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Private health insurance, shop around

AMA releases its PHI Report Card, p6

INSIDE

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AMA LEADERSHIP TEAM

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Dr Michael Gannon

Vice President
Dr Tony Bartone

In this issue

Freeze just the tip of the health iceberg

BY AMA PRESIDENT DR MICHAEL GANNON

The headline health issue for some time now has been the harm caused to patients (and doctors' practices) by the long-running freeze on Medicare patient rebates, and the need for it to be unravelled as soon as possible.

With the Federal Budget looming, the speculation in Canberra is no longer about whether or not the Government will end the freeze. The political reality is that the Government has to end the freeze if it wants any chance of winning the next election.

And that has now become the public stance of the Prime Minister and the Health Minister. It is not a question of if. It is a question of when.

There will be an announcement in the Budget. What is not known is the date of when the freeze will be lifted, and how far across the medical profession will the freeze lift extend.

I have had a number of discussions with the Minister pushing the AMA's preferred outcome – to lift the freeze across the whole MBS schedule, and for it to be implemented as soon as practicable (for the AMA, that means immediately). He has been very busy in what I am certain are difficult pre-Budget negotiations within Cabinet.

Minister Hunt is fully aware that the freeze affects not only patients attending GPs, but other specialists as well. And he knows that it is just one of the elements putting more pressure on the value proposition of private health insurance. It's a measure that is increasing the pressure on our public hospitals. It has effects across the entire health system.

The AMA has made it clear to the Government and the public – as we did with our Budget Submission – that fixing the freeze is the beginning, not the end, of health reform in the current political cycle.

Everything in the health system is interconnected – primary care, prevention, public hospitals, private health, medical workforce, the PBS, mental health, aged care, palliative care, electronic health, Indigenous health. The list goes on.

The Government is already working on reform in some of these areas, most notably the Health Care Homes trial, the MBS Review, and the PHI Review.

There is also important work underway in rural health and reviewing medical training.

But fixing the freeze is the breakthrough the Government needs to define its health policy narrative for the next two years and beyond. It will give them the clean air to negotiate other elements of their agenda.

The key theme must be looking at health policy and health funding as an investment, not a cost.

The Australian people sent strong health messages at the last election. They like Medicare. They like public hospitals. They like their doctors. They want easy access to affordable quality health care for themselves, their families and loved ones, no matter where they live and no matter their means.

That is the political reality. Australians care about health.

The AMA cares about patients, and we are the only body with the breadth of understanding of the entire health system to advocate for the best possible policies to ensure they get the care they need.

So, we want to work constructively with the Government. We want to move forward. And we are.

We agree that governments of all persuasions should aspire to balancing the Budget, but they must not keep cutting in areas like health, which can have devastating effects on working families and the disadvantaged.

The AMA is cooperating with all the Reviews, and the Government is starting to realise that there are not huge health dollars to be found hiding under a rock. But where there are genuine savings – savings that do not harm patients – we will help find them.

Health spending in Australia is not out of control. We just need to learn to spend it smarter. Invest in the things that are proven to work.

Minister Hunt understands this. He wants to put in place some long-term planning, especially in general practice and hospital funding.

To let the Minister pursue that vision, the Government must first remove the biggest impediment to progress – the Medicare freeze. And the sooner the better!

Future of PHI at a crossroads

BY **AMA VICE PRESIDENT DR TONY BARTONE**

With the impending price rise of private health insurance (PHI) premiums and the bombarding commercials that saturate our TV screens at the present time, it is opportune to reflect on PHI and whether it is still serving us well. More importantly, is it providing us with value and does it support the public health system in its very important complementary role of ensuring universal access to affordable health care?

The private health sector currently accounts for just under half of all hospital separations. Over recent years, a gradual shift has been occurring - from funds previously acting as passive payers, to active funders. The balance of power within the market is slowly shifting in favour of the insurers moving from a system of patient control to one more like managed care.

The prevalence of contracts with no-pay clauses (and patients unaware of this), with exclusions that have many potential unintended consequences, is increasing substantially.

Also, publishing certain information on websites with the medical practitioner's knowledge, including gap agreement usage, and average gap charges, allows for the establishment of closed shop referral databases (e.g. Bupa has a 'Find a Healthcare Provider' section of its website. Nib, Bupa and HBF are major shareholders of a system called Whitecoat, a database providing information on practitioner charging patterns.)

These types of websites have the potential for significant unintended consequences. The potential for reduced access to care is real, particularly for patients with chronic and complex health problems. They can also lead to the avoidance of high risk cases. Medibank's provision of information to the referrals database Healthshare will allow general practitioners to identify specialists who charge gap fees – and more importantly, those who are not part of Medibank's 'no gap' or 'known gap". This action could have a detrimental impact upon the referrals received by practitioners who are not part of Medibank's 'no gap' or 'known gap' schemes. It could influence the provision of services and determine who may provide services and set prices.

Vertical integration between insurers and providers is another case in point. Examples include: Medibank Private's move into primary care; Bupa now has two GP clinics, 200 dental, 30 optical businesses, and a new model of integrated care with GPs employed as a part of their aged care home teams. They also have a pilot model of home-based palliative care. A strong separation should exist between insurers and providers of care. It is a sensible safeguard to minimise possible conflict of interests inherent in a vertically integrated organisation.

PHI used to be run mainly by not-for-profit funds. However, about 70 per cent of the insured population is now covered by 'for-profit' funds, creating a greater need to ensure there are sufficient profits and resulting in increased premiums to ensure sufficient returns for their shareholders.

There is a need to ensure that private health insurance remains viable and attractive to consumers. If consumers withdraw from the private sector, demand for these services will move to the public sector, already overburdened and under-resourced.

Private health insurers should not determine who provides services in Australia and patients should not have the facilities available to them curtailed.

The current regulatory environment and the moves towards managed care mean that insurance offerings serve the needs of the PHI industry and not the needs of health consumers. PHI should provide choice for the patient. Without that choice, its value is diminished.

The AMA has consistently called for greater clarity. Last year the AMA released its first report card into PHI. The Government in part responded by establishing the Private Health Ministerial Advisory Committee. PHMAC was tasked with simplifying private health insurance. The variety of objectives included developing easy to understand categories for consumers, simplifying insurance policies into gold, silver and bronze, and addressing regulatory issues and increasing the cost of premiums.

The future of PHI is at a crossroads. With household income growth almost stagnant and healthcare costs growing around five to six per cent per annum - plus the enormous number of "junk" policies in the market - it is inevitable that PHI members are downgrading their coverage. Reforms are essential to lower costs. Of course the effects of the ongoing Medicare MBS freeze and its concomitant effects on PHI rebates only further compounds this situation. The complexity of the various policies, with more than 40,000 insurance variations available, is fertile ground for further disappointment. Action and planning are required to stem this exodus and reinstall value into PHI, and thereby support the universal access that underpins our public health system.

Looking at the ongoing value of private health insurance

BY **AMA SECRETARY GENERAL ANNE TRIMMER**

> "Coupled with product simplification, a working group of the PHMAC is looking at standardising clinical terminology, and a second working group is looking at the content of information provided to consumers."

One of the reviews instigated by former Health Minister Sussan Ley is the work underway by the Private Health Ministerial Advisory Committee (PHMAC), chaired by Dr Jeff Harmer AO. The PHMAC is tasked with examining several issues relevant to private health insurance. It was established by Minister Ley to look at the ongoing value of private health insurance (PHI) in the context of rising premiums, and followed a consumer survey in 2015, which received around 50,000 responses.

The main concerns identified by consumers were that:

- insurers do not pay an appropriate level of benefits for treatment (71 per cent);
- premiums are not affordable (58 per cent); and
- pHI does not cover the full range of services (44 per cent).

The PHMAC's initial work has been to look at product design in line with the simplified coverage announced by Minister Ley during the 2016 Federal election campaign. Simplified coverage would see gold, silver and bronze products offered with enhanced clarity on inclusions and exclusions, and the level of excess. The PHMAC is considering two approaches for possible recommendation to the Minister.

Coupled with product simplification, a working group of the PHMAC is looking at standardising clinical terminology, and a second working group is looking at the content of information provided to consumers.

Taken together the recommendations from PHMAC should considerably simplify PHI cover for consumers and make product selection more transparent and much less confusing. The AMA strongly supports a process that ensures value for PHI coverage, given the contribution played by private health as a key component of the Australian health system.

One of the peripheral issues raised for PHMAC consideration, but not yet dealt with, is the issue of transparency of doctors' fees. There will be increasing focus on this aspect of health expenditure in conjunction with greater transparency of the PHI coverage, hospital costs, and the cost of prostheses.

The AMA Federal Council considered the issue of fees transparency in a policy session at its most recent meeting. The AMA's long-held position is that a medical practitioner should be free to set his or her own fees. The AMA does not support the charging of excessive fees and AMA leadership over the years has spoken out on this issue. There are signs that the ongoing Medicare freeze is helping to drive up out of pocket costs with an increase from 10.2 per cent of services with a gap in 2013-14, to 14.6 per cent of services in 2015-16.

While the average gap is around $135, patients note the impact where there are multiple services with cumulative out of pocket costs.

Private health insurers are deploying online tools for fund members to understand the likely medical costs for a procedure, as well as hospital and other costs. These tend to be average costs but serve to provide basic information to a patient.

The AMA Federal Council considered ways in which more information might be made available to referring general practitioners to assist in selection of an appropriate specialist. The AMA will continue to consider different mechanisms to improve transparency in fees between medical practitioners. The time is right to do so.

Do homework before choosing private health insurance

AMA President Dr Michael Gannon has urged health insurance consumers to shop around.

Before buying private health insurance (PHI) or changing insurers, he said, consumers need to be assured they will get value for money.

"Too many Australians aren't getting value for money," he said, following the release of the *AMA Private Health Insurance Report Card 2017*.

"A lot are. Private patients admitted to private hospitals around Australia have normally got a very positive story to tell about the care they've received.

"But for too many people, when they get sick, when one of their loved ones gets sick, they either find they're not entitled to treatment in a private hospital, they're shipped off to the public hospital, or they're told that there's going to be a significant delay in treatment or significant out of pocket expenses.

"What the Report Card tries to do is give people an idea about which policies might suit them and their family best."

Dr Gannon said people should thoroughly research and compare the various and varied policies on offer to ensure they are getting value for money.

More importantly, he said, they should know exactly what they are covered for in the event of accident, illness, or injury.

"Australian families now contribute a substantial proportion of their household income towards private health insurance, so it is important they know exactly what they are getting from their investment," Dr Gannon said.

"Family budgets are under pressure with cost of living increases, which have been added to with the recent annual increase in PHI premiums.

"The *AMA Private Health Insurance Report Card 2017* provides consumers with clear, simple information about how health insurance really works.

"It shows that there are a lot of policies on offer, which provide significantly varying levels of cover, gaps, and management expenses. There are a lot of policies on the market that do not provide the cover patients expect when they need it.

"If people have one of these 'junk policies', the AMA encourages them to check their policy matches their current and anticipated health care needs. And, if not, dump it for better cover.

"Our Report Card will help people to understand their product, and allow them to make changes to get better cover and better value for money.

"We show what insurance policies may or may not cover, what the Medicare Benefits Schedule (MBS) covers, and what an out-of-pocket fee may be under different scenarios.

"The Report Card also highlights that private health insurer benefits vary significantly between policies and insurance companies.

> "The funds must put the interests of their policyholders first and foremost, and stop pointing the finger at doctors or pushing increased out of pocket costs onto patients when their products do not deliver what patients expect"
> *- Dr Gannon*

"Benefits vary State by State, so this year we've highlighted the percentage of hospital charges covered by funds in each State to help consumers better understand what they are buying.

