we're going to see people...start to say, 'We can't sustain it anymore, we can't absorb these rebate freezes, we're going to have to start to charge our patients'," Professor Owler said. "We're going to start to see that tipping point reached where Medicare patients now are going to start to be charged, and bulk billing rates are going to fall."

Health Minister Sussan Ley said the decision to extend the rebate freeze for a further two years had been taken "in recognition of the current fiscal environment".

But Ms Ley sought to reassure doctors by floating the possibility that the rebate freeze could be reviewed depending on the identification of improvements and efficiencies through its Healthier Medicare reform package, which aims to improve the care of patients with chronic and complex health problems.

Under the reform, dubbed Health Care Homes, chronically patients will nominate their preferred GP, who will then receive bundled payments to provide their care, while continuing to be paid fee-for-service for other patients.

The care model has been developed based on the recommendations of the Primary Health Care Advisory Group, and the Government envisages that the bundled payment model will give doctors the time and flexibility to develop care plans tailored to the needs of each patient.

In the Budget, the Government has allocated $21.3 million for a trial of up to 200 Health Care Homes involving around 65,000 patients with chronic and complex conditions.

But this is largely offset by a $21.2 million cut to the Practice Incentives Program (PIP).

The Health Department has announced the PIP system will be "streamlined and simplified" to reduce the regulatory burden on practices while ensuring incentives were better targeted.

"Redesigning the incentives will focus on quality improvement across the range of GP incentives, and will draw on best practice examples and feedback from across the sector," the Department said.

ADRIAN ROLLINS

Asylum seeker deaths fuel health care concerns

The standard of medical care provided to asylum seekers being held in offshore detention centres has been savaged by senior doctors including AMA President Professor Brian Owler amid claims lengthy delays in the medical evacuation of a burns victim contributed to his death.

Professor Owler, who was interviewed as part of an investigation by ABC's Four Corners program into the death in 2014 of a Manus Island detainee from a bacterial infection, asked "Why do we accept that this death may have been inevitable? It wasn't."

The AMA President, who has been a vocal critic of the standard of health care provided to those being held in offshore detention centres, told the program such an outcome "just wouldn't happen here [on the Australian mainland], and if it did happen, there would be consequences for the people involved".

"It's not moral or ethical to lock people up in detention on a tropical island and not provide them with adequate health care," Professor Owler said.

Since the death of Manus Island detainee Hamid Khazei in 2014, several other cases raising concern about the standard of medical treatment provided in offshore detention centres have come to light.

Late last month, a 23-year-old Iranian refugee who set himself alight died following a delay of more than 24 hours in evacuating him from Nauru, prompting calls from AMA Vice President Dr Stephen Parnis for a coronial inquiry into the incident.

"People under the care of the Australian Government are entitled to the sorts of standards of care that we would expect in Australia," Dr Parnis told Fairfax Media. "I think it will be essential that a coroner's investigation take place."

Just days after the incident, on 2 May, a young Somali woman also being held on Nauru set herself alight. She was rushed to the Republic of Nauru Hospital before being airlifted to the burns unit at the Royal Brisbane and Women's Hospital the following morning.

The incidents, and claims that an asylum seeker raped while on Nauru who wanted to have her pregnancy terminated in Australia was instead sent to the Pacific International Hospital in Port Moresby despite the fact that abortion is illegal in Papua New Guinea, have intensified the focus on the standard of health care provided by the Government.

The United Nations High Commission for Refugees, a long-standing critic of Australia's offshore detention regime, condemned the Government's policy and demanded that asylum seekers be immediately moved to "humane conditions with adequate support and services".

"There is no doubt that the current policy of offshore processing and prolonged detention is immensely harmful," the UNHCR said.

In February, Professor Owler told an AMA forum on asylum seeker health that the prolonged detention of children was "a state-sanctioned form of child abuse", and expressed grave concern that bureaucrats rather than doctors had the ultimate say over the care of asylum seekers.

But Immigration Minister Peter Dutton has rejected accusations that there were unnecessary delays in evacuating the critically injured Iranian man from Nauru, and the Labor Party has restated its bipartisan commitment to the offshore detention policy.

However, the policy is coming under pressure from another direction, after PNG Prime Minister Peter O'Neill ordered that the Manus Island detention centre be shut down following a ruling by the nation's Supreme Court that it was illegal and unconstitutional.

The Government is scrambling to make alternative arrangements for the approximately 850 men being held on the island. Mr Dutton has insisted they will not be brought to Australia.

But the Government's task has been complicated by indications that the Spanish infrastructure group Ferrovial, which has taken over a company contracted to manage the Manus Island and Nauru detention centres, does not see the provision of such services as part of its core business – though it has said it will honour existing contracts.

Professor Owler said it was time for a re-think of the country's treatment of refugees and asylum seekers, especially children, and the AMA has called for the establishment of an independent statutory body of clinical experts to investigate and report on the health and welfare of asylum seekers.

ADRIAN ROLLINS

Doctor health for all

The goal of ensuring all doctors and medical students nationwide have access to quality, dedicated health care no matter where they live is close to fruition following a major deal unveiled late last month.

Funds have already begun flowing after AMA subsidiary Doctors' Health Services Pty Ltd (DrHS) reached agreement with operators in New South Wales, South Australia, Northern Territory and the ACT to provide expanded health services for doctors and medical students within their jurisdictions.

The announcement came as DrHS confirmed it was in the final stage of discussions with providers in Victoria, Western Australia, Queensland and Tasmania.

AMA Vice President Dr Stephen Parnis said the new arrangements delivered on the AMA's goal of ensuring improved access to doctor health services right across the country.

Under the arrangement, funded by the Medical Board of Australia, doctors and medical students will have access to services including confidential health-related triage, advice and referrals; follow-up care, including for return to work; education and advice about doctor and student health issues; training for doctors treating doctors; and facilitation of support groups.

While health services specifically for doctors are not new, in most places they have been ad hoc and reliant on the goodwill and commitment of individuals operating without much financial support from regulators.

The need for dedicated doctor and student health services has long been recognised, but has been given added emphasis by recent revelations of bullying, harassment and stigma around mental illness in the medical profession.

But a key concern has been that doctors might be reluctant to seek help because of fears that if details were divulged it might adversely affect their career prospects or ability to practise.

To address this, the Medical Board engaged the AMA to keep the administration of the network at arm's length from it and the Australian Health Professionals Registration Authority. The AMA, in turn, created DrHS as a subsidiary to operate the program.

"The services will remain at arm's length from the Medical Board to ensure that doctors and medical students trust these services, and use them at an early stage in their illness," Dr Parnis said.

Under the new arrangement, the Medical Board is providing DrHS $2 million a year, indexed to inflation, to administer the national network of health services, with the key aim of ensuring equitable access to care.

DrHS received expressions of interest from all existing providers, and Chair Dr Janette Randall said her Board was delighted with the standard of submissions received.

Among organisations taking part are the Doctors Health Advisory Service (NSW), which will provide services in NSW and ACT, and Doctors' Health SA, which will serve both South Australia and the NT. In Victoria, the AMA already operates the Victorian Doctors Health Program in partnership with the former Medical Practitioners Board of Victoria.

Medical Board Chair Dr Joanna Flynn said the Board would continue to fund existing services as contracts with DrHS were finalised in the transition to the new national program.

Dr Flynn said the Board would closely monitor the operation of the national program to ensure each service received the right level of services to achieve the goal of nationally-consistent care.

ADRIAN ROLLINS

INFORMATION FOR MEMBERS

Doctor in Training selected for World Medical Association leadership program

The AMA's nominee, Dr Alan Pham, has been accepted into the WMA leadership program, *Caring Physicians of the World: Medical Leadership, Communication and Advocacy Course 2016.*

The course will be held in Jacksonville Florida in early May.

Dr Pham is a surgical trainee from Sydney. His first degree is a Bachelor of Arts in Cognitive Science from Rice University, Houston, Texas. He undertook his medical studies as a student of the University of Sydney Graduate Medical Program completing MBBS with Honours in 2011.

Govt pathology cuts a false economy

The AMA has intensified the pressure on the Federal Government to reverse cuts to pathology and diagnostic imaging bulk billing incentives amid revelations that pathologists are saving the public purse more than $2 billion a year.

In a sign the cuts could develop into a major issue in the forthcoming Federal election, more than 500,000 have so far signed a petition opposing the decision, and the industry – which treat more than two million patients a month – has vowed to campaign strongly on the matter.

Pathologists are providing $450 million worth of free services a year under a "coning" arrangement where the Government pays only for the three most expensive tests conducted any single time, while efficiency gains and productivity improvements saved taxpayers $2 billion last financial year, according to estimates prepared by consultancy Ernst & Young for Pathology Australia.

"The industry, through consolidation, economies of scale, technological advancement, specialisation and operations has, over the past decade-and-a-half, delivered an average annual growth in productivity of 4.3 per cent, compared with the Australian industry average of 1.5 per cent," the report said.

An international comparison of the cost of providing equivalent tests found Australian providers were $45 million cheaper than their Canadian counterparts, and $381 million less than charged in the United States.

AMA Vice President Dr Stephen Parnis said the report's findings confirmed the efficiency and quality of Australia's pathology services, and highlighted why the Government's planned cuts were "irresponsible".

"We have a highly efficient pathology sector that provides affordable services to the Australian community," Dr Parnis said. "[They] are vital to the work of GPs and surgeons who consult patients and conduct surgery every day across the country. It is irresponsible to disrupt this core element of the health system."

Health Minister Sussan Ley has argued the bulk billing incentive has not resulted in any increase in bulk billing by pathology providers, and has instead been used to fatten profits. The Government claims axing the incentive for pathology and reducing it for radiology services will save it $650 million over four years. The cut is due to come into effect from 1 July.

But the AMA and pathology groups have warned the change will force providers to charge patients, which will cause many – particularly the sickest and most vulnerable - to defer or forego vital tests, undermining the effective management of chronic disease and potentially leading to more serious and expensive health problems in the longer term.

Almost 88 per cent of pathology services are currently bulk billed, while 17 per cent are provided free of charge under the coning arrangement.

