AUSTRALIAN

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Collateral damage

Govt pathology rent plans could cost practices $150m a year, p6

INSIDE

7 Health record deadline pushed back
8 Bonds on rural doctors loosened
9 Vitamin sales compromise pharmacists
18 Hospitals could pay for mistakes
20 Doctor data released in Govt security bungle
31 Superbugs 'worse than global financial crisis'

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Vice President
Dr Tony Bartone

In this issue

National news 6-17, 31-32

Health on the hill 18-21

Research 29-30

Columns

3 PRESIDENT'S MESSAGE
4 VICE PRESIDENT'S MESSAGE
5 SECRETARY GENERAL'S REPORT
22 GENERAL PRACTICE
23 PUBLIC HEALTH OPINION
24 RURAL HEALTH
25 DOCTORS IN TRAINING
26 MEDICAL PRACTICE
27 PUBLIC HOSPITAL DOCTORS
28 ETHICS AND MEDICO LEGAL
33 WINE
34 MOTORING
35 MEMBER SERVICES

AMA demands a fair go for GPs on pathology rents

BY AMA PRESIDENT DR MICHAEL GANNON

The AMA is standing up for a fair deal for GPs in the Government's review of rental arrangements for pathology collection centres in practices.

This issue came to a head during the Federal election campaign when the Government suddenly and unexpectedly announced that it would examine pathology industry complaints about approved collection centre (ACC) rents. In response, Pathology Australia agreed to drop its simple, effective, and clever "Don't Kill Bulk Bill" campaign (see full story in this edition of *Australian Medicine*).

Ever since, GPs around the country have faced uncertainty about an important part of their business. More recently, this fear has turned to anger for many GPs, who are still struggling with the burden of the Government's ongoing freeze on Medicare patient rebates. GPs are sick of being told by politicians on both sides that they are highly valued, but then hit with Government policy that consistently hurts practice viability.

I have spoken with many GPs face-to-face about this issue. I participated in a RACGP national webinar and was left in no doubt about the degree of anger during GP16 in Perth.

They told me that they are at a loss to understand why the Government did this deal, which they see as essentially delivering a windfall gain to two large listed companies at the expense of GPs working hard to keep their small businesses afloat.

I assured them that the AMA will continue to support GPs in these negotiations, just as we have secured favourable arrangements on their behalf for the last five years.

I recently wrote to Health Minister Sussan Ley outlining our concerns, calling on the Government to re-think its current policy position and do the right thing by Australia's dedicated and hardworking GPs.

Last year, there was a review conducted by the Department of Health (DoH) about ACC rents, in consultation with key stakeholders. Following this, the Minister advised the AMA that she had asked DoH to develop a compliance strategy that would improve transparency and strengthen compliance under the existing regulatory framework.

At a subsequent stakeholder meeting organised by the Department, most agreed that more could be done to improve compliance. There was no discussion or inkling of any changes to the existing regulatory framework – not even from the Minister's adviser at the meeting.

This is why the Government's election campaign announcement took stakeholders, outside of Pathology Australia and Sonic Healthcare, completely by surprise.

Since the deregulation of collection centres, rents for co-located collection centres have grown significantly, largely as a product of competition between pathology companies.

There are now more than 5000 ACCs across the country. Many of these are co-located with a general practice or other specialist medical practice. These practices are small businesses and have negotiated leases in good faith with the much larger pathology providers.

They have made business decisions based on projected rental streams, including investment in infrastructure and staffing. For many practices feeling the impact of the current Medicare indexation freeze, this source of rental income has helped keep them viable.

The AMA estimates the Government's current policy will rip around $100-$150 million from general practice each year.

The magnitude of this cut goes well beyond an attempt to tackle inappropriate rental arrangements.

We understand that pathology providers have specific clauses in leases that will allow them to implement rent cuts rapidly, and with little regard for the impact on practices.

I doubt that the Government truly contemplated the extent of the impact of its election commitment when it was announced.

It is essential that changes that would be against the best interests of our patients are avoided.

It is important to the AMA that we address any inappropriate arrangements that could pose a reputational risk for the profession.