"The percentage of services with no-gap are detailed State by State, and we reveal what each of the PHI funds has reported they spend on management and administration compared to what they pay out as benefits to patients.

"There is data on the level of complaints each fund receives, and we've also warned people about the dangers of doctor rating sites."

Although it is understandable that people are looking to save money, the AMA advises they should not be deceived into downgrading to a junk policy.

From the AMA's perspective, junk policies should not exist at all.

Dr Gannon said PHI needed to be simplified, more transparent, and able to cover the real costs of treatment – including theatre fees, equipment, consumables, hospital costs, and staff time.

"The funds must put the interests of their policyholders first and foremost, and stop pointing the finger at doctors or pushing increased out of pocket costs onto patients when their products do not deliver what patients expect," he said.

"Benefits for doctors represent less than 10 per cent of the money paid out by Australia's biggest health insurer.

"We need to ensure that patients retain the right to choose the doctor that is right for them, and to have their treatment at a facility that suits them.

"Equally, we need to ensure that doctors can refer patients to the right specialist – not just the one that an insurer deems appropriate. Insurers do not know the difference between specialist and sub-specialist treatment.

"We must not end up with US-style managed care where a clerk in an office on the other side of the country, not the patient and their doctor, decides what care is affordable.

"Sometimes, preserving that choice might mean treatment in a public hospital. Products must preserve flexibility. Some of our best, most highly-trained doctors work in public hospitals.

"And for those in rural areas, it is often only the public hospital that is available. They should be able to use their insurance product as they need to.

"These decisions – these patient rights – are far too important to be taken away by insurers in an effort to further bolster their profits.

"The AMA wants this Report Card to be a catalyst for greater transparency and clarity from the private health insurers about their products, and a signal to consumers to thoroughly know their PHI product before signing up."

Since the release of the inaugural *AMA Private Health Insurance Report Card* in March 2016, the Government has established the Private Health Ministerial Advisory Committee to examine all aspects of private health insurance.

The *AMA Private Health Insurance Report Card 2017* is at https://ama.com.au/ama-private-health-insurance-report-card-2017

See Health on the Hill p,27

CHRIS JOHNSON

Do homework before choosing private health insurance

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The following table shows the likelihood of medical services being provided under a no-gap arrangement by State and fund.

Percent of services with no-gap

	ACT	NSW	VIC	QLD	SA	WA	TAS	NT
Australian Unity	82.3%	90.7%	94.0%	93.6%	94.8%	90.3%	92.7%	88.0%
ACA	73.4%	90.6%	94.6%	94.5%	89.1%	89.6%	97.5%	100.0%
BUPA	75.2%	83.9%	85.4%	80.6%	84.3%	71.2%	88.6%	81.8%
CBHS	80.7%	87.6%	92.0%	92.4%	92.4%	89.6%	93.5%	89.8%
CDH	55.6%	87.7%	61.7%	60.6%	58.8%	38.9%	100.0%	N/A
CUA Health	69.4%	88.9%	88.3%	93.3%	89.9%	85.3%	89.7%	96.0%
Defence Health	78.6%	88.5%	91.7%	92.3%	92.2%	88.4%	93.5%	86.4%
Doctors' Health	91.9%	92.6%	92.6%	94.6%	90.4%	91.7%	89.5%	90.4%
GMHBA	48.8%	70.4%	73.0%	75.2%	72.3%	63.6%	70.2%	56.6%
GU Corporate	84.1%	86.3%	93.0%	90.3%	94.9%	82.6%	90.4%	95.9%
HBF	57.9%	82.1%	85.5%	80.1%	73.1%	86.2%	69.8%	58.8%
HCF	77.7%	86.6%	80.9%	84.9%	81.9%	77.1%	81.3%	80.2%
HCI	94.2%	89.4%	88.5%	90.1%	89.4%	87.1%	92.1%	92.7%
Health.com.au	70.5%	81.8%	86.1%	86.6%	87.4%	81.9%	88.2%	82.8%
Health Partners	63.0%	85.7%	87.8%	90.8%	94.7%	76.6%	87.5%	72.5%
HIF	79.8%	81.6%	87.5%	87.4%	89.0%	87.9%	85.4%	94.4%
Latrobe	39.5%	74.0%	83.8%	79.0%	77.2%	74.8%	67.8%	33.9%
MDHF	36.4%	82.5%	82.1%	72.7%	73.5%	56.9%	45.4%	14.3%
Medibank	79.5%	87.6%	83.6%	87.4%	90.3%	77.5%	92.9%	77.5%
Navy Health	79.7%	87.8%	91.5%	90.8%	95.5%	88.3%	96.5%	89.1%
NIB	63.6%	86.0%	84.8%	80.6%	84.7%	72.5%	81.4%	66.4%
Onemedifund	100.0%	89.0%	89.5%	92.7%	91.7%	85.5%	95.2%	N/A
Peoplecare	77.5%	91.0%	90.1%	90.8%	92.2%	88.1%	94.9%	89.5%
Phoenix	53.8%	91.9%	91.5%	90.3%	93.9%	88.4%	90.6%	93.3%
Police Health	67.8%	85.5%	86.9%	89.0%	93.4%	84.1%	91.6%	83.7%
QCH	53.8%	88.2%	91.8%	90.7%	92.4%	86.4%	96.8%	76.3%
RT Health Fund	82.4%	92.6%	92.1%	93.2%	94.4%	77.7%	90.2%	85.3%
Reserve Bank	76.9%	89.0%	93.6%	93.1%	95.1%	90.5%	83.4%	97.1%
St. Lukes	88.5%	84.0%	82.9%	77.8%	81.6%	58.2%	90.5%	98.5%
Teachers Health	78.9%	89.4%	90.6%	92.7%	92.5%	86.9%	93.3%	89.6%
Transport Health	74.7%	87.0%	91.7%	92.1%	98.3%	66.7%	85.0%	N/A
TUH	83.8%	88.6%	87.8%	92.8%	96.2%	86.8%	90.2%	87.5%
Westfund	72.2%	83.8%	85.3%	83.4%	86.8%	90.7%	79.4%	80.3%

AMA contributes to new guidelines

Two members of the AMA policy team have been thanked for their contributions to the first edition of the *Guidelines for on-screen presentation of discharge summaries,* developed by the Australian Commission on Safety and Quality Health Care.

Chair of the AMA Council of General Practice, Dr Richard Kidd, and Chair of the AMA Ethics and Medico Legal Committee Dr Chris Moy both took part in developing the guidelines.

Chief Executive Officer of the Commission, Adjunct Professor Debora Picone, expressed her gratitude to the doctors in a recent letter to AMA President Dr Michael Gannon.

"Development of the guidelines was supported by a clinical expert group that included and informed through an extensive national consultation," Professor Picone wrote.

"I would like to take this opportunity to thank Dr Richard Kidd and Dr Chris Moy from the Australian Medical Association who contributed to this important work."

The *Guidelines for on-screen presentation of discharge summaries* are available on the Commission's website at: https://www.safetyandquality.gov.au/publications/national-guidelines-for-on-screen-presentation-of-discharge-summaries/

According to the site, the guidelines specify the sequence, layout and format of the core elements of hospital discharge summaries, as displayed in clinical information systems.

They were developed through extensive research, consultation and iterative testing with more than 70 clinicians.

The guidelines are intended to be adopted by vendors of medical software, and health services that procure and implement systems that generate and present discharge summaries.

"The clinical handover of a patient on discharge from hospital generally occurs using an electronic discharge summary (eDS)," the guidelines say.

"A discharge summary is a collection of information about events during care of a patient by a provider or organisation, in a document produced during a patient's stay in hospital, as either an admitted or non-admitted patient, and issued when or after the patient leaves the care of the hospital.

"Clinical handover is a known area of potential risk for patient harm, particularly in the transition from acute care to the community setting. Discharge summaries are critical for providing well-coordinated and effective clinical handover because they are the primary communication mechanism between hospitals and primary health care providers."

In July 2012, the Commission was appointed to develop and manage a clinical safety program for the My Health Record system, which is a secure online summary of health information, personally controlled by individuals.

Patients' discharge summaries can be added to their My Health Record. As part of the Commission's clinical safety program, eight clinical safety reviews of the My Health Record system were completed.

The fourth clinical safety review, conducted in 2014, included an end-to-end investigation of the accuracy and data quality of eDS.

The guidelines were endorsed by the National Health Chief Information Officer Forum in August 2016 and presented at the Commission's Inter-Jurisdictional Committee in October the same year, and are now freely available on the Commission's website.

Other safety in e-health findings can also be found on the Commission's website at: https://www.safetyandquality.gov.au/our-work/safety-in-e-health/

CHRIS JOHNSON

Post-Traumatic Stress – the Tony Dell story

Tony Dell is the only living Australian to have played Test cricket and served in active combat. Selected by Sir Donald Bradman as Australia's 255th Test cricketer, Dell, a tall left-arm fast bowler, played two Tests under legendary captain Ian Chappell. His debut was against England in the seventh Test at Sydney (1970-71), where he took five wickets; opening the bowling with Dennis Lillee. Dell claimed six Test wickets at 26.66, and took 41 first-class wickets at 26.70 (best 6/17) before retiring at just 27 years old.

Back in 1965, long before his Test and Queensland Sheffield Shield career began, a young Tony Dell was called up for National Service, and served in 2RAR (2nd Battalion, Royal Australian Regiment) in Vietnam from 1967-68.

About 10 years ago, Tony walked into the office of Mental Health Australia (where I was Director of Communications) and told me he had post-traumatic stress. He wanted to do something to help veterans and others who experience this condition. PTS (many feel the word 'disorder' stigmatises those with the condition), as Tony Dell's website explains, is "contracted when the human brain is subjected to some sort of adverse experience, tragic event or fear that it wasn't built to withstand. Many humans can be subjected to events that can cause this condition. In fact, nearly all of us can experience some sort of event that will challenge our senses. This can have just a short-term effect or it can be long lasting, depending on the person and the event."

For those with PTS, the memory of traumatic events can be suppressed into the subconscious. If the event isn't dealt with, it can foment and affect the person's life in debilitating ways. Symptoms can appear gradually without the person really noticing or being aware of the cause.

Tragically, for many war veterans and others who have untreated PTS, suicide is too often the outcome. It is reported that in the past decade Australia has lost more veterans to suicide than killed on the battlefield. Tony's story – from Test cricketer to divorce, and family problems – is commonplace for many veterans, but also for police, SES volunteers, firefighters and those who experience trauma through violence, accidents or natural disasters.

What Tony Dell did to change this should be an episode of *Australian Story*. From absolutely nothing, he created StandTall4PTS [http://standtall4pts.org/], a unique campaign that has brought together the Australian Defence Force, police, sporting celebrities and others to raise awareness of PTS. StandTall4PTS has Sir Angus Houston, retired CDF, as patron. His campaign has been endorsed and supported by Prime Ministers, Test cricketers and leading sportspeople.

Dell's aim is to ensure that medical practitioners and community health services understand what PTS is, how it impacts on the families and friends of those who experience it, and to ensure there are properly funded and appropriate resources in place for people with PTS.

The problem with PTS is that it is often couched within mental health, although many experts believe this isn't how we should understand and respond to PTS. Although there is no definitive data available, some estimates are that about 1.5 million Australians have PTS to some extent.

In an interview with CricInfo, Dell said this about living with PTS: "It can be bad dreams, flashbacks, night sweats, teeth grinding, fear of being in crowds. For 20 or 30 years if I went into a room or a restaurant or something, I'd sit with my back to a wall facing out. You can become a workaholic. I know in my case I'd get up at the crack of dawn, go to work and wouldn't come home until late at night because you're subconsciously keeping yourself busy and shutting out times when you can sit and think. A lot of guys can't handle it and start hitting the booze or drugs, substance abuse, and then it gets too much for a lot of people."