According to the Ernst & Young report, pathology's share of Medicare spending has fallen from 16 to 12.5 per cent since 2000, and the price of tests has fallen by 12.3 per cent over the same period.

Dr Parnis the report demonstrated that the industry had increased its efficiency and productivity to maintain high bulk billing rates.

But pathologists have warned they will be forced to begin charging patients from 1 July, with some planning a $20 fee for a blood test.

Ms Ley has dismissed the industry's concerns, and has argued operators have ample room to absorb the bulk billing cuts rather than passing them on to patients.

The Minister has used the highly concentrated nature of the industry – Sonic Healthcare and Primary Health Care between them hold almost 80 per cent of the market - as a political point of attack, accusing the Opposition of 'cozying up' to big companies by backing the campaign against the cuts.

Labor leader Bill Shorten last month visited QML Pathology, which is part of Primary Health Care, to lobby against the Government's plan.

Ms Ley said, "Mr Shorten needs to explain to patients why he is backing multi-national pathology companies who want to charge Australians more for tests for no justifiable reason other than to protect profits".

But according to the Royal College of Pathologists of Australasia, the consolidation of the industry and centralisation of testing has been driven by the fact that the Medicare rebate for pathology services has not been indexed for 18 years. This has forced operators to hold down costs by realising economies of scale.

ADRIAN ROLLINS

Medical Briefs

Medicare changes

Out-of-hospital benefits for more than 30 Medicare Benefits Schedule items have been scrapped, while 18 new items have been added and 22 axed under changes unveiled by the Health Department.

The changes, which took effect on 1 May, are separate to the major review of more than 5000 MBS items being led by Professor Bruce Robinson, and include new items for hernia repair and the treatment of incontinence, as well as amendments for the treatment for finger and wrist fractures.

Indigenous smokers in frame

The Federal Government has launched a $10 million advertising campaign to reduce the prevalence of smoking among Aboriginal and Torres Strait Islander people.

Indigenous Australians smoke at more than double the rate of the rest of the community, and Rural Health Minster Fiona Nash said the "Don't Make Smokes Your Story" was aimed at keying into values around the health and wellbeing of families to convince people to give up smoking or not take up the habit.

But the advertising campaign follows a decision by the Government last year to axe funding for anti-smoking programs in Indigenous communities, and comes against the backdrop of research casting doubt on whether generalised anti-smoking media campaigns in Indigenous communities are effective in getting peple to quit.

Melanoma drug listed

Melanoma patients now have subsidised access to the hugely expensive cancer treatment Opdivo following its listing on the Pharmaceutical Benefits Scheme.

The drug, which is credited with a major improvement in the survival rate of people with the skin cancer, had cost $170,000 for a course of treatment, but will now be available as a PBS-subsidised medication.

The Government expects about 1500 patients with advanced melanoma will receive the drug, which lifts the one year survival rate from 43 to 73 per cent.

Youth sex-ed program cut

The nation's only youth-led sexual health education program is shutting down after its funding was axed.

The Youth Empowerment Against HIV/AIDS (YEAH) service, which provided face-to-face sex health education to 10,000 young people last year, will close on 30 June after the Health Department announced its $450,000 a year contract had not been extended.

Critics have attacked the decision, which they complain comes as the rate of sexually transmitted infections is rising and condom use is declining. But a Department spokesperson told the *Northern Territory News* the Government was funding new approaches to tackle STIs, and YEAH had failed to be selected in a strongly contested funding round.

New NACCHO Chief Executive

Leading Indigenous administrator and academic Patricia Turner has commenced as Chief Executive Officer of the National Aboriginal Community Controlled Health Organisation.

Ms Turner has worked in government, business and academia for more than 40 years, including as the longest-serving Chief Executive of the Aboriginal and Torres Strait Islander Commission, founding CEO of NITV and 18 months as Monash Chair of Australian Studies at Washington DC's Georgetown University.

NACCHO Chair Matthew Cooke said her high level experience gave her good insights in negotiating the best solutions to help close the Indigenous health gap.

"[Ms Turner] has experience in regional communities, in the cut and thrust of Government in Canberra, and has travelled extensively throughout Australia in her various roles. This gives her an excellent appreciation of challenges facing our member services in remote, regional and urban settings, and how best to serve their interests," Mr Cooke said.

MARIA HAWTHORNE

AMA, RDAA call for federal action on rural health

> "With the 2016 Federal election set for 2 July, the AMA and the RDAA urged all parties to adopt the updated joint Rural Rescue Package – Building a Sustainable Future for Rural Practice"

The AMA and the Rural Doctors Association of Australia (RDAA) have joined forces to call on the major political parties to commit to practical and affordable reforms to improve health services for people in rural and remote Australia.

With the 2016 Federal election set for 2 July, the AMA and the RDAA urged all parties to adopt the updated joint Rural Rescue Package – Building a Sustainable Future for Rural Practice.

The Package details strategies to attract and retain doctors working in rural Australia, and programs to ensure ongoing skills development for the rural medical workforce.

It supports the Doctors for Rural Communities proposal released last month by the Australian Medical Students' Association, enabling doctors to undertake a period of training in regional, rural and remote Australia.

AMA Vice President Dr Stephen Parnis said successive Federal Governments had introduced initiatives to attract and retain doctors in rural and remote areas, without enduring success.

"Some gains have been made, but the maldistribution of doctors – both in terms of geography and skills – persists, and the sustainability of some rural health services remains under threat," Dr Parnis said.

"The major political parties must learn from these experiences, consult with the medical profession, including with local doctors, and look to other ideas such as those in the Package.

"A commitment by the major parties to implement the Rural Rescue Package before or during the next term of Federal Parliament would send a strong message to rural communities desperate for better health services."

RDAA President Dr Ewen McPhee said the Package, with two tiers of support to revitalise and sustain rural medical services, offered the best path for delivering much-needed doctors to the bush now and into the future.

"Rural medicine is a challenging and rewarding career that is different from metropolitan practice in terms of isolation, costs, scope, and complexity," Dr McPhee said.

"Rural doctors see patients in their general practices by day, often provide on-call and after-hours emergency services during the night, and many perform procedures at the local hospital on a regular basis.

"They are highly-skilled and provide a critical service to rural and remote communities.

"But, over the past two decades, many rural and remote communities have found it increasingly difficult to attract and retain doctors with the right mix of skills to meet their health and medical needs, including GPs with advanced skills training who can provide acute services in the hospital setting.

"The Rural Rescue Package would make a huge difference in attracting to country communities the right doctors with the right skills to the right places, now and into the future."

The first tier of the Package is designed to encourage more GPs, other specialists, and registrars to work in rural areas. It takes into account the greater isolation of rural practice, both for doctors and their families.

The second tier is aimed at boosting the number of doctors in rural areas with essential advanced skills training in a range of areas such as obstetrics, surgery, anaesthetics, acute mental health, and emergency medicine.

Rural areas need doctors with strong skills in these areas to ensure that communities have access to appropriate acute services locally, including on-call emergency services.

It is envisaged that the Package would be implemented via the Commonwealth's existing Service Incentive Program (SIP) and incentives would be calculated as a loading on rural doctors' Medicare billings, or as a special payment for salaried rural doctors.

The loading would increase with the rurality of the doctor/practice.

Building a Sustainable Future for Rural Practice: The AMA/RDAA Rural Rescue Package is available at www.rdaa.com.au (see Quick Links on front page, or Policies section) and https://ama.com.au/position-statement/building-sustainable-future-rural-practice-rural-rescue-package

MARIA HAWTHORNE

Rural and regional doctors – a case study

The case of a Toowoomba radiologist highlights the need for practical reforms to improve regional and rural health services.

The doctor is one of the small proportion (7.7 per cent) of Medical Rural Bonded Scholarship (MRBS) graduates who are now completing their return of service obligations.

He and his family have settled in Toowoomba, in the Darling Downs region of Queensland, and he is working 40 or more hours a week, well in excess of the minimum 20 hours specified in his MRBS contract.

He works across a number of practices and is on the local on-call roster for two hospitals.

To upskill in procedures currently unavailable in Toowoomba, and to maintain his skills in procedures only needed occasionally in the small regional community, he needs to work two days a month in a metropolitan centre.

Yet the Department of Health (DoH) rejected his application for special consideration for a provider number for his occasional practice in Brisbane.

AMA President Professor Brian Owler wrote to Health Minister Sussan Ley in December 2015 to plead the doctor's case – and to urge action on the growing evidence of the unfair impact the DoH policy was having on other graduates.

"The AMA's Council of Rural Doctors has identified the importance of rural doctors being able to access opportunities to upskill in metropolitan centres from time to time," Professor Owler wrote.

"It supports sustainable, high quality medical care and also enables practitioners to pass on the skills acquired to their colleagues, including doctors in training.

"MRBS contracts were never designed to be an impediment to this.

"Considering the very small number of graduates who have commenced their return of service under both the MRBS and Bonded Medical Places (BMP) scheme, they have clearly failed to meet their stated policy objectives and it is only through sensible reforms that we can turn this situation around."

Ms Ley replied with a promise to review the policy.

However, five months on and with the Federal Government about to enter the caretaker period before the 2 July election, the Toowoomba doctor remains unable to practise in Brisbane.

MARIA HAWTHORNE

INFORMATION FOR MEMBERS

Ukraine calling

A children's hospital in Ukraine is looking for Australian medical staff for academic and technical exchanges.

The Okhmatdyt National Specialised Paediatrics Hospital in Kiev recently received direct aid funding from the Australian Embassy to buy equipment for its Advanced Radiological Centre to improve the quality of diagnostics for children.

The hospital is now hoping to expand its connection with Australia through exchanges with medical staff who specialise in paediatric leukaemia, haematology and oncology.

Anyone interested in this opportunity can contact Mr Volodymyr Pliatsek at v.pliatsek@gmail.com. Mr Pliatsek works in the hospital's administration team and speaks English.

More information about the hospital is available at http://ohmatdyt.com.ua. Information about the Embassy's direct aid funding projects can be found at http://ukraine.embassy.gov.au.