The AMA is also conscious of the need to support its pathologist members. Much of the angst around the ACC issue stems from years of frozen indexation and the failure of consecutive governments to invest in both pathology and general practice (not to forget diagnostic imaging).

I have told the Minister that the Government must reverse this change in policy direction.

The AMA will keep piling the pressure on the Government to deliver on its promise to support general practice – on this and many other issues.

Unjustified attacks on primary care must end

BY AMA VICE PRESIDENT DR TONY BARTONE

> The MBS rebate freeze, coupled with rising practice costs, are pushing GPs to their breaking point. To downgrade and attack the speciality to justify minimal savings measures counteracts the Government's own agenda.

The AMA was cautiously supportive when the Government announced that they would conduct a review into the Medicare Benefits Schedule (MBS) in April 2015.

The schedule needed to be brought into the 21st century and reflect current practice. It was not reflective of current practice

However, the AMA made perfectly clear that we did not want to see the Review used as a cost-cutting exercise from the Government to improve their bottom line. Any savings from the Review needed to be reinvested into the MBS or back into funding medical practice.

To date, identified savings have been underwhelming, while the overall gatekeeper function of the local GP is being questioned by some submissions to the review as unnecessary or inefficient.

Reporting in the media of the MBS Review interim report suggests that GPs remain firmly in the target zone, and a significant proportion of their hard work is being labelled unfairly as low value.

The MBS review interim report defines low value care as: *"The use of an intervention which evidence suggests confers no or very little benefit on patients, or that the risk of harm exceeds the likely benefit, or, more broadly, that the added costs of the intervention do not provide proportional added benefits"*.

The MBS rebate freeze, coupled with rising practice costs, are pushing GPs to their breaking point. To downgrade and attack the speciality to justify minimal savings measures counteracts the Government's own agenda.

The facts do not lie. Long-term, appropriate investment in general practice will result in downstream savings.

General practice is keeping the nation healthy, and represents extremely good value for money.

GPs have had enough, and many have started contributing to the #JustaGP on social media to voice their frustrations

Medicare spending on GP services is not out of control. It only represents 6 per cent of total Government health expenditure. The Government has repeatedly pointed to data or statistics from 2004-13 when justifying its premise

Look back before 2004, and a completely different picture emerges. At the time, many GPs had walked away from their practices; their goodwill worthless. Many places were left with reduced access to services. This had been further compounded by provider number restrictions, reduced medical school intakes and fewer entrants into training programs for GPs.

Since 2004, we have seen an increase in medical school students and subsequent graduates, a concerted effort to attract IMGs, and an increase in Medicare and afterhours work incentives. Is it really that surprising that there has been bounce back in services since that time? Spikes in MBS usage always follow changes in Government policy.

Let's be clear. GPs are dealing with increasing chronic disease burdens. They are dealing with the pressures of managing patients longer while they wait for hospital care. They are more efficient, more integrated and coordinated than ever before.

The recent BEACH report confirms that GPs are working harder, longer and coordinating more complex problems.

The Government needs to listen to the feedback and consult with the profession, understanding that this might lead to winners and losers.

We don't want history to repeat itself, but the profession needs to be respected and consulted with by Government

As the Government takes the next steps in the Review process, we, as the medical profession, need to ensure Australia continues to have access to world class general practice, providing Australians with a high level of quality of care.

AMA gives doctors a global voice

BY AMA SECRETARY GENERAL ANNE TRIMMER

> "The AMA has had varying levels of engagement with the WMA over the time of its membership. For several years the AMA has held a seat on the WMA Council, representing the Pacific region"

An area of AMA activity that is perhaps less well-known to members is AMA's participation in international medical associations.

The most prominent of these is the World Medical Association (WMA), of which the AMA is one of 111 national medical association members.

The current President of the WMA, Sir Michael Marmot, has a high profile for his work on the social determinants of health. He has been in Australia recently to record the Boyer lecture series for the ABC.

The WMA was founded in 1947 with a mission to ensure the independence of physicians, and to work for the highest possible standards of ethical behaviour and care by physicians.

This was particularly important after the Second World War. The precursor of the modern AMA, the Federal Council of the BMA in Australia, was one of the founding members.