When I met Tony Dell, he had only recently been diagnosed with PTS. It was only through his local Vietnam Veterans Drop-In Centre that he discovered what had affected him for decades. Anecdotally, there are many similar stories of people with undiagnosed PTS who churn in and out of various health services because of a lack of awareness and understanding of this condition.

Today, Tony Dell runs a nationwide campaign to improve research to increase our understanding of PTS and ensure better pathways for help and treatment for those affected and their families.

SIMON TATZ, AMA, DIRECTOR, PUBLIC HEALTH

Labor commits to end the freeze

Bill Shorten addresses AMA Federal Council

Opposition Leader Bill Shorten addressed the AMA Federal Council in March – the first time he had done so – to discuss health policy and hear firsthand about the issues doctors want addressed.

Shadow Health Minister Catherine King accompanied the Labor leader for a 40-minute question and answer session before the full Council.

The Medicare rebate freeze topped the discussion, with Mr Shorten giving a rock-solid commitment to support it being lifted.

"There's no doubt in my mind that one big test coming up in the May Budget will be of course what happens to indexation," Mr Shorten said.

"Labor is firmly of this view that if you're going to fix the problem of the freeze, you need to do it with all categories – not just GP rebates.

"We understand that these payments are not payments to doctors or to specialists. This is lifting the rebate to patients... increasing the rebate that Australians receive.

"If the Government chooses to relinquish the freeze, we'll be very supportive of that. Full stop."

He said the Government knows the freeze is no longer sustainable, but he expressed concern that the Coalition might only tinker with a slow thaw.

"Do it once, do it right. Don't be back here arguing about it again in the future," Mr Shorten said.

"If we were to form government in a year-and-a-half's time, we won't start with the view that everything that's happened before is a waste of time.

"The more we can move health policy beyond changes of governments, the more we can create certainty in funding and certainty in direction."

Other issues discussed included private health insurance, mental health, hospital funding, Closing the Gap, the Pharmaceutical Benefits Scheme, the sugar intake of children, preventive health, 457 visas, the medical workforce and professional development.

"I'm asked about the big picture and the appetite for reform," Mr Shorten said.

"I'm determined at the next election that if people know nothing else about the brand of the party I lead, they know that one of our four issues will be health care.

"Health is not the most important issue, but there is no public issue in Australian life that is any more important.

"So we have a big appetite to get our health policies right.

"We regard health as mainstream business of Federal Government. You've got to be prepared to find priorities in the Federal Budget to fund health...

"We have plenty of appetite for good quality reform."

AMA President Dr Michael Gannon welcomed the Opposition Leader, saying the whole Council was looking forward to learning more about the ALP's policy position on health.

"You'll know that the AMA commended the Labor Party on many elements of its policy taken to the last election, but it's time to move forward," Dr Gannon said.

"And you know that I've commended you personally."

Ms King answered a number of questions and also expressed her desire to work more with the AMA on the issues of hospital funding and private health insurance.

CHRIS JOHNSON

INFORMATION FOR MEMBERS

Specialty Training Pathways Guide – AMA Career Advice Service

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

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

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

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

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

Information on the new website includes:

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

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

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

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

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

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

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

Let the AMA’s Specialty Training Pathways guide help inform your career decisions.

Former Prime Minister to take charge of beyondblue

Former Prime Minister Julia Gillard has been named the new Chair of mental health organisation beyondblue and will take over the role from former Victorian Premier Jeff Kennett in July.

Ms Gillard has been a member of the beyondblue board of directors since 2014.

Mr Kennett, who founded the organisation, said he was leaving with mixed feelings.

"Beyondblue is part of my DNA," he said.

"I'll miss it, but I'll miss it less knowing that in Julia's hands the organisation will go from strength to strength."

Ms Gillard said she was "delighted and excited to take over the reins" as beyondblue Chair later this year.

"Jeff Kennett has done an incredible job as beyondblue's founder and Chair – his advocacy has changed the landscape for mental health in Australia," she said.

"Thank you to the beyondblue board for your trust in me and your support. I am very excited to lead this important and impactful organisation."

Shadow Minister for Ageing and Mental Health, Julie Collins, said Labor welcomed the appointment.

She also praised Mr Kennett as a "strong advocate" for Australians living with mental illness.

"There is no doubt Ms Gillard will be a champion for people living with mental illness and her appointment as Chair will ensure the mental health of all Australians continues to be a national priority," Ms Collins said.

CHRIS JOHNSON

INFORMATION FOR MEMBERS

Essential GP tools at the click of a button

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

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

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

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

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

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

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

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

VP talks anaesthetist workforce

Mr John Ilott (ANZCA CEO), Associate Professor David M Scott (President ASA), Dr Tony Bartone (AMA VP) and Professor David A Scott (President ANZCA)

AMA Vice President Dr Tony Bartone met with the Australian and New Zealand College of Anaesthetists (ANZCA) and the Australian Society of Anaesthetists (ASA) in Melbourne on 14 March to build on previous discussions concerning current issues facing the anaesthetist workforce.

The Presidents of both organisations, Professor David A Scott (ANZCA) and Associate Professor David M Scott (ASA), joined with Dr Bartone to explore ways of addressing those concerns.

Following pressure from the three organisations, the National Medical Training Advisory Network (NMTAN) last year completed its modelling of the anaesthetic workforce.

The report, *Australia's Future Health Workforce - Anaesthesia,* highlighted that, while the overall supply of anaesthetists was in balance, workforce distribution is a significant problem that needs to be addressed.

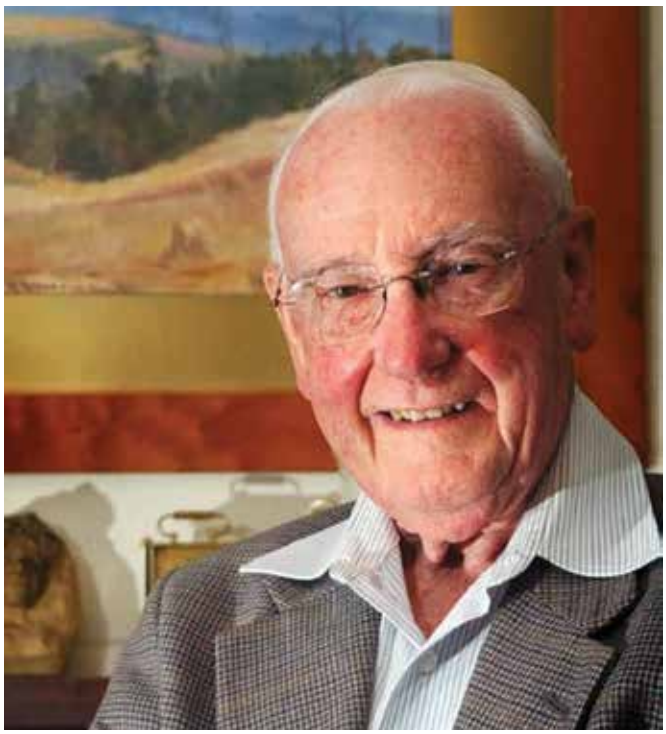
In discussing the findings of this report, Dr Bartone raised the issue of member concerns about the employment prospects for new Fellows and their level of preparedness for private practice.

There was strong agreement on the need for greater education about future career prospects across different specialties and further policy work to encourage doctors in training to look at working in under-supplied specialty areas and locations.

CHRIS JOHNSON

Dr John Morris, AO, MBE

24 December 1926 – 11 March 2017



One of Tasmania's most respected physicians, Dr John Morris, AO, MBE, has died at the age of 90.

Dubbed Launceston's champion of medical research, Dr Morris was known as a dedicated physician, a loving husband, father, and grandfather, and founding chairman of the Clifford Craig Foundation.

Tasmanian Health Minister Michael Ferguson described Dr Morris as "an eminent yet remarkably modest Tasmanian, gentle in character and greatly admired by all who had the honour of knowing or working with him".

"Few others could equal the significant positive impact Dr Morris had on Tasmanian life across a vast array of organisations, passions, disciplines and worthy causes," Mr Ferguson said on behalf of the Tasmanian Government.

Dr Morris was a dedicated family physician with a commitment to diabetes care, an author of local history, and the founder of the Clifford Craig Foundation for medical research.

Tasmanian Liberal Senator Jonathon Duniam said Dr Morris was a remarkable Tasmanian, whose vision for the Clifford Craig Foundation had changed lives.

"Dr Morris was absolutely certain that we could have a first-rate medical research organisation, and it would be feasible to have it in a major regional teaching hospital - that is, outside of one of our capitals, where medical services are often in abundance," Senator Duniam told parliament.

"With our regionally dispersed population in Tasmania, this was especially critical. Indeed, its regional location has been informative with regard to the types of work the foundation has supported, namely the medical and health issues facing Australians living in regional and remote areas.

"The establishment of this foundation and the amazing and, indeed, life improving, if not lifesaving work it has undertaken is just one element of the contributions that Dr John Morris made with his life."

Dr Morris was a former AMA Tasmania President and a former AMA Federal Councillor, Medical Council of Tasmania President, National Medicare Benefits Advisory Committee chairman, and chairman of the Royal Australian College of Physicians.

He was a visiting physician to the Launceston General Hospital for 40 years, where he was also chairman of the Department of Medicine and chairman of the Historical Committee.

He was also the President of the Association of Independent Schools of Tasmania, and the joint founder of the Lifelink telephone counselling service.

Dr Morris was also the President of the Royal Society of Tasmania, an organisation dedicated to the advancement of knowledge - historical, scientific and technological. The British Museum named the *Neopseudodogarpus scutellatus Morris*, a pseudoscorpion native to Launceston's Cataract Gorge, after him.

MARIA HAWTHORNE

INFORMATION FOR MEMBERS

AMA Public Health Awards 2017

Call for Nominations

The AMA is seeking nominations of people or groups who have made an extraordinary contribution to health care and public health.

Recipients will be invited to attend the 2017 AMA National Conference in Melbourne in May 2017, where the awards will be announced and presented. The AMA may contribute to travel costs for recipients to attend the presentation.

In the year following the presentation of the awards, recipients will have the opportunity to participate in interviews with interested media, and engage in AMA supported activities promoting their work in their field of expertise.

All awards are presented subject to a sufficient quantity and/or quality of nominations being received in each category.

Nominations are sought in the following categories:

AMA Excellence in Healthcare Award

The AMA Excellence in Healthcare Award is for an individual, not necessarily a doctor or AMA member, who has made a significant contribution to improving health or health care in Australia. The person may be involved in health awareness, health policy or health delivery.

The recipient of this award will be an individual who has made a major contribution to health care in Australia in one or more of the following criteria:

- showing ongoing commitment to quality health & medical care;
- contributing to medical research within Australia;
- initiation and involvement in public health projects or health awareness campaigns;
- improving the availability & accessibility of medical education and medical training;
- advancing health & medical issues in the political arena;
- promoting awareness of the impact of social and economic issues on health;
- contributing to community needs as a health care provider; and/or
- improving health care services in any field.

Nominations for this award can be submitted by any member of the community.

Recent previous recipients of this award include Associate Professor John Boffa, Ms Donna Ah Chee, Associate Professor Smita Shah, and Dr Mehdi Sanati Pour.

AMA Woman in Medicine Award

The AMA Woman in Medicine Award is for a female member of the AMA who has made a major contribution to the medical profession by:

- Showing ongoing commitment to quality care;
- Contributing to medical research within Australia;
- Initiation and involvement in public health projects;
- Improving the availability and accessibility of medical education and medical training for women; and/or
- Contributing to medical politics.

This award is presented to a female member of the AMA. Nominations for this award may only be made by a member of the AMA.

Recent previous recipients of this award include Associate Professor Diana Egerton-Warburton, Dr Joanna Flynn AM, and Professor Kate Leslie.