Hospital system 'under enormous stress'

The performance of public hospitals is set to deteriorate further as the system comes under increased pressure from inadequate funding and "incredible" patient demand, AMA President Professor Brian Owler has warned.

Professor Owler told a Senate inquiry into the latest Council of Australian Governments meeting that the extra $2.9 billion for public hospitals provided by the Commonwealth at the 1 April meeting fell well short of what was needed, and patients were paying the price in terms of increasingly longer delays before receiving treatment.

"I still do not think that we have seen an adequate amount of funding that has been put forward for funding public hospitals," the AMA President warned. "The system is under enormous pressure and is dealing with an incredible amount of patient demand for not only emergency department services but also elective surgery. I think we are a long way from being able to meet that demand."

Professor Owler rubbished claims that a lot of the growth in demand for hospital services is being driven by patients who would normally see a GP, and that improvements in primary health and greater efficiency in that way hospitals operate will deliver massive savings.

He said demand for hospital care was being driven by category 2 and 3 patients, who were among the sickest in the community, and the most expensive to treat.

"The real growth is not what is sometimes reported in the media...it is not patients who should be seeing their GP. It is actually quite sick patients, which obviously take up an increased amount of resources and clinicians' time as well," Professor Owler said.

He added that doctors and other hospital workers were annoyed by "this constant notion that there are enormous savings to be had by just being efficient. I would agree, as would every doctor and nurse, that there are efficiencies to be found in the system. But... that is not the simple answer to solving the public hospital funding problem that exists in this country".

The annual AMA Public Hospital Report Card showed that improvements in hospital performance had stagnated and, in some instances, had begun to decline, and Professor Owler warned this was likely to continue.

"I think we will see a decline in the performance and in the range of services that our public hospitals are going to be able to provide," he said, explaining that hospitals were coping with funding cutbacks by expedients including leaving open vacancies left by staff who quit or retire or, as Sydney's Westmead Hospital, shutting down elective surgery for extended periods.

But patients were paying the price of reduced services.

Professor Owler said that already there was enormous unrecorded demand in what he called 'hidden waiting lists' comprising people waiting up to two years to see a specialist before placed on a waiting list for surgery – and this would only get worse as more hospitals temporarily closed outpatient clinics to save funds.

"We really are not meeting the demands that are out there for health care services, and I do worry that patients are suffering needlessly," he told the Senate committee. "Elective surgery is about patients who are in pain and have significant problems. It stops them from working and contributing to the community and they often end up sicker as a result of longer waiting times."

The AMA President welcomed the Government's decision to re-establish activity-based funding and the National Efficient Price mechanism.

ADRIAN ROLLINS

Seriously ill put hospitals under pressure

Hospital emergency departments are being filled with patients with multiple chronic diseases rather than those simply trying to dodge paying GP fees, a nationwide study has found.

In a result which confounds attempts to simply blame the elderly or freeloaders for crowding hospital emergency departments, a National Health Performance Authority investigation has found that age and access to a GP matters less in determining who ends up in ED than the duration and complexity of their illnesses.

The NHPA reported that those with three or more long standing health problems were almost three times more likely to end up in ED compared with patients without chronic conditions, while those who avoided seeing their GP because of cost were only 1.3 times more likely to visit Emergency than those who saw their GP as needed.

And although significant numbers of the elderly attend ED, the Authority found that they were no more likely to do so than younger people with similar health problems and equivalent access to health care.

NHPA undertook the study to help establish what is driving demand for ED services. Between 2009-10 and 2013-14, the number patients attending emergency departments grew, on average, by almost 3 per cent a year, and it is estimated that in 2013-14 around 2.6 million (14 per cent) of Australians 15 years and older went to an ED.

Its findings bear out the assertion of AMA President Professor Brian Owler that, rather than treating crowds of patients who could be looked after by their GP, emergency departments are instead grappling with an influx of patients with multiple serious and complex health problems who place intensive demands on time and resources.

This influx reflects the fact that although Australians are living longer, many are developing significant co-morbidities that are difficult and complex to treat. The rise of non-communicable diseases like diabetes, heart problems, respiratory tract ailments and other illnesses has been particularly pronounced in advanced economies in recent decades, putting an increasing strain on health systems and Government budgets.

The AMA and other health advocates have argued the need for an increased focus on preventive health initiatives as well as greater investment in general practice to support patients with chronic and complex conditions.

In this vein, in March the Turnbull Government unveiled its Health Care Home model for primary care under which patients with chronic and complex conditions would make a specific general practice their medical home, making it the hub for coordinating and integrating their care.

But it is yet to detail what funding it will provide for the arrangement, and the AMA and other medical groups are worried it will take funds from other parts of health to pay for it.

The AMA is also highly critical of massive slowdown in Commonwealth funding for public hospitals.

In 2014 the Coalition Government changed the indexation formula for hospital funding which it has been estimated will rip $57 billion out of the public hospital system over 10 years. The Government argued that the cut would spur hospitals to achieve greater efficiencies, and a separate NHPA report has found the cost of caring for similar acute patients varied widely between hospitals, from $3100 to $6100.

Revealingly, the report found that the major metropolitan hospitals with the lowest costs were all in Victoria, which has the activity based funding (ABF) system in place longer than any other jurisdiction.

The Abbott Government had acted to abolish ABF, but it has been reinstated by Prime Minister Malcolm Turnbull as part of his $2.9 billion, three-year hospital funding deal with the states unveiled at the 1 April Council of Australian Governments meeting.

ADRIAN ROLLINS

Practices 'can do better' on privacy

The AMA has updated its advice to medical practices on safeguarding patient privacy following an assessment by the nation's privacy watchdog.

A review of the privacy policies of 40 GP clinics by the Office of the Australian Information Commissioner found that while a majority referred to requirements as set out in the Privacy Act, most fell short of full compliance with the Australian Privacy Principles (APP).

> "General practices are serious about protecting patient privacy, but the report sends a clear signal that we can do better, including with getting all the paperwork right"
> *- Dr Brian Morton*

The Office found that half the practices explicitly referred to the APPs in their privacy policies, but there were shortcomings in most, ranging from inadequate contact information to a failure to provide appropriate advice on how to access or correct personal information, or how to complain about a privacy breach.

Importantly, because the review focused only on the content, layout and availability of privacy policies, it made no claims about how patient information was handled in practice.

Dr Brian Morton, Chair of the AMA Council of General Practice, said although the OAIC report did not suggest patient privacy had been compromised, it was an important reminder for practices to regularly review and update their privacy policies.

"Privacy is fundamental to the trusted relationship between a doctor and a patient, and practices go to great lengths to protect this," Dr Morton said. "General practices are serious about protecting patient privacy, but the report sends a clear signal that we can do better, including with getting all the paperwork right," Dr Morton said.

A common shortcoming identified by the OAIC was that privacy policies were too difficult to read, did not include sufficient contact information, and did not go into enough detail about why and how personal information was collected, and the measures undertaken to ensure it was secure.

In particular, the Office found that many neglected to mention the collection, use and disclosure of personal information electronically, such as through the electronic transfer of prescriptions or the Government My Health Record system.

The Acting Australian Information Commissioner, Timothy Pilgrim, said the object of the exercise was to help GP clinics improve and enhance their privacy policies, rather than any punitive purpose.

"The OAIC works constructively with businesses and the wider community to build an integrated approach to privacy compliance," Mr Pilgrim said.

Dr Morton said the report provided some useful guidance for practices on how to improve their privacy policies, and the AMA had used its findings to update the information it provides to members.

"The AMA has already acted upon the concerns of the OAIC, updating our own *Privacy and Health Record Resource Handbook* to include an updated privacy policy template to guide practices when writing or updating their privacy policy," he said.

This Handbook can be downloaded at: https://ama.com.au/article/privacy-and-health-record-resource-handbook-medical-practitioners-private-sector

The review's findings came as an international report was released showing a rise in the frequency and sophistication of cyberattacks on businesses, including in healthcare.

Verizon's Data Breach Investigations Report found that although the finance industry was the top target for cybercriminals, health care organisations were sixth on the hit list of attacks involving the 'phishing' messages, ransomware, malware and the theft of personal information.

Verizon said most attacks involved exploiting known vulnerabilities, such as failing to patch software in a timely fashion, using weak, default or stolen passwords, or opening 'phishing' emails containing malware.

It warned that web apps were now the most common reason for data breaches, and recommended the use of two-step authentication for all systems and applications.