The General Assembly of the WMA adopts declarations, resolutions and statements that cover a wide range of subjects, including an International Code of Medical Ethics, the rights of patients, research on human subjects, care of the sick and wounded in times of armed conflict, torture of prisoners, the use and abuse of drugs, family planning and pollution.

The AMA has had varying levels of engagement with the WMA over the time of its membership. For several years the AMA has held a seat on the WMA Council, representing the Pacific region. The current AMA President, Dr Michael Gannon, represents the Pacific region in that role. Former AMA President, Dr Mukesh Haikerwal, served as Chair of the WMA for four years from 2011.

The next meeting of the General Assembly is in October in Taipei. The AMA reviews and comments on draft resolutions in advance of the meeting to ensure conformity with AMA's policies. Draft resolutions are then formally endorsed by the AMA Federal Council which provides guidance for the President in voting at the General Assembly.

The other area of important work undertaken by the WMA is to act as the international voice of the medical profession in commenting on, and responding to, actions taken against doctors, often in places of conflict. Recent examples have included the arrest of doctors in Turkey for treating injured demonstrators and the bombing of medical facilities in Syria.

In each of these cases, the WMA has released a condemnatory statement, often with supporting action by the national medical associations through liaison with national governments. On occasion, the AMA provides support through raising the issue with the Minister for Foreign Affairs.

Conversely, the WMA provided a supporting statement, and corresponded with the Australian Prime Minister, when the Australian Border Force Act was introduced with penalties that could be imposed on Australian doctors who speak out on their experiences in the treatment of asylum seekers in facilities managed under contract with the Australian government.

In the region, the AMA is a member of the Confederation of Medical Associations of Asia and Oceania (CMAAO) which met recently in Bangkok. The President, Dr Gannon, participated as the Australian representative.

In each of the WMA and CMAAO the voice of Australian doctors is represented by the AMA.

Govt pathology changes could cost practices up to $150m

Federal Government plans to change the rules regarding rents for pathology collection centres could be a disaster for medical practices, ripping up to $150 million a year from their income, the AMA has warned.

AMA President Dr Michael Gannon has told Health Minister Sussan Ley that a significant number of general practices will become "collateral damage" if the Government persists with plans to change the definition of 'market value' that applies to rents for pathology collection centres, with serious consequences for the provision of health care.

Dr Gannon said the Minister needed to re-think the proposed changes and adopt a more nuanced approach "consistent with the original intent of the…laws".

"If you do not get this right, a significant proportion of general practices will become collateral damage, which would be a disastrous policy outcome and contrary to your stated support for the specialty," he told Ms Ley.

Last month it was revealed that the Government had put off plans to axe bulk billing incentives for pathology services and abandoned its threat to impose a moratorium on the development of new collection centres.

In a climb-down, the Government pulled back from its threat to scrap the incentives on 1 October and advised it would not be proceeding with the moratorium, which was announced during the Federal election in order to head off a protest campaign by the pathology industry against the axing of a bulk billing incentive.

Instead of a ban, the Government has directed that collection centre leases be put up for renewal every six months, down from the usual 12 months, until a new regulatory framework is put in place. Existing leases will be grandfathered for up to 12 months, after which the new rules will come into effect.

The bulk billing incentive cut, meanwhile, which was originally due to come into effect from 1 July and save $332 million, will now not be implemented until 1 January 2017.

"Bulk billing incentives for the pathology sector will continue until new regulatory arrangements are put in place and the Government will continue to consult with affected stakeholders," a spokesman for Ms Ley told the *Herald Sun*.

But the Minister is persisting with plans to change the regulations governing rents for approved collection centres, particularly regarding the definition of market value as applied under the prohibited practices provisions of the Health Insurance Act.

Dr Gannon said that in talks earlier this year, the AMA had agreed with moves to strengthen compliance with existing regulations and "weed out examples of rents that are clearly inappropriate".

But he said the Government at that stage had given no hint it was considering changes to the regulations, and its election announcement had taken all stakeholders, except Pathology Australia and Sonic Healthcare, by surprise.

Dr Gannon said the Government's clear intent was to control collection centre rents, and the AMA opposed the proposed changes.

There are more than 5000 collection centres across the country, many co-located with medical practices.