INFORMATION FOR MEMBERS

AMA Women's Health Award

The AMA Women's Health Award goes to a person or group, who does not necessarily have to be a doctor or female, but who has made a major contribution to women's health by:

- Promoting and contributing to public health initiatives;
- Initiating, participating and promoting health awareness campaigns;
- Contributing to community needs as a health care provider; and/or
- Improving health care services in any field of women's health.

Nominations for this award can be submitted by any member of the community.

AMA Men's Health Award

The AMA Men's Health Award goes to a person or group, who does not necessarily have to be a doctor or male, but who has made a major contribution to men's health by:

- Promoting and contributing to public health initiatives;
- Initiating, participating and promoting health awareness campaigns;
- Contributing to community needs as a health care provider; and/or
- Improving health care services in any field of men's health.

Nominations for this award can be submitted by any member of the community.

AMA Youth Health Award

The AMA Youth Health Award goes to a young person or group of young people, 15-27 years of age, who have made an outstanding contribution to the health of young Australians by:

- Promoting and contributing to youth health initiatives;
- Initiating, promoting or participating in youth health awareness; and/or
- Development of youth health promotion programs.

Nominations for this award can be submitted by any member of the community.

Nomination Information

Nominations will be reviewed by a judging panel consisting of the Federal AMA President and two members of AMA Federal Council, after a shortlisting process undertaken within the secretariat. Award recipients will be informed as soon as possible after the panel has made its decision.

Nominations for each award must include:

- a personal statement by the nominator describing the merit of the nominee/s in relation to the criteria for the relevant award;
- a current Curriculum Vitae for the nominee/s; and
- any additional supporting documentation relevant to the nomination.

Nominations, including all required documentation, should be submitted electronically to awards@ama.com.au.

Please read the criteria for each award thoroughly, and ensure that your nomination clearly states which category you are putting the nominee forward for.

Nominations are open from 1 February 2017, and the closing date for receipt of nominations for each award is **COB Wednesday 19 April 2017**.

Addressing FGM in Australia

BY DR GINO PECORARO, CHAIR, FGM WORKING GROUP

Female Genital Mutilation (FGM) is the umbrella term for a range of procedures that involve the surgical manipulation of the clitoris or labia with the primary purpose of controlling female sexuality, specifically ensuring premarital virginity and sexual fidelity. There is no therapeutic benefit to undergoing any of these procedures.

AMA uses the internationally accepted term "FGM" to reflect the severity of outcomes for patients who have been subjected to the practice. However, some women who have undergone FGM do not identify with the term mutilation and prefer other terms more acceptable to them such as "cutting" or "khatna".

FGM can lead to significant ongoing problems affecting a woman's urogenital tract including difficulties with menstruation, bladder emptying, sexual function, ongoing scarring leading to pain and specific complications pertaining to childbirth. Superimposed on all of these physical consequences is the significant psychological trauma and need for often multiple surgical approaches to correct the initial damage.

Around the world, it is thought at least 200 million women and girls are affected by the consequences of FGM. In Australia, FGM occurs largely within migrant communities, particularly those from countries that practise FGM. Although secrecy surrounding the practice makes definitive data collection difficult, up to one in 10 paediatricians in Australia have treated patients who have undergone FGM.

FGM is illegal in Australia, as is taking a woman or girl overseas to undergo the procedure.

Many of the risk factors that increase the likelihood of a woman being subjected to FGM also reduce her propensity to proactively seek medical help for complications relating to the procedure. Australian health care workers need to be appropriately trained to identify women affected by the practice and also able to detect women and girls at risk. Newly arrived Australians may experience difficulty negotiating our complex but comprehensive health service and require specific targeted help to access the services and treatment needed.

The AMA believes that FGM risk factors, correct identification and treatment should be a major area of priority for ongoing training and professional development. Currently, the *National Education Toolkit for Female Genital Mutilation/Cutting Awareness (NETFA)* offers training modules to support clinicians to build their clinical knowledge and cultural competency around FGM.

I urge any doctor who comes into contact with a girl or woman who has experienced FGM or is at risk of becoming affected, to seek further training and skills acquisition in dealing with these patients, or at least become familiar with local practitioners who have received appropriate training in this area, to ensure the best outcomes for your patient.

The most significant risk factor for undergoing FGM is being born to a mother who has previously undergone the procedure. In recognition of this, any doctor who comes across an adult FGM survivor has a responsibility to open up a discussion with her to mitigate the risk of the practice being performed on her children, while ensuring that her own medical needs are being met.

While some defenders of FGM cite religious custom as justification for the procedure, it is important to note that there is NO mention of the practice in any major religious text or doctrine. Claims that FGM is a fulfilment of religious duty is completely false and its sole aim is to control the female body and limit sexual pleasure.

FGM is a violation of women's human rights and its abolition is highlighted as a priority within the Sustainable Development Goals. Doctors are in a unique position to lead in the eradication of these procedures. We must be vigilant, in both preventing new victims and in caring from women who have already suffered from this practice. Underlying all of this is the commitment to ongoing education of all of our patients of the potential harms of this unnecessary illegal practice that has no religious basis for its existence. Although difficult, we must not shy away from our responsibility to tackle this problem head on and have what might be, on occasion, an uncomfortable discussion with our patients.

End the loss on consumables

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

> "The high incidence of chronic wounds produces a heavy burden on the Australian health care system. And a study on wound care costs in general practice conducted in 2011 showed that, in most cases, general practices are not recouping the costs of wound care."

Readers will need to pardon the pun, but the ban on charging for consumables like dressings when bulk billing a patient is an open wound that GPs and general practices have been struggling with for over a decade. It is estimated that more than 400,000 patients at any one time are suffering from hard- to-heal wounds. Venous leg ulcers, which are prevalent in the older population, for example, affect around 43,000 people. KPMG, as far back as 2003, estimated that $166 million a year could be saved by treating these patients with compression bandages and stockings.

The high incidence of chronic wounds produces a heavy burden on the Australian health care system. And a study on wound care costs in general practice conducted in 2011 showed that, in most cases, general practices are not recouping the costs of wound care. In providing this critical service for patients, GPs and practices typically incur a loss.

Before the introduction of the Practice Nurse Incentive Scheme, the practice nurse item for wound management helped offset the cost of wound care. Bandages and dressings generally cost anywhere from between $4 and $21, with the median just under $10. However some, such as a four-layer compression bandage, can be around $50.

As you know, many of the patients who need wound care are vulnerable. They are often aged and suffering from multiple conditions. GPs are faced with a difficult choice and tend to bulk bill them out of compassion. The GP/practice then is left with carrying the cost of the dressings, which in the context of an inadequate Medicare rebate is not a trivial sum.

Of course GPs could raise a charge for the bandage and just bill the patient the MBS fee for the attendance, which they can then claim on Medicare, but in doing this lose access to any bulk billing incentive. For GPs it is a lose-lose.

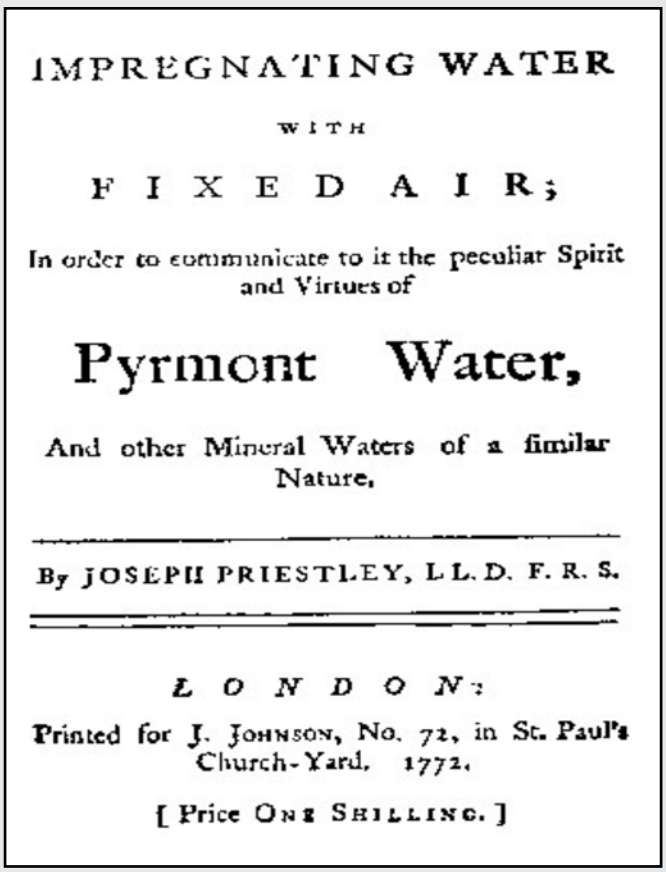
The Government's freeze on Medicare rebates has made this situation even more intolerable.

As is so often the case when it comes to supporting best practice, the Department of Veterans' Affairs is at the forefront, providing veterans with access to subsidised dressings for treating a range of wounds. While the Government may not want to pursue this model for non-DVA funded patients, it is time for a conversation about the potential for cost recovery on consumables like dressings, while still being able to bulk bill a patient. This is a conversation the AMA is now starting with the Government.

Ideally, the same arrangements that apply to vaccines should apply to consumables. Proper wound care is essential to managing patients in the community and keeping them out of hospital. It's a classic situation where prevention is better than the cure and, from a patient's perspective, a much better alternative than asking them to pop down to the pharmacy to purchase dressings (with a retail mark-up) and then having to return to the practice to have the dressing applied.

Joseph Priestley and a bottle of pop

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



IMPREGNATING WATER

WITH

FIXED AIR;

In order to communicate to it the peculiar Spirit and Virtues of

Pyrmont Water,

And other Mineral Waters of a similar Nature,

By JOSEPH PRIESTLEY, LL.D. F.R.S.

LONDON:

Printed for J. JOHNSON, No. 72, in St. Paul's Church-Yard. 1772.

[Price ONE SHILLING.]

A South African friend, passionate about finding effective ways of combatting obesity worldwide, recently sent me a clipping from *The Yorkshire Evening Post* of March 22, titled 'How fizzy drinks were invented in Leeds on this day 250 years ago'.

The inventor was Joseph Priestley, the quirky theologian and polymath who had discovered oxygen years earlier.

Priestley came to live next door to a Leeds brewery, in which he took an inquisitive interest. He found that the gas given off by fermenting beer, which he called 'fixed air' to distinguish it from ordinary air, while toxic to mice, could be dissolved in water, giving it an agreeable flavour. He served the water to his friends, who liked it. And then, in the late eighteenth century, the Swiss J J Schweppe developed a large-scale process to carbonate water.

Today our concern with fizzy drinks is mainly with their huge sugar content and sugar's contribution, the world over, to weight gain. With several countries introducing a sugar tax, such a tax is being considered here.

But as Linda Cobiac, King Tam, Lenner Veeman and Tony Blakely wrote in a paper in PLOS Medicine recently, 'the cost-effectiveness of combining taxes on unhealthy foods and subsidies on healthy foods is not well understood'. Cobiac and colleagues are public health and health policy professionals in Melbourne, Brisbane, and Wellington, NZ.

They have developed a complex model of prices, relationships of salt, fat, sugar and fresh vegetables to disease states, and have used data from several countries about what could be achieved by taxing or subsidising certain foods.

Their simulations showed that 'the combination of taxes and subsidy could avert as many as 470,000 disability-adjusted life years (that is, loss of life due to premature death and discounted years due to illness) in Australia's 22 million people with a net saving (yes, a SAVING!) of $3.4 billion a year'.

I have a message for those who tell us that the costs of health care in Australia are unsustainable. If you want to save money, here are some approaches that could be tried – and confirmed or refuted by experimentation. This is an important caveat given that models are not the same as RCTs.