ADRIAN ROLLINS

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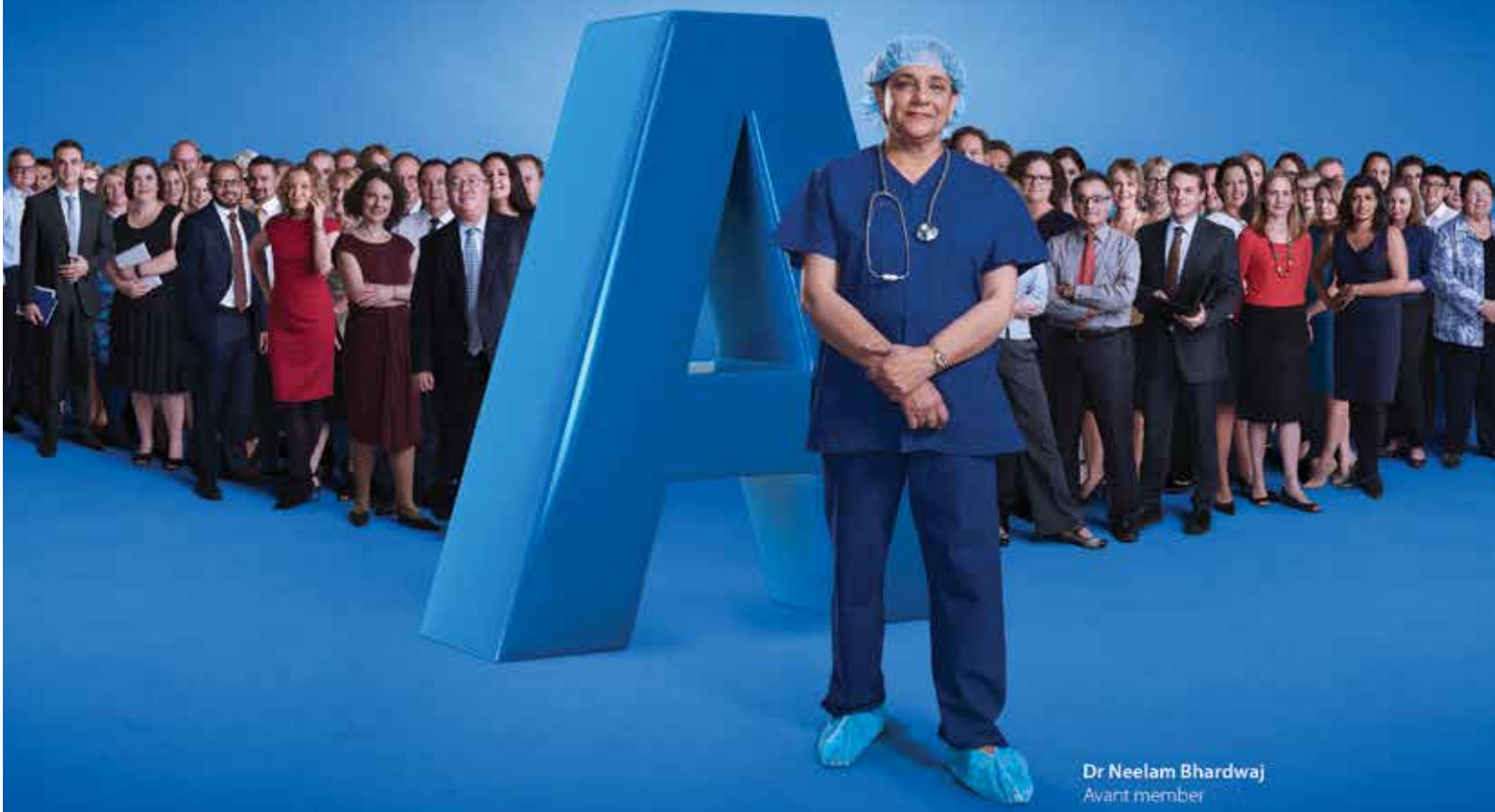

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Avant member

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Integrating care for patient with serious and continuing illness

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

Rising numbers of patients with serious and continuing illness are set to change the way we provide medical care. They need care that, like their ailments, is both serious and continuing.

> "Middle-aged people with cancer or heart disease or mental illness, now saved from death from an acute illness, likewise need continuing care"

This is not a new insight. We have known about the increasing load of chronic illness for decades. We know that its pattern has changed. We know that, while chronic illness afflicts mainly older people, children and adolescents, who would have died decades ago, live on now. They, too, need continuing care. Middle-aged people with cancer or heart disease or mental illness, now saved from death from an acute illness, likewise need continuing care.

Prime Minister Malcolm Turnbull has committed $20 million this year to trying out ways of linking the care of patients with chronic problems. What demands would be placed upon those providing the care?

A patient with emphysema

Meet George Henderson – let's give him that name. I saw him at home several years ago when I was working at the Respiratory Ambulatory Care Service (RACS) at Blacktown Hospital. Two of the nurses who do most of the work of the clinic took me to see him. They had a panel of over 100 patients who had been through the six-week program and were living at home. The service nurses had a laptop loaded with the basic records of all patients. The laptop was kept by the nurse on-call, and was available to them in dealing with their patients at night.

George lived in a Community Services house. His principal carer was his former wife, who had come back for this purpose as their children had threatened never to speak to her again unless she returned!

We arrived at 10am. George came slowly to the door in his pajamas, trailing a long cord to an oxygen concentrator in his kitchen. He was exhausted when we got him to bed. It was a tiny, lonely room. At his bedside were a torch and copious bottles of tablets. On the shelves were several small and intricate balsa boat models he made as his hobby.

The nurses chatted, examined his chest, and measured his blood pressure and oxygen saturation. How did he bathe? I asked. He had to clamber over the edge of the bath. There were no handrails. Could we get them installed? One nurse told me that this would require authorisation from the hospital social worker. When can she come? I asked. 'Oh!,' the nurse laughed. 'To this suburb? Four weeks! To [an up market neighbouring suburb] one week!' If he slipped and survived with a broken femur, who would be to blame?

I noticed, when I assessed him, that his teeth were poor. A dental appointment at a hospital outpatient department would take many months. One nurse told me that, when they found an acute and serious dental problem, they would send the patient to hospital 'with an exacerbation'. That way, the nurse said, his dental problem would be speedily attended to. But getting him to hospital ran the risk of oxygen overdose on the way and ICU on arrival for hypercapnia.

One of the nurses who was on the RACS 24/7 roster told me how George had called her at 2am one night, acutely breathless and anxious. She was able to 'talk him down', encourage him to breathe as he had been taught, and make himself a cup of tea. She avoided a hugely disruptive emergency visit to hospital. On other occasions, as you might expect, she had arranged immediate hospital admission for patients who called her.

To give George a sense of confidence, he would need to be able to talk to someone 24/7 who knew and understood him. He needed access when required to physios, nurses and more, preferably at home. Connection to a specialist would have to be immediately available to his carer.

The challenge

The needs of people like George call for new ways of providing both general and specialist care. For example, the part played by allied health professionals will be greater than it is today. In the publicly-funded system, payment for the services of nurses and allied health professionals will be needed. The way we pay general practitioners will need to change from payment for episodic to continuing care.

In our study of patients with chronic illness in western Sydney, we were surprised by the extent to which their illnesses led to poverty, often due to loss of employment for patient and carer, but also because of out-of-pocket costs for so many services other than those covered by Medicare.

We should also assess the extent to which hospital-based services can assist through specialized outreach programs – like RACS. Continuity of integrated care is crucial and probably most easily achieved by hospitals. There is a growing interest in major public hospitals in providing programs such as the RACS.

Perhaps in order to achieve the best integrated care, the reality is that hospitals should do much of the organising and management, with general practitioners playing whatever their part is compatible with the current demands and structure of general practice.

There is a lot to integrating care for patients with serious and continuing illness.

It is a matter, most fundamentally, of our response to the real, grounded problems of the people we care for, the way we respond to growing human needs. Money matters, but it can be found. Attitude and willingness to take on the challenge matter more.

AMA advocacy delivering for GPs

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

In reflecting on the last six years as Chair of the AMA Council of General Practice, I was reminded of the significant work the AMA does in advancing the interests of GPs and patients.

Much of this work has been in the background. The AMA has seen off many thought bubbles that thankfully have never seen the light of day.

There have, of course, been some very public battles, because successive governments have failed to appreciate the value and role of general practice.

In my time as Chair, we have had five prime ministers (albeit one twice) and four health ministers. Over that time we've seen some big visions in health, but progress has rarely matched the ambition.

When I first came to the role of Chair, funding had just been announced for the Practice Nurse Incentive Program (PNIP), Medicare Locals, additional GP Super Clinics, the establishment of Personally Controlled Electronic Health Records and chronic disease reform in the form of capped funding for bundled care for patients with diabetes.

The AMA welcomed the PNIP because it supported a GP-led model of team-based care, and offered significant extra funding for practices to employ a practice nurse. The AMA also won grandfathering arrangements to ensure practices were not disadvantaged by the removal of practice nurse items in the Medicare Benefits Schedule.

The former Government's Diabetes Plan proposed the introduction of a capitated model of payment, replacing fee-for-service for eligible patients. The plan lacked detail and would have rationed access to care for patients. It was quickly dumped by the Government in favour of a trial that ultimately confirmed that the plan would have failed.

Over my term the AMA has continued to prosecute the reform of chronic disease items through its plan *Improving the care for patients with chronic and complex care needs*, and has outlined principles for formalising Medical Homes in Australia - elements of which have been incorporated in the Government's recent *Health Care Homes* proposal.

AMA advocacy has helped ensure policy failures such as Medicare Locals and GP Super Clinics were short-lived, and after hours funding was returned back to practices via the PIP.

The inclusion of GP-referred MRI in the MBS may have taken a while, but we got there in the end. The introduction of these items is good for patients and has improved access to timely care.

I have also been delighted to see the importance of teaching championed by the AMA, with our efforts resulting in the PIP teaching incentive doubled and the ongoing funding of rural and regional teaching infrastructure grants. Our campaign to increase GP training places has borne fruit. There are now record numbers of doctors in training entering the GP training program.

Maldistribution of the GP workforce remains an issue, although the AMA has supported expansion of GP training places in rural and regional settings. We also played a big role in the establishment of the Rural Junior Doctor Innovation Fund to finance rural GP rotations for interns.

From a professional perspective, it is reassuring that more young doctors than ever want to be GPs, and that the colleges are to have a greater role in trainee selection.

I would have liked to have seen a commitment to fund the Pharmacist in General Practice Program in my time as Chair, but the ground work has been laid, and I am confident that in time the common sense of this proposal will prevail.

Of course, there are still challenges ahead, particularly around ensuring policies and funding arrangements that truly support GPs in providing quality preventative, holistic, coordinated and longitudinal care.

In closing, I wish to thank you and the members of the Council of General Practice for all the support. It has been a privilege to serve you. To my successor, I wish you all the best and every success as you lead the profession forward.

The 'she' in medical leadership

BY DR DANIKA THIEMT, CHAIR, DOCTORS IN TRAINING COMMITTEE

In Australia, medicine as a profession has been available to women since the late 1800s. Our first female graduate was registered to practice in 1891, and our profession now boasts a strong female presence.

Female medical graduates have outnumbered males since the 1990s, and female trainees currently make up two-fifths of our vocational cohort. Medicine no longer belongs to a specific gender. However, there is one area of medicine that is still catching up – medical leadership.

Medical leadership is vitally important to our health system.

As a self-regulated profession, doctors hold a unique power in being able to shape the fabric of our health system. As a united front, doctors are simultaneously the voice for our patients, for our health system and for our profession. This requires strong and vocal leadership with a clear vision. It also requires a degree of diversity in order to accurately represent the profession it has been charged to lead.