"These practices are small businesses and have negotiated leases in good faith," Dr Gannon said, and had made business decisions based on projected rental revenue streams, including staffing and investment.

He warned that ripping this source of revenue away could be disastrous for many.

"For many practices feeling the impact of the current MBS indexation freeze, this source of rental income has helped keep them viable," he said, adding that AMA estimates were that the Government's changes would cost practices between $100 million and $150 million a year in lost rent revenue.

"The magnitude of this cut goes well beyond an attempt to tackle inappropriate rental arrangements. It is causing significant distress, particularly for general practice," Dr Gannon said. "I doubt the Government truly contemplated the extent of the impact of its election commitment when it was announced."

ADRIAN ROLLINS

GPs win an ePIP breather

Medical practices being pushed to the financial brink by the Medicare rebate freeze and other Government cuts have won a partial reprieve after Health Minister Sussan Ley pushed back the deadline on shared health summary uploads to early next year.

In a breakthrough following intense lobbying by the AMA, Ms Ley has advised GPs will be given until 31 January 2017 to comply with new rules that require practices to upload shared health summaries (SHS) for at least 0.5 per cent of patients every quarter to remain eligible for the Practice Incentive Program Digital Health Incentive.

AMA President Dr Michael Gannon, who has raised the issue at a several meetings with the Minister, said the decision was "very welcome".

"GPs are already under significant financial pressure from the Medicare rebate freeze and other funding cuts, and the last thing they needed was to also lose vital PIP incentive payments," he said.

The Government originally required practices to comply with the new eligibility criteria from May this year, but the AMA warned at the time that this would be unworkable for many practices and risked undermining the goodwill of GPs which was essential to making the My Health Record system a success.

In June, the AMA called for a moratorium on the new rules after a survey it conducted found that just 24 per cent of practices considered themselves able to comply, while almost 40 per cent said they would not be able to and 36 per cent were unsure.

Government figures show that in the first three months of operation, 1500 practices failed to meet their SHS upload target and 69 practices withdrew from the scheme altogether.

Dr Gannon said failure to comply had the potential to deliver a heavy financial blow to practices already under substantial financial pressure.

"If the Government had not relaxed its approach, close to a third of previously eligible general practices faced losing significant financial support," the AMA President said. "In many cases, practices would have been more than $20,000 worse off. With so many already close to breaking point, this could have been disastrous."

The Minister's decision follows a resolution passed by the AMA Federal Council in August calling for a moratorium on the new upload requirements and urging the Government to investigate the reasons why so many practices were struggling to comply.

The Federal Council said the Government should get the Practice Incentive Program Advisory Group (PIPAG) to conduct the review and provide recommendations on what could be done to improve practice compliance.

Dr Gannon said the episode highlighted the importance of the Government heeding the views and advice of general practitioners and their representatives.

The Government had pushed ahead with its SHS requirements against the advice of all the GP groups sitting on PIPAG, and the AMA President said in future it should ensure that any changes to the PIP Digital Health Incentive were based on the Advisory Group's advice.

Dr Gannon said the medical profession strongly supported the Government's My Health Record, and the Minister's decision to extend the SHS requirement deadline would help shore up the goodwill of GPs to support its successful implementation.

"It is pleasing that the Minister has recognised the concerns that have been consistently raised by the profession, and this decision provides some breathing space for practices," Dr Gannon said.

"With adequate time, education, and support, many of the affected 1500 general practices may well begin to genuinely engage with the My Health Record, and eventually champion it.

"But it is important that the Government continues to review the implementation of the PIP Digital Health Incentive in consultation with PIPAG.

"We need to know why practices failed to comply, and ensure that any of these issues are addressed before the end of January deadline. If a large number of practices still cannot comply by the new deadline, we may still need to revisit the policy."

ADRIAN ROLLINS

Bonds loosened on rural doctors

The Federal Government has relaxed the rules surrounding return of service obligations on doctors working in bonded placements, in a decision hailed by AMA President Dr Michael Gannon as a victory for common sense.