But this experimentation is surely better than trying to save health dollars by coordinating care, for patients with serious and continuing illness, between hospital and home – a demonstrably worthwhile thing to do – but which, because of the needs it uncovers, inevitably ends up costing more than standard fragmented care.

The authors draw a quiet and modest conclusion. "With potentially large health benefits for the Australian population and large benefits reducing health sector spending on the treatment of non-communicable diseases, the formulation of a tax and subsidy package should be given a more prominent role in Australia's public health strategy."

Their approach might seem unorthodox, but I can imagine that Priestley, the radical preacher, might be supportive. His beliefs cost him a berth as science adviser on Cook's second voyage. He and his family, by fleeing to Pennsylvania, only just escaped death for their unorthodox theology.

He was a critical thinker and explorer. I fancy that, were he with us today, he might have encouraged us to try this out.

Engaging Aboriginal and Torres Strait Islander doctors to become members of AMA

BY DR SANDRA HIROWATARI, CHAIR, AMA COUNCIL OF RURAL DOCTORS

The Council of Rural Doctors has pushed strongly for greater Indigenous representation on councils and committees, and I was delighted to see the Australian Indigenous Doctors' Association (AIDA) attend the last AMA Federal Council, with arrangements being put in place to give Indigenous doctors a permanent voting presence on the Council. Collaterally, the AMA has a strong wish for Aboriginal and Torres Strait Islander doctors to become AMA members. The culture of Indigenous doctors will make the profession stronger. It is therefore in the interests of the profession to have more of this group join.

But it is not as simple as a motion or a wish. There are differences between non-Indigenous and Indigenous doctors. But rather than focusing on the differences, a wise elder has advised me to focus on the similarities.

The similarities are profound and predate the migration of Western culture to the Australian shores:

1. Respect for elders. In Aboriginal and Torres Strait cultures, respect for elders is fundamental to good order. If a young warrior were to disagree with an elder, one would not pursue this in open defiance, but rather seek to gently and seamlessly change the mind of the elder whilst being sure to protect the dignity of the elder, so that the elder would not subsequently face accusations of back-flipping. Exactly the same can be seen in our medical profession, with Registrars and Junior Consultants going to great lengths to gently encourage the Senior Consultants to consider a new approach, whilst ensuring the preservation of the dignity of their senior colleague.

2. Both Indigenous Australians and doctors will circle the wagons around a fellow member of the group who is under attack from outside forces. This is not to say that poor practices should be encouraged, but we are all very aware how easy it is to make a small error of judgment, that quickly precipitates very serious consequences. From my non-Indigenous point of view, this circling of wagons around a colleague needs to be cultivated. If a colleague were to tell us they are doing poorly, are we willing to let them do the collegial equivalent of letting them sleep in our spare bedroom or, if someone is already there, on a mattress on the floor? Do we have a buddy system? Can we see ourselves dipping into our pocket and paying for another's membership fees until they are strong again? If not, why not? They would do that for us later when they are strong. You see, because we come from the same pool of life. We need to prevent some of the tragic doctor suicides we have seen in the past year.

3. Both groups face an exaggerated level of psychological trauma and PTSD. In the case of Indigenous Australians, this is from the ongoing cycles of trans-generational trauma, and grief of constant funerals and untimely deaths. Among our colleagues, we see the sequelae of being immersed in other people's grief and suffering, and untimely demise. We can learn from each other how to best handle these stressors to care for our own mental health, relationship stress, and professional distress.

4. We also share the touchstone of our profession – the Hippocratic Oath. This Oath is familiar in the heart of our Aboriginal medical colleagues long before the first Indigenous doctor graduated.

To hold my teacher in this art equal to my own parents; to make him partner in my livelihood; when he is in need of money to share mine with him; to consider his family as my own brothers, and to teach them this art, if they want to learn it, without fee or indenture; to impart precept, oral instruction, and all other instruction to my own sons, the sons of my teacher, and to indentured pupils who have taken the physician's oath, but to nobody else.

This is a familiar description of the Uncle-Nephew Relationship and how Lore is passed from one generation to the next. Although much of the technology of modern medicine is very new and at the cutting edge of science, the Art of Medicine is an Ancient and Sacred Craft.

Surely it is in the greater interest of the profession that, should we wish to preserve this ancient craft, we would seek to recruit a people to whom such precepts are already familiar.

There are just over 250 Indigenous doctors in Australia. If their numbers roughly were in the same ratio as the rest of us, there ought to be 60-80 Indigenous AMA members. The onus is on us to bring into our family any Aboriginal or Torres Strait Islander member. We in the AMA are looking into these ratios and numbers. Can you look into your hearts and find a personal way to recruit our medical brothers and sisters?

Thank you to my mentor, Dr Louis G. Peachey.

Not alarmist, just the boring truth

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

The truth is often incredibly boring. It doesn't sell papers. It doesn't get people tuning in. It doesn't win votes. And thus it follows that when things don't make sense, one should assume incompetence before malice. But I'm finding it incredibly hard to suspend my disbelief when I stand back and take a look at the medical training system that we have in front of us today.

I'm not trying to be alarmist. I'm not here to tell you all that medical training is broken, and we should burn the books, burn the witches and behead Ned Stark. But I hope that I can convince you at the very least that the current progression to Fellowship is entirely unnatural and is fertile ground for unhealthy professional culture. To really understand this progression, I want you to pair up with each other, junior and senior doctors alike, and I want you to compare your respective paths through your medical journey. I find that often people have no idea what is or was on the other side of the fence. Let's begin.

We finish medical school as the ultimate in medical pluripotency: the intern. We complete a year of heavily regulated and supervised training where we meander through medicine, surgery, emergency and whatever else might lie in our path that year. We then transition to residency, where without the pressure of training progression, we expand our medical buffet of specialisation and become more attuned to our final path in the journey. Armed with the knowledge of our experiences in areas such as general practice, ICU and plastics, and well rested from the safe hours worked, we apply for a training college. We get onto a program and begin to complete the pathway to specialty. Along the way, we have kids, and we do this by working part time at points along the way to balance the load. We complete our final exams and we become a Fellow of our chosen College, and apply for jobs in what is a reasonably well-balanced workplace. Right? Wrong. The truth is boring, but the truth is the truth, and this picture definitely isn't the truth.

We finish medical school as the ultimate in medical pluripotency: the intern. We apply for internships, and a number of us will fail to get them as State governments are defaulting on their COAG agreement to provide medical graduates with internships. Without an internship, a number of doctors are unable to progress to general registration and are out before they begin. Those who remain become residents. With no national body to oversee PGY2+ terms, and with health services hungry to provide services to increasing populations with shrinking budgets, these residents work terms that don't provide any meaningful experience. This veritable army of night cover and discharge summary monkeys are forced to scrounge around for the breadcrumbs falling off the training table. The smart ones quit, locum and complete further study, but not without further financial and temporal penalty. We've built a system in which the best way to advance your career is to quit the system for a while; a perverse incentive. This of course leaves behind fewer residents to fill the gaps in the roster, who are already at breaking point due to being denied leave for three years.

Nevertheless, you move towards a College. You identify the entry requirements and you undertake the extra mile to become a candidate with a chance. In some instances, that means completing a $5000 exam before you're even a trainee. Once in, you work full-time and then the rest of it. You complete graduate diplomas, Masters and PhDs to progress. You fill your CV with publications and courses that cost thousands of dollars to progress. But you do it anyway. Because at this point you're the blackjack player with a hard twelve. You've sunk enough cost into this game that you can't quit, and there's a glimmer of a nine sitting on top of that deck. But there are many more face cards, and maybe it's just me, but I swear I'm seeing more and more doctors folding and busting around me.

So, you make it through. With everyone else. You've completed a number of extra qualifications and courses. With everyone else. You've participated in the medical arms race, and you're surrounded by tens of thousands of other nuclear nations who'll do anything for that job. The fat has been trimmed and now we've hit muscle. Welcome to exit block; a nation of Australian Fellows who can't move on to consultant positions because we're doing more with less, in every sense of the phrase. Competition is one thing, but when you've got multiples of trainees to every consultant position, you don't have a competition. You've got a war.

I told you I wasn't going to be alarmist and I stand by that. My examples above are all based on real life cases. I believe firmly in having a competitive workplace. I believe that smart hard work should be rewarded in the workplace. But this is not the system we currently have. We have a system that rewards the single-minded.

This is nobody's fault. But it's definitely our problem. It's up to us as a profession to recognise that this isn't about doctors eschewing hard work. It isn't about people wanting an easy life. This is about a culture that has not kept up with the times and it's important for those working in well-run institutions to recognise that this is not the norm anymore.

Pain for Your Thoughts

BY ROB THOMAS, PRESIDENT AUSTRALIAN MEDICAL STUDENTS' ASSOCIATION

> "... we ask ourselves, as young medical students or doctors, is there an acceptable level of pain that one should expect to live with? And who would determine that acceptable level? The medical staff? The patient?"

One of the more difficult issues dealt with on a daily basis in medicine is patients with pain – not to mention the chronic pain patient. Pain is difficult to describe, complex in nature and specific to the individual. Unlike many other symptoms, chronic pain is largely invisible, hard to prove and even harder to disprove. It comes with a range of comorbidities, such as unintended weight gain, social isolation, and an increased rate of mental health conditions. Depending on one's age, cultural background and personal experience, the experience of pain may vary widely.

Doctors, particularly junior doctors, find it especially hard to acknowledge chronic pain, probably because it is so difficult to treat. Our "fix it" mentality means that we find it testing when there is no simple solution. An opioid will dull it for now, but what does that do for the patient long term? Pain requires more than just a prescription. It requires scans, blood tests, referral to allied health and management plans. From this we ask ourselves, as young medical students or doctors, is there an acceptable level of pain that one should expect to live with? And who would determine that acceptable level? The medical staff? The patient?

We are taught to ask patients to scale pain on an arbitrary 0-10 scale. This scale may in fact be telling us more about a patient's tolerance for pain than their symptom, and indeed may confuse the treating doctor who may suspect a high subjective score to be driven by a desire for strong pain medication. This may be an alert to staff to acknowledge and validate their pain, as well as to provide a plan of care in the treatment of it. The truth is the patient wants to lower their pain, they are not just "drug seeking". The patient wishes to have their pain at a level under where it currently is. This would enable them to do activities of daily living, self-care and to get back to their everyday routine, where possible. Our journey with the patient is to navigate that pain with them, manage it and ensure a plan is put in place.

The next patient into your general practice is John, a 26-year-old man with a complaint of chronic back pain. You take a full history and find no red flags – in fact, his pain has already been investigated previously and found to be non-specific "musculoskeletal". He has no significant past medical history and is otherwise well. His pain is currently 7/10 and constant for the past two weeks. He's obviously in distress – what do you do?

Of course, there is no easy answer in a case like this, and that's something that students need to be aware of. In particular, the use of non-evidence-based treatments must be acknowledged as "potentially helpful" – if nothing else, it can give patients hope. Adjuncts to the chronic health management plan could be physiotherapy, chiropractics, Pilates and other allied health referrals. The patient journey up until walking through your door will affect how they respond to your suggestions, and it's important that we become comfortable with the uncertainty that is chronic pain.

Pain is an exceedingly difficult topic to cover in such a short passage. Junior doctors and medical students need to acknowledge the complexity of the nature of pain, then assess, treat and come up with a management plan. The patient journey starts with validating the patient's pain and them trusting you enough to come back to develop a plan.

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Advice on professional standards submissions released for public comment

BY PROFESSOR ROBYN LANGHAM, CHAIR, MEDICAL PRACTICE COMMITTEE

One of the benefits of the National Registration and Accreditation Scheme is the transparent development and revision of all registered health practitioners' professional standards.