Female representation in medical leadership is topical. A study of medical leadership last year found that, despite women making up more than a third of specialist medical practitioners, they were under-represented in medical leadership positions. In fact, females made up just 12.5 per cent of leadership roles in larger tertiary hospitals, and only 28 per cent in medical schools and colleges.

While logic would suggest that fair representation of women in senior leadership positions would evolve naturally, this has not been the case. In fact, while the argument for gender equity seems simple and rational, there still remains systemic opposition.

There are three common justifications used: that women have not been in the profession long enough to be leaders; that women do not seek leadership positions due to family commitments; and that women do not possess inherent 'natural leadership' characteristics.

Gender parity was achieved among medical graduates in the 1990s, so it is hard to make the argument that women have not been in medicine long enough to be leaders. Female graduates are now in the majority. Currently, 31.5 per cent of the approximately 51,000 medical specialists in Australia are female, as are 45 per cent of vocational trainees.

If women have been in the profession long enough to comprise a third of all specialists, surely we have been there long enough to make up a third of medical leaders. The biggest issue is not time, but instead the inherent barriers that have stopped women progressing to medical leadership positions.

One barrier is the idea that women lack the skills required to be natural leaders. This is based on the assumption that women do not possess the inherent traits that make a good leader. But the very nature of our job means that all doctors are leaders. We are charged with the duty of leading medical teams and supervising our juniors early in our career. As we progress, we become leaders in our field, in research or in our communities.

While not all doctors are destined to (nor wish) to become leaders, all possess the skills that it takes to be a leader. Not inherent traits, but traits learnt and taught. Society needs to lean away from the belief that all leaders should possess the same traits - a belief that is stifling our female colleagues - and embrace the concept that leadership is at its strongest when it is diverse.

The belief that women do not seek leadership opportunities due to parental responsibilities is perhaps embedded in some truth. The barriers affecting doctors who are also parents are not unique to the female members of our profession. But they disproportionately affect women, who spend twice as much time as male colleagues undertaking childcare and household work.

Doctors who are both parents and practitioners are forced to choose between working and caring for their families due to a lack of flexible training and working opportunities. This is exacerbated by the traditional and structured way in which medicine is taught and practiced.

... from p23

The belief that medicine is a 24/7 job means that many often leave the workforce for extended periods of time rather than juggle the demands of both. This affects not only the path a doctor may take to a medical leadership position, but also the position itself.

If we truly want to encourage doctors in training to become medical leaders then we need to reconsider if the traditional, linear 'up the ladder' pathway is the only way we wish to recruit leaders. Additionally, we need to embrace flexible training and working arrangements that facilitate those with families to participate both in the workforce, and in medical leadership.

While the argument can be made purely on equity grounds, there is a greater and more compelling argument for boosting female participation in medical leadership.

A growing body of literature suggests that strong female leadership at senior management and board level is associated with better performance. A diverse, representative board is more engaged with their stakeholders, and benefits from the broad experiences and fresh perspectives that are introduced.

Logic says that a leadership structure made of up people with different strengths, skills, lifestyles, backgrounds and passions leads to a more productive organisation with more engaged leaders. This, in turn, leads to better decision making with more positive outcomes.

Strong female leaders will continue to seek out leadership opportunities. They will plan their career and embrace the challenges that come with medical leadership, as have those who have become before them.

It is not the female leaders that I am proposing need assistance – these are the women we should be celebrating. We instead need meaningful, systemic, and whole-of-profession change that both acknowledges and addresses inherent gender bias in medicine.

Diverse leadership can surely only strengthen the decision-making and organisational strength of our health system, and it should be the job of the profession to cultivate the leaders we believe we need.

So I am calling on all of you, as AMA members and as members of our profession to examine the environment around you. Be a champion for gender equity in medical leadership and in your professions. Celebrate the skills that your trainees bring to your organisations, and recognise and cultivate the leadership potential in all that hold it - regardless of gender.

INFORMATION FOR MEMBERS

FEDERAL AMA FUTURE LEADERS PROGRAM

CALL FOR APPLICATIONS

One of the roles of the AMA is to develop the future leaders of the medical profession. In keeping with this, Federal AMA is launching a program for future leaders in which the successful applicants will spend a weekend in Canberra learning about the intricacies of the Federal political process, the development of AMA policy, working with media and political decision-makers.

The program will be held on 6 and 7 August at AMA House in Canberra. Federal AMA will fund travel and accommodation for 12 attendees.

Eligibility

To be eligible you must be a financial member of the AMA and have taken on a leadership position within the past five years in a State AMA or the Federal AMA. This might include membership of an AMA committee or working group, an AMA board or council. Applicants with a strong interest in the development of medico-political health policy and advocacy within the AMA are encouraged to apply.

Selection

Selection will be by competitive application against the criteria in the application. The decision will be made by the Policy Executive of Federal Council after a shortlisting process undertaken within the secretariat.

Application

An application can be downloaded at https://ama.com.au/sites/default/files/AMA_Future_Leaders_Program.docx. All applications must be submitted to AMA secretary General, Anne Trimmer, via Lauren McDougall (lmcdougall@ama.com.au) no later than 31 May 2016. A decision will be made by 30 June 2016.

Teaching doctors how to live

BY **ELISE BOISSON**

From the day I sat my first interview for medicine, there was a decision to be made about what place medicine would take in my life. The interviewer asked how I felt about personal sacrifice in medicine, given that the degree was difficult and time consuming, and that it would take away time I could have spent with friends, parents and siblings.

> "I knew from the outset that commitment would mean long hours, a long training pathway and moving a long way from home, and those remain sacrifices well worth making in order to become a better doctor"

There seem to me to be two types of answers that an applicant could give. The first, that they're committed to sacrificing whatever is necessary in order to be a doctor. The second, that they're committed to doing whatever is necessary to strike a successful balance between medicine and the other parts of their life.

As is the case with so many who've entered the medical profession before me, I'm driven by a commitment to providing the best possible patient care.

I knew from the outset that commitment would mean long hours, a long training pathway and moving a long way from home, and those remain sacrifices well worth making in order to become a better doctor.

Unfortunately, I've seen this same commitment to medicine drive medical students and doctors alike into the ground. The 2013 *beyondblue* study of doctors and medical students, now well known to many of us, highlighted the impact of stressful and demanding work on a dedicated profession. One in 10 doctors reported having had suicidal thoughts in the 12 months prior to the study; for medical students, that number was one in five.

I have the great privilege this year of hearing the views of medical students all around the country. I've frequently heard that even during a medical degree, there are rotations where students find balancing hospital hours with time to study, exercise, eat a reasonable diet and get a serviceable amount of sleep a challenge. That balance will only get more difficult as they progress through medical training. As students develop their habits around work and wellbeing, they look to interns, registrars and consultants to set an example of what being a good doctor looks like.

Doctors have a great deal of influence in teaching those junior to them, and those lessons aren't limited to anatomy and physical examination.

When doctors promote doctors' wellbeing as important, that shapes the way wellbeing is seen in that team all the way down to the student. Similarly, doctors who make sure their teams are aware of initiatives such as the Doctors' Health Advisory Service, shape the ability of their juniors to seek help when it's needed.

Sitting in that first medical interview, I said I'd do whatever it takes to become a good doctor. Today, I know that no small part of 'whatever it takes' is prioritising personal wellbeing. I have some outstanding doctors to thank for that understanding; watching the example they set shapes the way I live and work.

The statistics tell us just how high the stakes are in making doctors' wellbeing a priority.

You too will set an example that influences the lives and livelihood of those around you; give thought to the lessons you want to teach.

Email: elise.buisson@amsa.org.au

Twitter: @elisebuisson

Rural internet as useful as a blunt chainsaw

BY DR DAVID RIVETT, CHAIR, AMA RURAL MEDICAL COMMITTEE

As a long time rural internet user, I was shocked when going online in Hong Kong last December.

No time was wasted watching an arrow endlessly circling, nor were there long pauses where one is forced to consider taking up smoking or knitting to pass the time while switching between screens. Just click, and the next screen is there faster than one can blink.

The internet is a big part of our lives, and essential to our provision of health care. It enables us to learn from the most current resources, explore treatment options, watch demonstrations of procedures and attend live discussions with experts. It permits our patients to receive specialist care online, and is the backbone for the My Health Record.

Soon, it will lessen the burden of obtaining authority prescription - online authorisation is around the corner after much AMA lobbying to minimise the time currently wasted.

While I never expect those of us outside the big cities to be provided with a service matching speeds provided to inner city residents, we should at least get a half decent service and costs per gigabyte similar to city users - not 20 times more expensive, as recently outlined in The Land.

I have a mate who gets up at 2am to post his online billing to NSW Health. Their system is one from the Dark Ages, designed to save their accounting department time and money with no realisation that with tortoise speed rural internet it is a pain in the derrière for all those using it.

Assumptions are made that we have oodles of time to waste in rural Australia, when the reverse is true.

We want to spend more time on fun and families, not online with clunky unfriendly software battling to overcome a very slow internet system.

Having to get up at 2am to get a speedy connection is just cruelty.

So we have a double whammy - poor internet speeds that waste our time, and higher costs per GB for the lousy service we get.

Currently, consumer protection laws give some protection for fixed line phone users. But there is none for mobile and internet users in rural locations.

The Government has admitted change is needed, and is seeking the Productivity Commission's direction on reforms. This cannot come too soon.

So, next time you find poor connectivity is annoying the hell out of you don't waste the moment. Get online to your local Federal Member and express your frustrations.

Just as a blunt chainsaw wastes fuel and time, lousy internet connectivity at high cost lessens our output as rural doctors.

Assisted dying up for debate

BY DR MICHAEL GANNON

At this year's AMA National Conference, I will be chairing a Q&A session on assisted dying (euthanasia and physician assisted suicide) as part of the AMA's five-year policy review.

The session will be facilitated by Tony Jones, the compere of the ABC's Q&A program, and features a panel including Dr Karen Hitchcock and Associate Professor Mark Yates, two medical practitioners who oppose doctor involvement in assisted dying, and Professor Bob Douglas and Professor Malcolm Parker to advocate the contrary view. Medico-legal expertise will be provided by Avant's Georgie Haysom.