Health Minister Sussan Ley has responded to representations from the AMA by directing the Health Department to take a more flexible approach when applying return of service obligations on medical graduates enrolled in the Bonded Medical Places (BMP) program and the Medical Rural Bonded Scholarship Scheme (MRBS).

The move means that BMP and MRBS doctors will no longer be prevented from travelling to metropolitan areas for extra training or instruction.

Dr Gannon said the policy shift addressed a damaging and unintended consequence of the obligation rules.

"The Department was previously bound by rigid guidelines to applying these return of service obligations, often leading to outcomes that made little sense," the AMA President said. "Doctors who clearly were committed to their rural patients and more than meeting their obligations found that they were being essentially blocked from undertaking extra training or keeping up their clinical skills, simply because they would have to go to a city for a brief period to do so."

Under the original terms of the BMP program, doctors were required to complete a period of eligible service in a rural area or district of workforce shortage equivalent to the length of their medical degree. MRBS graduates were required to complete at least six years eligible service in a rural area.

Former AMA President, Professor Brian Owler, wrote to the Government last year highlighting that the rigid application of return of service obligations was having an unfair effect on participants who were trying to meet these obligations, particularly when they needed to undertake up-skilling and further training in a metropolitan area.

The AMA Council of Rural Doctors has previously identified the importance of rural doctors being able to access opportunities to up-skill in metropolitan centres from time to time.

The Council said such opportunities were vital to support sustainable, high quality, medical care and enable practitioners to share skills and knowledge with their rural colleagues, including doctors in training.

Dr Gannon said return of service arrangements were never intended to be an impediment to this, and the new, more flexible approach taken to their application was an important piece in the puzzle for supporting high quality rural health services.

Under the new policy approach, Health Department officials will have greater scope to approve requests by participants to undertake work in a broader range of areas, provided they are otherwise meeting their return of service obligations.

Dr Gannon urged a sensible approach to the more flexible arrangement.

"It is important that the Department of Health takes a practical approach when it applies the new policy so that it supports doctors who are committed to working in areas of workforce shortage," he said.

"By taking steps that support a good working experience, this will encourage them to commit to long term practice in these areas - for the benefit of local communities."

ADRIAN ROLLINS

INFORMATION FOR MEMBERS

Essential GP tools at the click of a button

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

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

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

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

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

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

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

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

Conflicted pharmacists distracted by profit motive

Pharmacists under commercial pressure to sell unproven vitamins and other complementary medicines have a conflict of interest between their professional calling and retail imperatives, the AMA has said.

The AMA has told a Federal Government review of pharmacy regulation and remuneration that while pharmacists have a valuable contribution to make to improve the health of patients, this is being undermined by the focus in many pharmacies on retail sales.

"Pharmacist expertise and training are underutilised in a commercial pharmacy environment where they are distracted by retail imperatives, including the sale of complementary medicines that have no basis in evidence," the AMA said in a submission to the Pharmacy Regulation and Remuneration Review. "It would be difficult for anyone to argue that there is no inherent conflict of interest in this situation."

The Association's concerns have been echoed by a pharmacy insider who has warned that the industry is skewed toward pharmacists owning shares in multiple pharmacies who are primarily driven by profit.

"A significant number of these owners do not even work one day a year in a community pharmacy providing healthcare," the community pharmacist employee said in a submission to the Government's review. "These owners have a significant conflict of interest. Their primary goal is profit. The pressure is all for financial goals, never for patient outcomes."

The employee, who did not want to be identified, said there needed to be regulations in place to "stop pharmacists being distracted by retail issues."

"The practical operation of the ethical side to a community pharmacy should be completely separate to the retail side. Pharmacies should stop looking and operating like supermarkets."

The structure and regulation of the pharmacy sector is coming under scrutiny amid concerns that it is increasingly prioritising commercial interests and seeking to expand the services it offers while simultaneously trying to frustrate competition and innovation in the industry.

In service of what?

The $18.9 billion Community Pharmacy Agreement struck with the Federal Government last year includes $1.2 billion to support an expanded role for pharmacists in primary care.

The development was lauded by Health Minister Sussan Ley, who said at the time that: "We want to make sure that we give them a key role in the primary care teams of the future. That's an exciting new structural reform for the future".