Whenever one of the 14 national boards under the Scheme wishes to revise, update or expand its professional standards, it must undertake a public consultation process, which includes disseminating a discussion paper, inviting submissions, and publishing the submissions and outcomes.

This allows considerable public scrutiny of proposals by Boards that sometimes seek to expand their practitioners' scopes of practice beyond their training and education, and without sufficiently heeding workforce or public safety considerations.

In March, the Medical Practice Committee provided advice on the AMA's submissions to two professional standards released for public consultation.

The first was the draft revised *Professional Practice Standards* for pharmacists developed by the Pharmaceutical Society of Australia (PSA). The draft standards, which have not been updated since 2010, are comprehensive and set a high bar for pharmacist practice.

Our submission commended the PSA for emphasising that standards in collaborative care, ethics and professionalism, evidence-based practice, and quality use of medicines must underpin the application of all pharmacists' professional practice standards.

However, we made recommendations to further strengthen and clarify some of the draft standards to enhance patient privacy, patient safety, the quality of patient health care, and the collaboration between medical practitioners and pharmacists in providing person-centred care and services.

For example, in upholding principles of providing safe, evidence-based, effective and cost-effective services, the AMA commented that pharmacists must limit screening and risk assessment to services that:

- provide a demonstrated benefit to patients (actually lead to better health care outcomes);
- complement and do not duplicate existing services provided by other health professionals or services (e.g. general practitioners, community-based clinics); and
- do not lead to higher out-of-pocket costs for patients or higher costs to the health system as a whole.

The AMA's second submission responded to the Optometry Board of Australia's (OBA) revised *Endorsement for scheduled medicines registration standard,* which sets out the requirements for an optometrist to have their registration endorsed to prescribe scheduled medicines. This standard was also last updated in 2010.

The OBA is proposing to remove the list of scheduled medicines (including prescription-only medicines) that is currently attached to the standard, and attaching it instead to the *Guidelines for endorsement for use of scheduled medicines*. Changes to the standard must be approved by the Australian Health Workforce Ministerial Council, while changes to the guidelines do not. So moving the list of medicines from the standard to the guidelines would mean the OBA could make changes to the list of medicines without Ministerial approval.

The OBA argues that the current situation is slow, inefficient and causes unnecessary delays to patient access to new medicines.

However, the AMA strongly opposes this proposal.

Australian Health Workforce Ministerial Council approval of the standard and the medicines list is an important measure, ensuring that there is additional scrutiny at the highest level of any changes to prescription-only medicines within an optometrist's scope of practice.

Administrative efficiency should not compromise patient safety. No evidence has been provided to support the claim that patient access to appropriate eye care is being compromised because the list is attached to the standard or that removing the list from the standard will enhance delivery of care.

It's important that the AMA is vigilant in ensuring that non-medical practitioner prescribing does not expand beyond their scope of practice, training and education.

Public Hospital Doctors gearing up for a productive meeting

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

As part of our busy schedule, the Council of Public Hospital Doctors will be meeting on 20 April. As always, there are many issues to discuss and we can't cover them all, but a couple of the more topical ones we'll be looking at are:

Private patients in public hospitals

Whilst private health insurance is a topic unto itself, patients can be lawfully treated privately in a public hospital by a doctor who has private practice privileges as a workplace employment condition. They may be admitted through the ED, referred from a GP's or a specialist's rooms, or be eligible for third party payments.

In March, the Independent Hospital Pricing Authority released its report: *Private Patient Public Hospital Service Utilisation*.

Key findings of the report include:

- the number of separations in public hospitals funded by private health insurance has almost doubled from 451,591 in 2008–09 to 814,702 in 2014–15 (i.e. an average increase of 10.3 per cent per annum);
- there is considerable variation in the proportion of public hospital separations funded by private health insurance between jurisdictions from 2007–08 to 2014–15 with QLD (an 8.1 per cent increase) and TAS (a 5.1 per cent increase) experiencing larger growth; and
- a number of practices have developed encouraging patients in public hospitals "to elect" to use their private health insurance if it happens they possess it, including job descriptions for private patient liaison officers, and websites promoting the savings to the public hospital from patients electing to be treated as private patients.

The report concludes that there is sufficient evidence that the national Activity Based Funding model has not been a significant driver in the upward trend in privately funded public hospital separations.

It's an interesting trend and we'll be looking at this issue with a view to developing a position on it, as it now appears such patient elections are a major revenue line for all public hospitals.

Public/Private Partnerships in Hospitals

This is another growing issue, with a chequered history and many implications for public hospital doctors.

Public-private partnerships are gaining some traction in Australia, with recent developments such as Sydney's new Northern Beaches Hospital developed under such arrangements.

Public/private partnerships can have a variety of forms, including:

- a private company takes responsibility for both building a hospital and providing maintenance on the building for a 20 - 50 year period. The jurisdictional government saves paying the full capital costs up front and it reduces the immediate debt burden on the State's balance sheet; and
- private-sector management takes responsibility for all aspects of service provision in the hospital, including clinical care.

The stated benefit is usually that private management will more thoroughly drive efficiency because of the desire to generate its profits.

A main issue for both the AMA and ASMOF is that of identifying the employer, which has profound industrial implications, including accountability of government as an employer, the award under which staff will work, and the transferability of entitlements from previous State Government employment.

Public-private partnerships are typically long-term, with complex contractual arrangements setting out the responsibilities of the parties. They have regularly attracted criticism from Auditors General in several States. Some have been returned to public control, code for being a failure.

Facts we know are that this is a growing phenomenon, and it doesn't always work. We will be taking a careful look at both the industrial implications but also the clinical care implications, of these partnerships and discussing how they have affected, and are likely to affect, public hospital doctors all around the country.

I look forward to engaging with as many public hospital doctors as possible on these and other important issues as they arise. I also look forward to seeing as many of you as possible at National Conference in Melbourne in May.

Code of Ethics essential to meet professional and community expectations

BY DR CHRIS MOY, CHAIR, AMA ETHICS AND MEDICO LEGAL COMMITTEE

Doctors are granted a high level of professional autonomy and clinical independence because of the highly specialised knowledge and skills that we possess and upon which our patients and the health care system rely. But this autonomy and clinical independence are contingent on us maintaining high standards of practice, competency and conduct through an open and accountable process of profession-led regulation that meets both professional and community expectations.

An essential component of profession-led regulation is the development and maintenance of ethical codes of behaviour and standards of conduct. By articulating and promoting a body of ethical principles to guide doctors' conduct in their relationships with patients, colleagues and society, the AMA's *Code of Ethics* makes an integral contribution to setting and promoting high standards of ethical behaviour for doctors in Australia.

Although these principles may sometimes feel almost restrictive and burdensome in our daily work, it is their very existence, and our ability to care for patients while upholding them, which leads patients and the public to trust and respect doctors.

An essential feature of any *Code of Ethics* is that it is responsive to, and reflective of, the changing values and expectations of the community it serves. The AMA's *Code of Ethics* has grown out of other similar ethical codes stretching back into history including the Hippocratic Oath and those from other cultures.

In 1964, the (then newly independent) Australian Medical Association published its first *Code of Ethics*. Since then, the Code has been formally updated 12 times, the most recent iteration being the *Code of Ethics 2004. Editorially Revised 2006. Revised 2016*.

The Code has transformed significantly since 1964, from a 25-page 'statement of policy, definitions and rules' to a (currently) seven-page framework of overarching ethical principles and guidance.

There are common themes inherent to every iteration of the Code, most importantly the commitment to the primacy of our patients. As highlighted in the AMA's first *Code of Ethics*:

> *The Medical profession occupies a position of privilege in a society because of the understanding that a doctor's calling is to serve humanity, and because members of the profession have built up a tradition of placing the needs of the patient before all else.*

Over the last 50 years, the entire tone of the Code has shifted to recognise changing societal values and expectations regarding the relationship between doctors and patients – where doctors no longer make decisions on behalf of patients but where doctors and patients work together in partnership.

The contemporary versions of the Code are patient-centred, treating the relationship as a partnership where both doctors and patients have rights as well as responsibilities. The Code serves to guide doctors in supporting patients to be active in managing their own health care and make their own informed health care decisions.

The dynamic nature of the AMA's *Code of Ethics* continues with the most recent update including new guidance on:

- close personal relationships;
- patients with impaired or limited decision-making capacity;
- patients' family members, carers and significant others including support persons;
- working with colleagues, including on bullying and harassment;
- working with other health care professionals;
- supervising/mentoring; and
- health standards, quality and safety.

Significant amendments have also been made to existing sections on consent; conscientious objection; complaints; control of patient information; fees; professional boundaries; managing interests; stewardship; medico-legal responsibilities; and protecting others from harm.

Copies of the *AMA Code of Ethics 2004. Editorially Revised 2006. Revised 2016* are available on the AMA's website in PDF and brochure format at https://ama.com.au/position-statement/code-ethics-2004-editorially-revised-2006-revised-2016. Brochures and A2 posters of the Code are available in hard copy from ethics@ama.com.au.

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Latest submission to Senate on private health insurance

The following is an edited and condensed extract of the AMA's submission to the ACCC report to the Senate on private health insurance.

In Australia, the public and private systems work together as a part of a health system that provides patients with universal access to affordable health care. The balance between the private and public system cannot be overlooked.

The private health sector is a large contributor to the system. In 2014-15, 42 per cent of all hospital separations were funded by private health insurance; where 50 per cent were public patients and the remainder were self-funded. Not only is it a large contribution, but it is a cost-effective one. In 2014-15, there were 4.1 million privately insured hospital separations for approximately $12 billion in outlays, or around $3000 per separation, compared to 5.9 million separations in the public sector for a combined government outlay of $48.1 billion (or $8,100 per separation). While the service mix and complexity may differ between the sectors, the private sector very efficiently complements the public sector. If consumers withdraw from the private sector, these services will need to be provided by the public sector. Under current capacity, the public sector will either not meet the additional demand, or will only do so at a higher cost to governments.

We need to ensure that as private health insurers interact with patients and hospitals, the underpinning regulation promotes the efficient supply of health services. Private Health Insurance (PHI) has specific features that make the design of efficient regulation especially complex. This is further compounded by the specific historical development and place of PHI in the Australian context – as a form of supplementary insurance to Medicare, with the primary purpose of providing private hospital cover. Current regulation, as well as defining the scope of the cover PHI provides, includes restrictions on premiums through Community Rating and Lifetime Cover, means-tested subsidies for PHI take-up (the PHI rebate which is among the top 20 most expensive Federal Government programs), along with means tested tax penalties (the Medicare Levy Surcharge) for the failure to take out cover, and price controls over increases in PHI premiums.

Managed care

Australians can choose to obtain their health care solely from Medicare or use a combination of Medicare and PHI to meet their medical needs.

PHI offers several advantages over the public system: a patient has the option of being treated by their own doctor, they have more control over when and where they receive medical care, and the waiting times for elective surgery tend to be considerably shorter. In short, PHI provides choice for the patient and, without that choice, its value is diminished.

Yet there is a subtle, and defined, shift from a system of patient control to managed care occurring in Australia. Australians do not want US-style managed care imposed on a system that currently produces superior health outcomes at lower cost (USD$4420 here compared with $9451 in the United States). Managed care, in terms of health care, means a person agrees to only visit certain doctors and specialists within their health care plan – limiting their choice of practitioner. Australia and Australians have not had a public conversation about whether they agree to relinquish control over their health and their health system to the private health insurers. (This change has occurred through the change to the contracting with hospitals with no-pay clauses; publication of practitioner details; establishing closed shop referral databases; and demanding pre-approvals prior to surgery.)

Competition in the sector

The level of competition along the supply side of private health services impacts upon the competition between private health insurers. Both insurers and providers (hospitals and practitioners) have indicated that competition is not as effective as it might be.