While fully acknowledging the growing political and community interest in assisted dying, this Q&A session has been specifically designed to facilitate an intra-professional discussion – giving doctors the opportunity to discuss among their colleagues whether the medical profession should, or should not, be involved in assisted dying (were it to become legal in Australia).

Only medical practitioners will be allowed to ask questions during the session, though we have invited interested individuals outside the profession to attend and observe.

The issues raised during the session will be considered in the wider policy review, and a summary of the session will be prepared for a future edition of *Australian Medicine*.

The AMA member survey on euthanasia and physician assisted suicide has now closed. Thank you to all those members who completed the survey.

We received more than 3500 responses, which will need to be collated and analysed. Members will be kept informed of the survey results, which will be used to inform the review.

I would like to take this opportunity to assure all members that the AMA has made no commitment to change, nor to retain, the current policy on assisted dying.

I have heard from members opposed to assisted dying who fear our member consultation, particularly the member survey, indicates the AMA has already made a commitment to change our policy.

Ironically, I have also heard from members who support assisted dying that the AMA has already decided to retain the current policy, and that efforts to consult the membership are not serious.

Neither is true. We have not, and will not, pre-empt any policy decision.

What we have done is be careful and respectful of differing views. I have declined personal invitations to speak to organisations on 'either side of the debate'.

Over the years, the AMA has been criticised by members (and others) for not surveying members on assisted dying. When the time came to review the policy as part of our five-year review cycle, we considered it imperative that all members have the opportunity to be heard on this very important issue.

As I have highlighted previously, we are providing a variety of opportunities for members to express their views – from the call for open-ended comments on current AMA policy in Australian Medicine last year, to the member survey and the National Conference Q&A session.

In addition to member consultation, we will consider issues such as national and international views and legislative initiatives in relation to assisted dying, and will consult with other medical organisations within Australia.

The AMA Federal Council will decide on the final policy direction, and members will be kept informed of those decisions.

Please be assured that we are doing our best to facilitate this process as fairly, and as transparently, as possible for our members. If you have any questions regarding the review, please do not hesitate to email them to ethics@ama.com.au.

For more information on the 2016 AMA National Conference, please refer to the AMA website at ama.com.au. This site includes information on how to register for the conference and information specific to the Q&A session on assisted dying including panel biographies.

Cheaper drugs a path to better health

BY **AMA PRESIDENT PROFESSOR BRIAN OWLER**

Medicines save lives and improve health and wellbeing when they are available, affordable, and properly used.

With Aboriginal and Torres Strait Islander people experiencing double the rate of chronic illnesses than their non-Indigenous peers, access to affordable prescription medicines is essential. Unfortunately, Aboriginal and Torres Strait Islander people are not accessing medicines at a level that is appropriate to their needs, with cost being reported as a major barrier.

> "While the outcomes under this measure have been encouraging, there is still a long way to go until we achieve equality in access to medicines for Aboriginal and Torres Strait Islander people"

As evidenced by the Closing the Gap (CTG) Pharmaceuticals Benefits Scheme (PBS) Co-payment measure, reducing out-of-pocket costs for medications increases access to, and use of medications, ultimately resulting in improved health outcomes.

Since its inception in 2010, the CTG PBS Co-payment measure has increased access to medicines for more than 280,000 Aboriginal and Torres Strait Islander people in urban and rural areas, by reducing or removing the patient co-payment for PBS medicines. Substantial reductions in hospitalisations have also been seen in areas with the greatest uptake of the CTG PBS Co-payment incentive.

While the outcomes under this measure have been encouraging, there is still a long way to go until we achieve equality in access to medicines for Aboriginal and Torres Strait Islander people.

A good starting point is to promote the CTG PBS Co-payment more widely to all prescribing doctors across Australia, to increase awareness and uptake of the initiative and build on its success.

In August 2012, *Australian Doctor* reported that, alarmingly, thousands of doctors were unaware of the existence of the CTG PBS Co-payment measure – an important initiative that has the potential to make a real contribution to closing the gap.

With chronic diseases being one of the main reasons for the life expectancy gap between Indigenous and non-Indigenous people, it is unacceptable that so many Australian doctors are unaware of such an important scheme.

Doctors working in Aboriginal and Torres Strait Islander Community Controlled Health Services are generally aware of this initiative, and regularly prescribe medications covered by the CTG PBS Co-payment measure for the benefit of their patients. However, many doctors working in mainstream general practice may not be aware of this scheme.

To participate in the CTG PBS Co-payment measure, practices must be able to first identify eligible Aboriginal and Torres Strait Islander patients. All patients across Australian medical practices should be asked whether they identify as being of Aboriginal and Torres Strait Islander origin by asking the National Standard Identification question - 'Are you of Aboriginal or Torres Strait Islander origin?' Once Indigenous patients are recognised, they are eligible to be registered for co-payment assistance.

Improved access to medicines is critically important if we are to see generational change in health outcomes for Aboriginal and Torres Strait Islander people.

The Australian Medical Association encourages all medical practitioners to increase their awareness of the CTG PBS Co-payment measure to improve health outcomes for Aboriginal and Torres Strait Islander patients.

Public hospitals need more than drip feed

BY AMA PRESIDENT PROFESSOR BRIAN OWLER

At the COAG meeting on 1 April, the states and territories reluctantly signed up to the Commonwealth's 'take it or leave' it offer of $2.9 billion additional funding for public hospitals over three years to June 2020.

This as an inadequate short term public hospital funding down-payment to appease desperate states and territories ahead of the Federal election.

The AMA has consistently argued Australia's public hospitals are under pressure and not meeting key performance benchmarks, as clearly shown in the AMA's 2016 *Public Hospital Report Card*.

The additional funding agreed at COAG will help relieve some pressure, but will not be sufficient to meet the demand for services. Providing a small amount of additional funding for three years goes nowhere near meeting the long term needs of the nation's public hospitals, and falls well short of replacing the funding taken away from the states in the 2014 Federal Budget.

Under the new agreement, to operate until June 2020, the Commonwealth will fund 45 per cent, rather than 50 per cent, of growth funding, and it will be capped at 6.5 per cent of growth. If growth exceeds 6.5 per cent, the Commonwealth will adjust its contribution. Exactly how the growth cap will operate is yet to be determined.

The Independent Hospital Pricing Authority (IHPA) will continue to set the National Efficient Price and Cost (NEP and NEC) for use with activity based funding (ABF). The continued use of ABF is clearly preferred to the Commonwealth's original decision to switch to annual indexation by CPI and population growth. However, ABF and the NEP, as currently implemented, have shortcomings.

The AMA has advocated that these shortcomings should be addressed, including the need to give appropriate regard to quality, performance and outcomes; to remove the focus on reducing costs to the lowest common denominator; and to ensure the NEP methodology does not lock in the historically low costs of an underfunded and underperforming system and provides for adequate indexation.

The Agreement reached at COAG includes other reforms which either will or may be funded from public hospital funding. These include chronic disease coordinated care trials, a model to integrate quality and safety into hospital pricing, and a mechanism to reduce avoidable readmissions.

The starting point for these additional matters should be that any worthwhile proposals are funded in their own right, and not by retention of public hospital funding.

For example, penalising hospitals for not meeting safety and quality standards is counterproductive. Inadequate resource levels are a key factor in poor safety and quality, and reducing resources further simply compounds existing problems.

The Health Financing and Economics Committee considered these issues at its meeting on 26 April. It agreed that key points to guide AMA advocacy on public hospital funding over coming months, including the expected election period, should include:

- the need for significant new investment in public hospital funding, with the reinstatement of the reductions to the NHRA funding as an upper benchmark;
- a long term plan that provides certainty of sufficient funding for at least a decade, and removes hospital funding from vulnerability to the short term political cycle;
- essential improvements to ABF and the NEP process, as consistently identified and advocated by the AMA; and
- detailed information on proposed reform initiatives referred to in the 1 April Agreement, and clear confirmation they will be funded in their own right, not by the diversion of public hospital funding.

The Committee also agreed that AMA advocacy on public hospital funding will be strengthened by using practical clinical examples and mini-case studies that illustrate the impact of under-funding in ways that are directly accessible to the general public.

If you have come across such examples, either working in hospitals or that may have affected your patients receiving hospital services, please let us know and help strengthen the AMA's advocacy for public hospital funding.

Industrial Relations: who looks after you?

BY PROFESSOR GEOFFREY DOBB, PRESIDENT, ASMOF, AND FORMER AMA VICE PRESIDENT
DR RODERICK MCRAE, AMA FEDERAL COUNCILLOR FOR PUBLIC HOSPITAL DOCTORS AND DEPUTY SECRETARY/TREASURER, ASMOF
DR TONY SARA, VICE PRESIDENT, ASMOF

The government-engendered doctors' dispute in Queensland and the distasteful ongoing junior doctor dispute in England demonstrate why there is a need for an organised response by our profession to unreasonable attacks on doctors' terms and conditions of employment.

This is especially important when governments are unwilling to engage in meaningful negotiations.

One of the benefits of being an AMA is the representation it provides for doctors who are salaried employees in hospitals and other organisations.

The industrial relations scene is constantly changing across all Australian jurisdictions. Federally, the 'rules of the game' are now being set by Fair Work Australia.

One of the constants has been the Australian Salaried Medical Officers Federation, which on 22 May will mark its 25th year in operation.

As long ago as 1977 the AMA adopted a policy that industrial representation of medical practitioners should occur through organisations consisting solely of medical practitioners, rather than conglomerate unions that include non-medical members.

Most industrial representation occurs at the State and Territory level with State and Territory employers, though the model varies around the country.

In Queensland, New South Wales, Victoria, Tasmania, and the Northern Territory there is a conjoint arrangement between the AMA and ASMOF, while in Western Australia the AMA alone has coverage, and in South Australia and the ACT ASMOF acts as a stand-alone union.

The stimulus to form a national organisation to represent the interests of doctors in the Federal jurisdiction came from a ruling of the High Court of Australia which struck out the view that employees in certain occupations, including salaried doctors, could not be parties to industrial disputes falling within the jurisdiction of Federal industrial tribunals.