But the AMA and other medical groups are alarmed by the Pharmacy Guild of Australia's push to boost pharmacy income by offering a range of services that they argue go well beyond pharmacist areas of expertise.

In addition to blood pressure tests, medication reviews, vaccinations and the writing of medical certificates, pharmacists want authority to prescribe Schedule 4 medicines, undertake early detection and diagnosis of mental illness, advise on nutrition, weight loss, pregnancy and baby care, and undertake chronic disease management.

In its submission, the AMA said this was wrong-headed and dangerous, and should not be funded under the CPA.

"These additional services represent an expansion of pharmacists' scope of practice beyond their core education and training," the AMA said.

"By lobbying for these types of services to be funded under the Community Pharmacy Agreement, the Pharmacy Guild of Australia, representing for-profit business owners, is trying to drive the scope of practice of a health profession.

"This is not an appropriate way to design a health care system to meet the future needs of the community."

Conflicted pharmacists distracted by profit motive

... from p9

It said any move to expand the pharmacist scope of practice must be underpinned by a process that ensures there is no increased risk for patients, that it is related to the qualifications and competencies of the profession, that it does not come at the cost of training opportunities for other health practitioners and that health system costs will be lower.

The Pharmacy Guild has argued that allowing pharmacists to provide a greater range of health services would meet unmet demand for care from people unable to see a doctor.

But the appropriateness of pharmacies as a venue to conduct health checks and other medical services has been challenged.

A community pharmacy employee told the Government review that the current practice of pharmacy assistants talking to customers about medications and other products was intrusive and of little benefit.

"I receive nil to pointless interaction with a pharmacy assistant when purchasing a medicine, and can count on [one] hand the times that a pharmacist was involved," the worker said in a submission. "What is the point? Exactly the same transaction can be offered in any retail store."

In addition, the employee said, "I am not the only patient in Australia that has no interest in discussing in public, with no privacy, my thrush problem, piles issue, worm problem etc. It is just not good enough. Pharmacy owners have been given enough chances to fix this."

The AMA said many of the services proposed by the Guild were beyond the competency of pharmacists, and giving them scope to provide them would only "duplicate effort and fragment care."

Pharmacist in the house

Instead, the AMA has proposed that the Government support general practices to make non-prescribing pharmacists an integral part of the primary health care team.

The Association said the Government would save money and improve patient care by establishing a Pharmacist in General Practice Incentive Program, which enable practices to employ non-prescribing pharmacists to support GP prescribing and assist with medication management and patient education.

An analysis prepared by Deloitte Access Economics found the program would save $1.56 for every dollar invested in it by cutting down on adverse drug reactions, reducing the number of PBS-subsidised prescriptions and lowering patient co-payments for consultations and medicines.

Deloitte estimated that if 3100 practices participated in the program, it would cost the Government $969.5 million over four years, but this would be more than offset by $2.1 billion in savings over the same period from lower hospital admissions, fewer prescriptions and reduced doctor visits.

ADRIAN ROLLINS

" What they said ...

Pharmacist[s]… are distracted by retail imperatives, including the sale of complementary medicines that have no basis in evidence. It would be difficult for anyone to argue that there is no inherent conflict of interest in this situation – AMA

[Pharmacy] owners have a significant conflict of interest. Their primary goal is profit. The pressure is all for financial goals, never for patient outcomes – community pharmacy employee

I am not the only patient in Australia that has no interest in discussing in public, with no privacy, my thrush problem, piles issue, worm problem etc. It is just not good enough - community pharmacy employee

The greatest barrier to my profession receiving the credit and remuneration it deserves is the impact of retail focused pharmacy chains and aggressive discounters. The emphasis on low prices and prescription volume is not a formula that delivers a great degree of pharmacist access and optimal delivery of services – pharmacy proprietor

Total health care solutions for consumers require the supply of prescription and non-prescription medicines. As a practising pharmacist, my pharmacy requires a sufficient OTC offer to adequately treat my patients. A dispensing-only pharmacy would provide a less than adequate service – community pharmacy owner

The location rules do, by nature, provide certainty for a pharmacist, which encourages them to invest - community pharmacy owner

I know of many young/new pharmacists who wish to own their own pharmacies, but cannot afford the prohibitive goodwill and prices charged for many current community pharmacies – young pharmacist

Putting the community in pharmacy

Outdated and anti-competitive industry rules are frustrating attempts to improve the service pharmacists provide to patients, critics including the AMA have warned.