Some of the inputs to the provision of health can be influenced or controlled by the private health insurer. These are generally limited to hospital contracts, but do stretch to the pre-approving of surgery. As a result, contracting between the insurers and hospitals (large groups through to day surgeries) has become more vexed and publicly acrimonious at times.

Contracting is a voluntary, deliberate, and legally binding agreement between two or more competent parties. However, it can be argued that firms are not operating in a competitive market and the factors at play are such that agreements are not voluntary. Hospitals need to have a contract with the major private health insurance funds (suppliers). Some insurers have such a strong market position that they would be considered price makers, where others are considered to be smaller, and thus price takers. Smaller insurers are beginning to contract as a collective to improve market power, and the Australian Health Service Alliance now represents 28 of the 36 registered health funds, creating what they claim is the third largest buying group.

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Furthermore, a small day surgery that may be practitioner-led may not have an equal power relationship when entering a contracting arrangement, nor the ability to undertake the detailed financial modelling that insurers can use to gain a more attractive contracting outcome – this can effectively provide the ability for insurers to determine what small day practices remain viable. This is problematic as small day surgeries can remove cases from the higher cost environment of overnight hospitals, as well as be areas where innovation can flourish.

As a result of this imbalance, the AMA is beginning to see variations in contracts that shift the nexus of control from the provider/patient to the private health insurance fund - managed care.

Publication of a practitioner's details

Private health insurers offer gap cover schemes to provide their members with certainty about out-of-pocket expenses for their privately insured medical care. Medical practitioners electing to participate in a gap cover scheme must agree to the terms and conditions that are set by the insurer. One of the common terms and conditions is that the medical practitioner agrees to information about them being published including their name, practice address, contact details, gap agreement usage and participation rate, and average gap charges.

Bupa has a 'Find a Healthcare Provider' section of its website. It provides information on the gap payment that may apply with providers it is contracted with, as well as information on the percentage of services, roughly, under which providers participate in its gap scheme.

Nib, Bupa and HBF are major shareholders of a system called Whitecoat, which owns a database that provides information on practitioner charging patterns using data gleamed from the HICAPS system. Under the Whitecoat system, a provider's agreement with the payment processing system (HICAPS) will lead to publication in the directory. The directory is segmented by insurer, and only a customer of Nib can find Nib data about a practitioner's billing practices or percentage of services provided under a no-gap or known-gap scheme.

Not unlike Trip Advisor, the Whitecoat site also allows consumers to search, find and book a clinical provider as well as review and share their experience. Whitecoat has stated that the customer reviews are vetted to ensure they do not contain clinical details, however, members have raised concerns that the vetting process is not foolproof.

Already it hosts over 40,000 providers (thus far, mainly allied providers such as dentists) and shares 250,000 patient reviews. Around six million private health insurance members will have access to this information.

However, these types of websites have the potential for significant unintended consequences. Far from helping health consumers, posting outcomes of treatment online could lead to reduced access to care, particularly for patients with chronic and complex health problems.

Referrals databases for consumers and general practitioners

Medibank has announced it is providing information to the referrals database Healthshare that will allow general practitioners to identify specialists who charge gap fees.

This initiative will provide information to approximately 85 per cent of general practitioners as to which doctors are part of Medibank's 'no-gap' or 'known gap' schemes. The converse of this is that general practitioners will therefore know which doctors are not part of Medibank's 'no-gap' or 'known gap' schemes as they will not be on the Medibank list.

Effectively this action by Medibank (which will undoubtedly be followed by the other large funds) could have a detrimental impact upon the referrals received by practitioners who are not part of Medibank's 'no-gap' or 'known gap' schemes, as patients are increasingly weighing gap charges into their decision on which specialist they choose. It is a closed shop, and it means that who is the most appropriate clinician for the referral, based on medical advice, may not be the consumer's driving motivation.

Again, this is a private health insurer influencing the provision of services and determining who may provide a service and, since they set the 'no-gap' or 'known gap' amounts, at what price.

Setting of premiums

The regulation of PHI premiums sits on top of this complex regulatory environment. It has a dual goal of protecting consumers from excessive pricing and the Commonwealth from fiscal risk. However, it has been argued by the PHI sector that this regulation provides an inefficient outcome.

Many stakeholders are of the view that the compliance costs of the premium setting process are out of proportion to the benefits that are obtained. These concerns tended to focus on

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the process being too long, the amount of information required, and claims that outcomes would be the same even if the requests for increases in insurance were not reviewed.

A relevant consideration to the process and its ongoing appropriateness is whether market failures exist in the PHI market that justify the current suite of regulations. There are 36 PHI entities competing in the market. However, the Australian industry is highly concentrated. The two largest insurers, Medibank and Bupa, have 55.4 per cent of the market. The Private Health Insurance Administrative Council in 2013 indicated that there does not appear to be 'unbridled competition'.

Premiums are a key driver in the choice of insurance for consumers. The increase in exclusionary products has not been at the expense of growth in excesses and co-payments that are also used to mitigate premium costs. This indicates that consumers are purchasing products with excesses, co-payments and exclusions to minimise their premiums. Therefore any methodology to set premiums must ensure that this product remains viable and attractive to consumers.

PHI used to be run mainly by not-for-profit funds. However, around 70 per cent of the insured population are now covered by 'for-profit' funds. The shift to a for-profit industry has created a greater need to ensure that there are sufficient profits to allow a respectable return to shareholders. It would appear that the private health insurers are not averse to increasing premiums in order to ensure a sufficient return for their shareholders. APRA data show an industry surplus (before tax) of $1.56 billion for the 2015-16 financial year (up from $1.45 billion for the previous year). Nib's 2017 half-year results showed a sizable return on equity of 31.7 per cent.

The Federal Government has a decided stake in ensuring participation in PHI. The Government's regulatory environment of incentives and penalties all but guarantees customers to private health insurers and has ensured that the PHI industry is one of the Australian economy's more protected industries. However, it also has the effect of undermining consumer confidence in the product. Allowing an industry with limited competition to set its own premiums may contribute to a further decline in confidence.

The full submission can be found at: https://ama.com.au/submission/ama-submission-accc-report-senate-private-health-insurance

JODETTE KOTZ - AMA SENIOR POLICY ADVISOR

Bupa keeps the best the PM has to give

The country's largest private health insurer, Bupa, has secured the services of one of Prime Minister Malcolm Turnbull's top bureaucrats.

Rebecca Cross, head of domestic policy in the Department of Prime Minister and Cabinet, has been seconded to the multi-billion-dollar insurer through a direct arrangement between Bupa and the department.

She was originally seconded under a partnership program between the Australian Public Service Commission and the Business Council of Australia.

Her contract has now been extended directly with Bupa.

CHRIS JOHNSON

Research

Aussies not eating enough fruit and veg

CSIRO has released findings of Australia's largest ever survey about the intake of fruits and vegetables.

Its report, *Fruit, Vegetables and Diet Score*, found one in two Australian adults are not eating the recommended intake of fruit, while two out of three adults are not eating enough vegetables.

Produced by CSIRO and commissioned by Horticulture Innovation Australia, the report compiled the dietary habits of adults across Australia over an 18 month period, involving 145,975 participants nationwide.

It has revealed that most Australians are not as healthy as they think they are.

More people need to eat higher quantities and a greater variety of fruit and vegetables every day to meet the minimum Australian benchmark.

To help meet the benchmark, CSIRO suggests adults eat at least three serves of different vegetables every dinner time.

"Many Aussies believe themselves to be healthy, yet this report shows the majority of those surveyed are not getting all the beneficial nutrients from fruit and vegetables needed for a healthy, balanced diet," CSIRO Research Director Professor Manny Noakes said.

"Increasing the amount of fruit and vegetables we eat is one of the simplest ways Australians can improve their health and wellbeing today as well as combat the growing rates of obesity and lifestyle diseases such as heart disease, Type 2 diabetes and a third of all cancers.

"Diets high in fruit and vegetables have been shown to improve psychological and physical markers of wellbeing. In particular, phytochemicals from fruit and vegetables reduce systemic inflammation which can lead to chronic disease."

One of the key findings in the research is that a focus on variety could be the solution to boosting consumption.

People across Australia, in all occupations and weight ranges, were invited to participate in the online survey between May 2015 and October 2016. CSIRO researchers analysed this data to develop a comprehensive picture of the country's fruit and vegetable consumption.

CHRIS JOHNSON

Evidence vapourised on e-cig safety

Insufficient evidence exists to support safety claims of electronic cigarettes, according to the National Health and Medical Research Council.

Chief Executive Officer Professor Anne Kelso has released a statement on the latest evidence for the safety, quality and efficacy of e-cigarettes, concluding that: "There is currently insufficient evidence to support claims that e-cigarettes are safe, and further research is required to enable the long-term safety, quality and efficacy of e-cigarettes to be assessed."

E-cigarettes continue to be promoted as a safe alternative to conventional cigarettes, or as a quit smoking aid. But there is a lack of evidence to support these claims, Professor Kelso said.

While e-cigarettes may expose users to fewer toxic chemicals than conventional tobacco cigarettes, the extent to which this reduces harm to the user has not been determined.

There is also some evidence to suggest that e-cigarettes could act as a gateway to tobacco cigarettes for non-smokers.

"Until evidence of safety, quality and efficacy can be produced, health authorities and policymakers should continue to act to minimise harm to users and bystanders," Professor Kelso said.

"This particularly applies to young people."

NHMRC has provided close to $6.5 million for research into e-cigarettes since 2011. Outcomes from this research should be progressively available from June 2018.

Consumers are advised to seek further information about e-cigarettes from reliable sources, such as their State or Territory health department or local quit smoking service.

CHRIS JOHNSON

Medicos in thick of Paraguayan protests

Doctors and medical students in Paraguay not only joined recent pro-democracy demonstrations in the nation's capital Asunción, but many were at the forefront of attending protestors wounded by trigger-happy riot police.

The tiny landlocked South American nation sank into violent chaos in the last days of March (and into April) after its President Horacio Cartes, a tobacco and soft-drink mogul, moved to trash the country's constitution in order to hang onto power.

A secret meeting of Senators voted to change the constitution that currently forbids a president to seek re-election after a single five-year term.

Cartes' term expires next year.

The vote did not take place on the Senate floor but behind closed doors.

Once news broke of the clandestine meeting and its dubious result, riots broke out in the capital.

Paraguayans spent more than 30 years under the cruel dictatorship of Alfredo Stroessner and now many fear their country is headed for another tyrannical reign.

Congress was set on fire and riot police resorted to rubber bullets in a bid to control protesters.

But in an even more brutal show of force, police stormed an opposition party's offices and shot dead 25-year-old Rodrigo Quintana who was trying to flee them.

Despite initial reports the man was killed with rubber bullets, it was later revealed the police used real bullets to shoot him in the back.

The incident has sparked even greater outrage among the general population.

Dr Herminio Ruiz, the doctor who attended Quintana, said the young man had received a blow to his head.

Other medicos were first on the scene to help injured protestors, despite authorities dragging many away.

One medical student, Juan Andrés del Puerto, who joined the protests and subsequently gave aid to others, told reporters on the scene: "I think this country deserves politicians who genuinely respect the constitution."

The President has called for calm, but the opposition has accused him and his co-conspirators of staging a coup on the nation's democracy.

CHRIS JOHNSON

WHO targets depression

Data released by the World Health Organisation show more than 300 million people around the globe are now living with depression.

It is now the leading cause of ill-health and disability worldwide.

The latest calculations were revealed to mark World Health Day, April 7.

"These new figures are a wake-up call for all countries to re-think their approaches to mental health and to treat it with the urgency that it deserves," WHO Director-General Margaret Chan said.

The number of people with depression has grown more than 18 per cent from 2005 to 2015.

WHO is now conducting a year-long campaign called *Depression: let's talk*, with the aim of encouraging more people with depression to seek help. This is also the theme of the 2017 World Health Day.