The AMA President and Federal Council of the day recognised the importance of the decision and the opportunity it and, after extensive discussions with the State and Territory entities representing salaried doctors, ASMOF was formed on 16 December 1984. An application for recognition under the then relevant Conciliation and Arbitration Act was then lodged on 23 January 1985.

The application was strongly opposed by a number of large (non-medical) trade unions, so it took until 1991 for ASMOF to receive registration. This came after protracted negotiation and a successful outcome to litigation.

The first ASMOF President was the late South Australian orthopaedic surgeon Dr Lloyd Coates, who was also for many years the Salaried Doctors representative on Federal Council.

An article, 'ASMOF Heralds New Era for Industrial Relations', appeared in Australian Medicine on 2 September 1991.

It provided the historical context for ASMOF's first Federal Council meeting, and a picture of Council members appeared on the front cover. The final paragraph of the report of the meeting remains as relevant today as it was then:

"The AMA, together with its various state branches and the medical unions, is cooperating with ASMOF in developing conjoint membership arrangements. These arrangements are seen not only as an essential vehicle for the recruitment tasks faced by the new organisation, but also as an expression of mutual commitment to united and coordinated representation of the medical profession by its members".

The conjoint arrangements still exist with the Federal AMA and most States and Territories. The arrangements are currently under their regular periodic review for renewal.

Over the last 25 years there have been many twists and turns in the industrial relations landscape, and who knows what more will come over the next five, 10 or 25 years?

ASMOF remains an essential part of the representation of salaried doctors, working with the AMA and the state organisations to ensure that terms and conditions of employment are well looked after – essential for peace of mind, and more than repaying the cost of AMA membership, which in most States includes conjoint ASMOF membership.

Hospitals, doctors in gun sights

The AMA has joined international calls for combatants to respect the neutrality of health workers and medical facilities amid widespread outrage at an attack on a Syrian hospital that has reportedly left at least 55 dead and 60 injured.

AMA Vice President Dr Stephen Parnis said it was "unacceptable" that health professionals and facilities were being targeted in armed conflicts in many parts of the world, most recently in Syria.

> "It is the duty of the international health community to speak out and protect the non-discriminatory provision of health care to all those in need." - *Dr Stephen Parnis*

"It is unacceptable that health personnel and facilities are ever regarded as legitimate targets," Dr Parnis said. "It is the duty of the international health community to speak out and protect the non-discriminatory provision of health care to all those in need."

The AMA Vice President was commenting following a recent spate of deadly attacks on hospitals and clinics in strife-torn parts of the world, including Syria and Afghanistan, in which hundreds of patients, doctors, nurses and other health workers have been killed and injured.

In one of the most recent incidents, Syrian Government forces were blamed for killing at least 55 people and injuring 60 late last month after launching an air strike on the al-Quds Hospital in Aleppo.

Several doctors and nurses were among those killed in the attack on the hospital, including one of the city's few remaining paediatricians, Dr Mohammed Wassim Maaz.

A spokeswoman for Medicins Sans Frontieres (MSF) which, along with the International Committee of the Red Cross (ICRC), has been supporting the hospital, told *The Guardian* that 95 per cent of doctors from opposition-held parts of Aleppo had fled or been killed, leaving fewer than 80 doctors to care for around 250,000 still living in the war-torn city.

The al-Quds Hospital is the latest in a string of attacks on medical facilities. According to media reports at least seven MSF-supported hospitals and clinics have been bombed since the beginning of the year, and the US Government has punished 16 military officers over a deadly airstrike on a MSF hospital in the Afghan city of Kunduz last year in which 42 people, including 13 doctors, nurses and other health workers, were killed.

In a report on the incident released late last month, the Pentagon blamed a chain of human errors and failures of procedures and equipment for the attack, but rejected accusations from MSF that it amounted to a war crime.

MSF is furious that the hospital was bombed despite the fact all combatants had been notified of its location, and that the attack continued despite repeated calls from the medical charity to the US military alerting it to the fact it was bombing a medical facility.

The military personnel involved, including a general, will not face criminal charges and will instead receive a range of "administrative actions" including suspension, letters of reprimand and removal from command.

The ICRC, the World Health Organisation and the World Medical Association have in recent years been sounding increasingly loud warnings about the incidence of attacks on health workers and medical facilities.

Late last year they issued a joint call for governments and non-state combatants to adhere to international laws regarding the neutrality of medical staff and health facilities, and ensuring this commitment is reflected in armed forces training and rules of engagement.

The ICRC, through its Health Care in Danger project, recorded 2398 attacks on health workers, facilities and ambulances in just 11 countries between January 2012 and the end of 2014.

Disturbingly, while many incidents involved health workers and facilities caught in cross-fire or being hit in indiscriminate attacks, the ICRC has also identified numerous incidents where they have been deliberately targeted.

Governments attending the 32nd International Conference of the Red Cross and Red Crescent last December reaffirmed their commitment to international humanitarian law and a prohibition on attacks on the wounded and sick as well as health care workers, hospitals and ambulances, and the ICRC is also working with non-state combatant groups to raise awareness of laws and conventions around the protection of patients, health workers and medical facilities.

ADRIAN ROLLINS

Deadly stomach bug exacts heavy toll

Health experts have called for redoubled efforts to control one of the world's most common stomach bugs amid revelations that it kills 212,000 a year and costs more than $US64 billion in health care and lost productivity.

Research has found that the norovirus is the most common of cause of diarrhoea attacks in the world, is the second-most common cause of severe gastroenteritis in young children, and is involved in many outbreaks of mass food poisoning, hospital-acquired infections and stomach upsets in travellers.

A collection of studies coordinated by the Public Library of Science to highlight the global impact of the highly-contagious norovirus has found that the infection is ubiquitous across low-, middle- and high-income countries, and is a major social and economic burden.

One of the studies estimates that norovirus costs $US4.2 billion a year in direct health system costs, and inflicts an additional $US60.3 billion in societal costs, principally as a result of lost productivity from workers being ill themselves or having to care for a sick child.

Diarrhoeal disease has long been acknowledged as a major killer, particularly of young children, and the PLOS Collections research reported that the widespread use of a vaccine for the rotavirus had resulted in a significant decline in related deaths. Global deaths from diarrhoea halved in 23 years, from 2.6 million a year in 1990 to 1.3 million in 2013, and it now ranked fourth globally as a cause of mortality.

But the research found that while the rotavirus threat has declined sharply, norovirus remains a major pathogen. It was estimated to cause 684 million diarrhoeal attacks a year.

Children are the most at risk. The highest incidence of the disease is among children younger than five years, who are also the most important group in driving transmission in the community. The disease is estimated to kill about 70,000 young children a year.

But the perception that norovirus is largely a problem for low- and middle-income countries is mistaken, the PLOS Collection research shows. Its prevalence is roughly similar regardless of the wealth of a society.

But whereas in developing nations it is primarily a problem for the very young, in wealthier countries it is also afflicts the elderly – reflecting longer life expectancies. In Europe, for instance, around 62 per cent of infections are among young children, but almost 17.5 per cent occur in the over-55 age group – and this age group accounts for 72 per cent of all norovirus deaths in the region.

The authors of the PLOS report argue the disease's huge social and economic impact underlines the urgent need to develop a vaccine.

Noroviruses are a diverse group of pathogens, and although understanding of immunity to the disease is incomplete, it is believed that any immunity people develop is specific to a particular strain, and last no longer than about nine years.

Because of these characteristics, it is expected that a polyvalent vaccine updated as new strains emerge will be needed to provide protection.

Recent advances in developing a robust in vitro cell culture system for the virus has raised hopes for the rapid development of a vaccine, particularly one suitable for children.

ADRIAN ROLLINS

Ebola crisis: the world must do better

The reputation of the global system for preventing and responding to infectious disease outbreaks has taken a battering in the wake of the west African Ebola epidemic.

Yet a prestigious Independent Panel believes it is possible to rebuild confidence and prevent future disasters, releasing a roadmap of 10 interrelated recommendations for national governments, the World Health Organisation, non-government organisations and researchers.

The Independent Panel on the Global Response to Ebola, launched jointly by the Harvard Global Health Institute and the London School of Hygiene and Tropical Medicine, spent months reviewing the worldwide response to the outbreak that began in 2013.

"The west African Ebola epidemic ... was a human tragedy that exposed a global community altogether unprepared to help some of the world's poorest countries control a lethal outbreak of infectious disease," the Panel wrote in The Lancet.

"The outbreak continues ... It has infected more than 28,000 people and claimed more than 11,000 lives, brought national health systems to a halt, rolled back hard-won social and economic gains in a region recovering from civil wars, sparked worldwide panic, and cost several billion dollars in short-term control efforts and economic losses."

The Panel said its goal was to convince high-level political leaders worldwide to make necessary and enduring changes to better prepare for future outbreaks while memories of the human costs of inaction remained vivid and fresh.

It identified four key phases of inaction:

- December 2013 to March 2014, when Guinea's lack of capacity to detect the virus allowed it to spread to neighbouring Liberia and Sierra Leone;
- April to July 2014, when intergovernmental and non-government organisations started to respond, health workers struggled to diagnose patients and provide effective care, national authorities played down the scope of the outbreak, and WHO and the US CDC sent expert teams but withdrew them prematurely;
- August to October 2014, when global attention and responses grew, but so did panic and misinformation, leading to unnecessary and harmful trade and travel bans; and
- October 2014 to September 2015, when cases began to decline, and large-scale global assistance started to arrive, albeit with weak coordination and a lack of accountability for the use of funds.

"This Panel's overarching conclusion is that the long-delayed and problematic international response to the outbreak resulted in needless suffering and death, social and economic havoc, and a loss of confidence in national and global institutions," the Panel said.

"Failures of leadership, solidarity and systems came to light in each of the four phases. Recognition of many of these has since spurred proposals for change. We focus on the areas that the Panel identified as needing priority attention and action."