Controversial regulations that limit the ownership and location of pharmacies are being challenged by the AMA and other contributors to a Federal Government review of the pharmacy industry amid concerns that they are standing in the way of reforms to improve patient access and enhance collaboration between health professionals.

In its submission to the Pharmacy Regulation and Remuneration Review, the AMA said current rules prevented greater co-location of pharmacies in medical practices, to the detriment of patients.

Currently, pharmacies can only be co-located in medical practices where there are at least eight full-time prescribers, and cannot be opened within 500 metres of an existing pharmacy.

The AMA said the rule failed to take into account changes in the GP workforce, particularly an increase in the proportion of doctors who worked part-time.

"The current restrictions are inflexible and are difficult to justify in terms of public benefit," the Association's submission said. "Restricting co-location of pharmacies and medical practices also reduces the opportunities of increased collaboration and communication provided by close proximity of doctors and pharmacists."

The AMA said it had "no concerns" about the idea of locating pharmacies within or adjacent to supermarkets – an idea long championed by major retailers - as long as responsibility for dispensing medicines remained with a registered pharmacist.

ADRIAN ROLLINS

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Science delivers another jab at anti-vaxxers

Doctors and parents have been given a potent extra weapon in the battle against myths and misinformation about vaccinations with the launch of a revised and updated guide to immunisation by the Australian Academy of Science.

Persistent low rates of vaccination in several areas of the country including the Gold Coast, the north coast of New South Wales and parts of western Sydney have underlined concerns that many children remain vulnerable to outbreaks of serious diseases such as measles, whooping cough and diphtheria despite national immunisation rates above 90 per cent.

AMA President Dr Michael Gannon and 1996 Nobel Prize winner Professor Peter Doherty earlier this month supported Australian Academy of Science (AAS) President Professor Andrew Holmes in launching the latest edition of *The Science of Immunisation: Questions and Answers* booklet.

Dr Gannon said vaccination had been one of the great success stories of modern medicine and public health, and the booklet armed doctors and parents with robust scientific evidence about the benefits of immunisation, as well as a sober and well-informed assessment of the risks.

"The booklet will, importantly, help counter dangerous misinformation circulated by groups opposed to immunisation," the AMA President said. "The scientific evidence, clear explanations and easy-to-understand language of the Academy's booklet about the safety and efficacy of immunisation will help ensure Australia's immunisation rates remain high."

The latest data from the Australian Childhood Immunisation Register show that 93 per cent of children nationwide are fully immunised at 12 months, 90.7 per cent are fully vaccinated at two years, and 92.9 per cent are fully covered at five years.

Immunisation rates above 90 per cent are considered vital in order to sustain herd immunity to contagious diseases such as measles.

In addition to the country's National Immunisation Program, the Federal Government this year introduced No Jab, No Pay laws to withhold childcare benefits and tax breaks from the parents of children who are not fully immunised.

According to the Government, the new rules have resulted in almost 6000 children previously denied vaccination on the grounds that their parents were conscientious objectors being

... from p12

fully immunised, while a further 148,000 whose vaccinations were not up-to-date have been immunised again.

But public health experts remain wary that the No Jab, No Pay measure may have done little to budget relatively low vaccination rates in some relatively affluent areas.

Objections to vaccination are typically based on claims about safety, including widely and repeatedly discredited allegations that immunisation is associated with autism.

The latest outbreak of anti-vaccination sentiment accompanied plans by the Castlemaine Local and International Film Festival to screen a show claiming that US health authorities have covered up evidence linking a vaccine to autism.

The festival eventually withdraw the film following widespread community outcry, including from Dr Gannon, who said the director of the show was a “charlatan” and “entirely discredited”.

Dr Gannon said vaccines are subject to rigorous safety assessments and surveillance, and are carefully scrutinised before being added to the immunisation schedule.

Though a small number of children suffer mild and temporary side effects from vaccination, serious problems are very rare.