"The continuing stigma associated with mental illness was the reason why we decided to name our campaign *Depression: let's talk*," said Shekhar Saxena, Director of the Department of Mental Health and Substance Abuse at WHO.

"For someone living with depression, talking to a person they trust is often the first step towards treatment and recovery.".

CHRIS JOHNSON

Have You Planned Your Heart Attack

by Dr Warrick Bishop

RRP: $34.99

REVIEWED BY **CHRIS JOHNSON**

Anyone for a self-help guide to having a heart attack?

Actually, a new book by Hobart-based cardiologist Dr Warrick Bishop is all about discovering what you might need to understand in order to reduce your risk of having one.

Have You Planned Your Heart Attack? is an engaging read, full of cases studies, graphics and easy-flowing chapters explaining the advances in technology that make it possible to determine risk and make informed preventive decisions.

Bishop's enthusiasm for CT imaging is evident throughout.

"Taking a picture of the coronary arteries using CT to determine their health isn't new, it just isn't being done routinely," he says.

"Yet, by using these technological advances you can be ahead of the game about your cardiovascular health.

"Wouldn't you want to know if the single biggest killer in the Western world was lurking inside of you?"

According to the Australian Heart Foundation, 55,000 Australians suffer a heart attack each year.

This self-published book poses the questions: But what if we could be forewarned or prepared for a potential problem with our own arteries? What if we were able to put in place preventive measures that may avert a problem?

The book is all about preventive care and is very much directed at patients – the kind of book a doctor might suggest or recommend a patient reads.

While not bogged down in jargon or technical explanations, it is also substantial enough for doctors to gain further insights into cardiovascular disease and particularly cardiac CT imaging.

Bishop is a practising cardiologist with an interest in cardiovascular disease prevention – with a special interest in cardiac CT imaging, lipid management and eating guidelines.

The introduction to the book aptly sets the scene for what follows, with the author describing how he helped resuscitate a 52-year-old man who had collapsed with cardiac arrest on a fun run in 2005.

The man survived and the outcome was so good it made the front page of the local newspaper.

"When I arrived at work on the Monday I felt fairly pleased to have been a contributor to such a positive outcome," he writes.

"Before I could become too proud, however, one of my staff pointed out that I had seen the very same gentleman two years earlier for an exercise treadmill test.

"The test had been normal and I had reassured him that 'everything's okay'. This revelation shocked me!

"Had I done the wrong thing by this man? Had I misinterpreted the test? Were there other factors of which I had not been aware?

"As it turned out, I had done nothing wrong ... My original assessment in 2003 had limitations. This book is about how, with today's technology, we can do better – potentially much better.

"It is about improved dealing with risk through investigation and management."

High-profile television journalist Charles Wooley, who reveals he is a patient of Dr Bishop, writes an eloquent foreword to the book.

"Warrick Bishop is a lean and determined-looking man whose shaven head and athletic fitness bring to mind Vladimir Putin, without the unhappy associations," Wooley writes.

"Indeed, what drew me to Dr Bishop was that he specialises in looking inside the working heart. Using non-invasive imaging technology, he sees inside our coronary arteries to determine just how encrusted the pipes have become.

"For you and me, Warrick Bishop's picture is worth a thousand words."

Ah, the sweet life

BY DR MICHAEL RYAN

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And I thought Sauvignon Blanc was a polarising topic! Just like Ford versus Holden, the Maroons and the Blues or Lennon versus McCartney, as is sweet versus dry wine. The topic often immediately results in a bold display of crow's feet and pursed lips of disapproval.

It's a shame a lot of so-called vinophiles dismiss sweet wine. I suppose the rub is that like a lot of products, it has to be made well and in a thoughtful purposeful process. Just any old sweet concoction will see the drinker spit it out akin to a fire breather. Good fruit, appropriate handling and technique with supporting acidity for balance are the trick.

The spectrum of sweet wine includes those lightly sweet ones known as "off dry" to the cloying heavy syrup like wine and fortified wines. Like all things in nature's kingdom they all have their place. A little knowledge of the type of wine and its structure paired with its appropriate food match will result in an enhanced gastronomic experience. The versatility is that they can start an evening and bookend it.

Some grape varieties are naturally sweeter, such as Muscat Blanc. Some are dry but are perceived as sweet with rich fruit aromas e.g. Viognier. The residual sugar can be quite low, but certain aromas trick our brain into thinking it is sweet. Sometimes the grapes can be left to ripen longer and hence more acid is converted into sugars. This is known as "late harvest."

The wine fermentation process can be halted by the addition of brandy spirit or cooling the fermentation down resulting in higher residual unfermented sugars. Grapes can be left on straw or racks to allow water to evaporate and hence increase residual sugar. Sugar can simply be added as a dosage as in Demi sec Champagne.

Ice-wine is made in Canada and Germany. It is made when it snows and the resultant frozen berries allow sugars to separate from water. They are expensive as they occur rarely with the right climatic event and require the whole crop to be picked within hours.

A most elegant technique is to allow one of nature's micro-machines to suck water out of the grape. Step forward the fungus known as Botrytis cinera. When the conditions are moist, Botrytis can develop, covering the grape skin, using its micropipette, piercing the skin to extract water. If dry weather follows it dies off leaving a sultana like grape.

This process is known as Noble Rot. It can be a curse or a blessing depending on the wine maker's mission. The great Sauternes of Bordeaux, Hungarian Takaji and German Spatlese Rieslings are made this way. The fungus also adds complexity in the form of compounds called phenyl acetaldehyde.

Wines Suggested

1. **2015 Jim Barry Lavender Hill Riesling**

   This is an off dry style with lower alcohol of 12 per cent and increased residual sugar, White peach and rose petals and hints of citrus make this wine enticing. The palate snicks the front end with soft fruit and gentle acidity. Great with a soft cheese but I enjoyed this with ceviche king fish.

2. **2014 De Bertoli Noble One Riverina Semillon**

   This is the King of Australian dessert wines, always showing intense golden yellow colors. The bouquet explodes with honeyed peach aromas. These secondary layers start to exude Asian spice and vanilla, the palate is smooth and long with nice acidity like candied pineapple. I love this with crème Brule.

3. **Lustau san Emilio Pedro Ximenez (PX)**

   This is a Spanish Sherry that is ace of spades black. Complex licorice, Muscat raisins fill the bouquet. It has a silky voluptuous palate. Serve chilled with a midnight soft blue cheese and homemade walnut and fig log.

Digital Disruption

BY **DR CLIVE FRASER**

Taxis versus Ride-sharing

Uber ride-sharing arrived in Australia five years ago.

Undoubtedly, it has been popular and a great commercial success, much to the detriment of the established taxi industry.

There were initial issues about the legality of private drivers taking fare-paying passengers, but Governments have bowed to public pressure and have allowed Uber to blossom, and left the taxi industry to wither on the vine.

But I'm right behind the taxi lobby, which is understandably furious about livelihoods being trashed by Uber.

Just a quick look at the economics before driving off shows that taxi owners were paying up to $500,000 for a taxi plate in a highly regulated industry.

Owners of the taxi plates then forked out $50,000 for a Toyota Camry Hybrid with the GPS and cameras for security along with regular safety checks and expensive insurances.

I've just spent some time in Melbourne sampling various ways of getting around.

A trip from Richmond to the Tullamarine Airport cost me $75 in a cab.

The driver who owned the cab had no kind words for Uber.

He said the cab would gross about $300 in a 12 hour shift.

The driver kept $165 or 55 per cent of the fares, and with most drivers doing five 12 hour shifts (60 hours per week) the drivers would gross about $825 per week.

After paying for fuel and running costs the Taxi owner kept $80 to $90 per shift.

That's not a great return for anyone considering the hours worked by the driver and the capital outlay by the owner.

He told me that the cab did about 10,000 kilometres per month and had an annual mechanical inspection.

It was also inspected for safety every time it was serviced every month.

The same trip in an Uber would have cost me $44 to $57, or much, much more if there was surge-pricing in peak demand times.

The Uber owner's only outlay was $32,000 for a Hyundai i40 diesel and a few dollars per week for an iPhone.

The Uber driver also told me that he worked 60 hours per week, broken up into five hour shifts each morning and five hours each evening, six days per week.

He liked the fact that he could spend most of the day-time at home with his family and he would only drive for Uber when the demand was high.

He told me that he was happy to pick me up because I rated very highly with Uber!

I didn't have the courage to tell him that my Uber rating was based on an N=1 because I'd only taken a single trip with Uber Black before in Sydney which cost me a small fortune to go from Potts Point to Coogee Beach.

The Uber driver told me that he was driving about 8,000 kilometres per month and that he'd done over 200,000 kilometres in the Hyundai i40 in the past two years.

He'd bought the Hyundai because it had a five-year unlimited kilometre warranty and he was fairly sure he wouldn't be spending anything on the car other than basic service items.

He told me that he made about $2,000 per week doing Uber (minus $120 for fuel plus other vehicle running costs).

At this point in the chaotic world of digital disruption I decided to take a reality check and Google the fine print of Hyundai's five-year warranty which said that: "Hyundai warrants against defects arising in materials or manufacture for all vehicles other than vehicles used at any time during the warranty period for commercial application."

I wondered whether the good people at Hyundai would regard an Uber ride-share (aka taxi) as a "commercial application".

I also thought it was best not to ask about insurance as I was a fare-paying passenger in a private vehicle.

I was after all trusting my safety/livelihood/career into the hands of a total stranger.

I decided definitely not to raise any of these concerns with the Uber driver lest he gave me a bad review which would immediately halve my rating as N would then equal 2 and I might be left by the road-side from now on.

Whilst I'm all for the free-market and competition, unlike many of my colleagues I haven't fallen in love with Uber.

Safe motoring,

Doctor Clive Fraser
doctorclivefraser@hotmail.com

Thousands flock to folk festival

BY CHRIS JOHNSON

Thousands of music lovers from all across Australia flocked to the nation's capital on the Easter long weekend to soak up 200 performing artists, including 27 acts from various parts of the world.

The National Folk Festival was another big success in 2017, bringing Canberra to life for five days with a wide variety of musical experiences.

International acts included the stirring rhythms and five-part harmonies of Flats and Sharps from Cornwall, the Afro jazzy Himmerland from Denmark, from Quebec Les Poules a Colin, and the alt-country flavour of one of New Zealand's hottest new stars Mel Parsons.

Bluegrass was a highlight with outstanding US act The Galax Bogtrotters, as was UK doctor Jarlath Henderson with his Uileann pipes. The Bridge Project featured artists from Israel, Turkey and Australia sharing a united spirit of musical cooperation, while Daiori Farrell Trio and The Aoife Scott Band merged old and new traditions of Ireland.

Outstanding Australian acts included 2017 Golden Guitar Winner Fanny Lumsden, as well as Mic Conway's National Junk Band, Dubmarine, and The Mae Trio. Heath Cullen brought his dark country music to the festival, which was a real crowd pleaser. The Lowdown Riders were another big hit. Other acts such as Charm of Finches, The Bean Project, Ben Whiting, Crazy Old Maurice and Conchillia all were well received.

Returning this year after being so well received last year was Aussie-US duo Phil Wiggins and Dom Turner. A trans-Pacific blues duo, these guys lifted the roof with their Piedmont, delta, and hill country blues. Wiggins is one of America's foremost harmonica virtuosos, while Turner is the renowned Aussie guitarist and singer from the Backsliders.

The National has a unique feature known as FringeWorld, a new playground for the cool and the quirky. A precinct with its own dedicated program of adventure, food tents, chill out spaces, crazy games and immersive workshops presenting a very different folk experience. That's where the groovy people hung out. The rest of us flitted between pavilions, marquees and tents to catch the best the festival had to offer.

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