The Panel made 10 recommendations:

- develop a global strategy to invest in, monitor, and sustain national core capacities;
- strengthen incentives for early reporting of outbreaks and science-based justifications for trade and travel restrictions;
- create a unified WHO Centre for Emergency Preparedness and Response with clear responsibility, adequate capacity, and strong lines of accountability;
- broaden responsibility for emergency declarations to a transparent, politically protected Standing Emergency Committee;
- institutionalise accountability by creating an independent Accountability Commission for Disease Outbreak Prevention and Response;
- develop a framework of rules to enable, govern and ensure access to the benefits of research;
- establish a global facility to finance, accelerate, and prioritise research and development;
- sustain high-level political attention through a Global Health Committee of the Security Council;
- a new deal for a more focused, appropriately financed WHO; and
- good governance of WHO through decisive, time-bound reform, and assertive leadership.

"The human catastrophe of the Ebola epidemic that began in 2013 shocked the world's conscience and created an unprecedented crisis," the Panel concluded.

"The reputation of WHO has suffered a particularly fierce blow. Ebola brought to the forefront a central question: is major reform of international institutions feasible to restore confidence and prevent future catastrophes? Or should leaders conclude the system is beyond repair and take ad hoc measures when the next major outbreak strikes?

"After difficult and lengthy deliberation, our Panel concluded major reforms are warranted and feasible."

MARIA HAWTHORNE

AMA pressure on Government to act

It was during the third phase of the Ebola outbreak that AMA President Professor Brian Owler, other health groups, and the international community began putting pressure on the Australian Government to directly contribute to the fight.

"When organisations such as the CDC and WHO start talking about 1.4 million cases, this is not something where we can stick our heads in the sand, it's not something that we can ignore as a country," Professor Owler said on 10 October 2014.

"But there is also a role here for the Australian Government to put the resources in to facilitate and resource our teams to go and do work in a coordinated fashion to support our colleagues in Sierra Leone, Liberia, and Guinea, to make sure that we control the crisis that's occurring there."

A fortnight later, with still no Australian Government action, Professor Owler expressed his frustration on Sydney radio 2UE.

"Well, look, I really can't understand it. I'm not sure whether there's some political problem, where they're worried about the consequences should someone become infected and the political consequences of that," Professor Owler said.

On 5 November 2014, then Prime Minister Tony Abbott acceded to the pressure and announced a $20 million contract with Canberra-based private provider Aspen Medical to operate a 100-bed Ebola treatment centre in Sierra Leone.

MARIA HAWTHORNE

Driving fatigue

BY **DR CLIVE FRASER**

Doctors are very well acquainted with what it's like to work long hours under pressure.

The experience begins in the undergraduate years with what seems like a Herculean effort to keep passing all of those exams.

By my second year as a medical student, I didn't even sneeze when the anatomy lecturer said that we could be examined on anything at all from the 820 pages of Gardner, Gray and O'Rahilly's textbook - that is, except for anything about teeth.

Looking for some respite, I quickly flicked through the pages to find that Chapter 61's description of teeth was only eight pages long, leaving another 812 pages to memorize.

On my first day as a resident in a hospital with 300 beds I was rostered to do the 4pm to midnight shift in Casualty, with the last two hours in the hospital on my own.

That was until a phone call just before midnight to tell me that the night RMO had called in sick and that I'd need to work on my own until 8am.

Fast forward to life as a hospital registrar with the once-a-week 8am to 5pm (the next day) shift.

Or worse still, the monthly 8am Friday until 5pm Monday mix of on-duty and on-call.

The words "proximate" and "remote" don't quite convey how gruelling the work was.

Of course, there was no possibility of complaining about the hours worked. The threat of not having a position in the following year would silence any complainers.

You are most vulnerable to fatigue when you don't get enough sleep, you work at night, are awake for long periods of time, or some combination of the above.

But my experiences pale in comparison to the hours involved in some forms of surgery.

One well-known neurosurgeon recently found his gown dripping with saline and blood after a 14-hour operation.

He commented, "Oh my God, it looks like I wet myself", only to then find himself the subject of an AHPRA investigation when his off-the-cuff comment was taken literally.

Thankfully, heavy vehicle drivers can attend to calls of nature in a more timely fashion, compliments of the Heavy Vehicle National Law (2012).

After 5¼ hours of work they can take a 15 minute break or, if they choose to keep working, they must have a 30 minute break after 7½ hours or at least a one hour break after 10 hours.

They also must have a full seven hours of rest every 24 hours, and can't work for longer than a total of 12 hours in that period.

There are heavy penalties for not taking the stipulated rest breaks, and all of this is recorded in a National Driver Work Diary for verification.

That is, of course, everywhere in Australia except for Western Australia and the Northern Territory, where they presumably don't drive long distances.

Oh, by the way, any hours spent waiting to be loaded and not resting in a bed are all counted as work hours.

The fatigue-regulated heavy vehicles that this legislation applies to includes any truck with a gross vehicle mass (GVM) over 12 tonnes and buses over 4.5 tonnes with a seating capacity of more than 12 adults (including the driver).

There are very good reasons for preventing fatigue on the road, as truck drivers are more than 12 times as likely to be killed on the job compared with the average worker.

This easily makes road freight transport Australia's most dangerous job. It carries a 50 per cent greater risk than farming, which is our next most dangerous occupation.

The community expects that pilots and truck drivers are taking enough breaks to ensure they are performing well and are not fatigued.

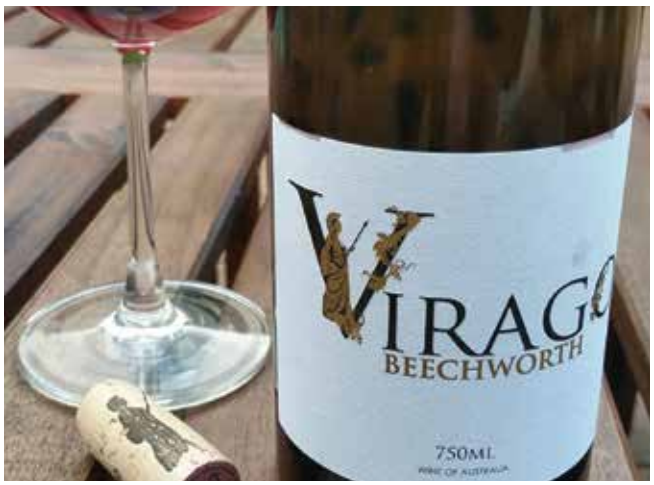
Undoubtedly, fatigue management practices have improved in medical workplaces, but as I recall it, this change has always lagged behind other industries, which is just not good enough.

Safe motoring,

Doctor Clive Fraser
doctorclivefraser@hotmail.com

Nebbiolo – lifting the fog

BY DR MICHAEL RYAN



Why Nebbiolo? I asked this question of Karen Coats and Dr Prue Keith, owners of Virago Estate in Beechworth, Victoria. They both replied that the serendipitous exposure to this red grape variety left an alluring wine experience, something akin to the sirens of Homer's Odyssey.

Why Nebbiolo? It's such a finicky, lesser-known red grape that is tricky to grow, with early bud burst and late ripening often requiring soils dominated by calcerous marls. It requires meticulous hands-on effort.

Perhaps Karen, an ex-tax accountant, Dr Prue, a practicing orthopedic surgeon and winemaker Ric Kinzbrunner (owner of Giaconda), a retired Engineer, had between them enough OCD to tackle these vagaries.

Nebiollo is an ancient grape first mentioned in the 13th century. The Italian word for fog is "nebbia". This probably refers to the fog-like cover of the skins of the dark gray Nebbiolo grape. It has been suggested that the reference is to the valley in Piedmont as the fog rolls in in late autumn.

The Piedmont region in north-western Italy sits at the foot of the Alps and is home to sumptuous foods, including truffles. Barolo and Barbaresco are the most lauded of Nebbiolo "Cru" regions. It is Burgundian-like in its classification restrictions, and in the way it marries traditional food and wine. There is a comparison with Pinot Noir, which is another finicky grape that rewards its grower with tantalizing bouquets and multi-layered structural elements.

Why Nebbiolo? It seems fitting that an ancient grape variety is finding its place in the ancient soils of Beechworth. This pocket of paradise must surely be tied in a kindred spirit to Burgundy and Piedmont. Beechworth exudes its own array of amazing local produce and wine producers, including some of the country's best vignerons, such as Savaterre, Castanga and Giaconda. Just like Piedmont, the fog forms in the valleys of Beechworth after picking season.

Karen and Dr Prue are the type of wine growers who keep passionate authors writing about wine. There is the enthusiasm and pride of newly expectant parents. There is the sense of focus and determination. There is the sense of artistry in producing Nebbiolo. In 2007, 2100 vines were hand planted and organic principals are called upon - but not as a definitive process. It's what Karen and Dr Prue believe is best for the vines and, hence, the wine.

I firmly believe that Nebbiolo is the next journey of discovery in wine in Australia. Merlot had a run but pulled up lame. Shiraz and Cabernet Sauvignon are still powerful in their own right. Wines like Nebbiolo, Pinot Noir and Riesling are renowned for expressing their terroir. To me, this means that these wines are guided by the winemaker and, when drunk, transport you to the birthplace of the vine.

WINES TASTED

1. 2011 Virago Nebbiolo Beechworth

Light garnet, with tinges of brown in couloir. The initial bouquet includes rose petals, sundried fruits and herbs. A complex vanillin aroma hides in the background. An hour after opening, the bouquet developed into dusty glazed cherries, rose petals and some earthy funk characteristics. An amazing transformation. The palate dances and flitters on the taste buds. It surfs easily over the palate, with supporting tannins and acidity. Will cellar for a decade. Have with thyme-roasted Pousson.

2. 2012 Virago Nebbiolo Beechworth

Brighter garnet in color, exuding youth. Brighter red fruits, with essence of smoky notes. As the wine opened up, candied fruits with herbal notes, more delicate than a Grenache, were released. This is quite a youthful, camouflaged beast of a wine. The wine stands up boldly in the anterior palate then pauses slightly, enough to give space for the structured tannins to shine. Cellar 15 years or more. Have with wild duck pie.

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