By comparison, the World Health Organisation estimates that vaccinations saves between two and three billion lives each year.

More than 70,000 copies of the original AAS booklet have been distributed since its launch in 2012, and Dr Gannon said the latest version would be an important aid for doctors and parents in helping counter the dangerous misinformation being circulated by opponents of immunisation.

ADRIAN ROLLINS

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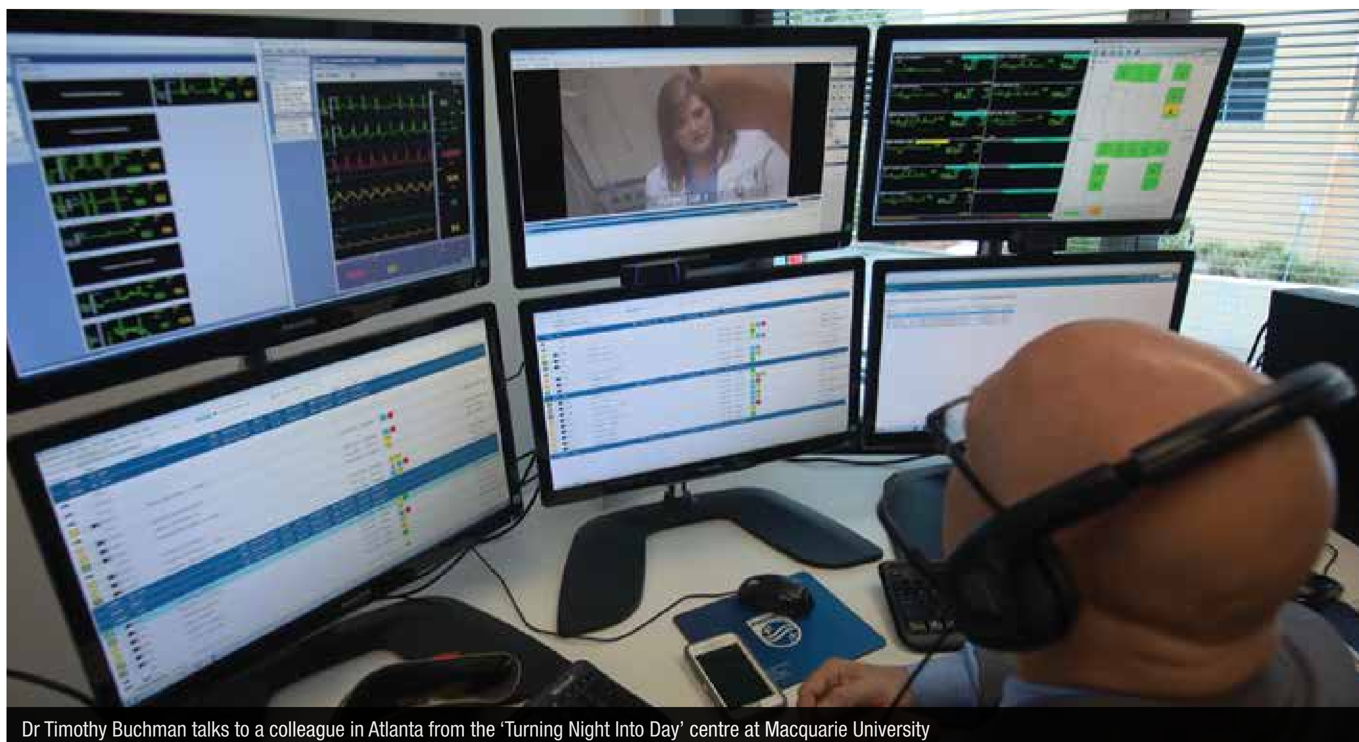
Hospital trial turns night into day for US doctors, patients



Dr Timothy Buchman talks to a colleague in Atlanta from the 'Turning Night Into Day' centre at Macquarie University

Night has become day for a group of US doctors and critical care nurses, who are using new technology to remotely monitor their intensive care patients in hospitals in Atlanta from a Sydney health campus.

The intensivists and nurses from US health provider Emory Healthcare are part of a clinical trial to assess the health benefits for both patients and doctors of having highly experienced clinicians available to provide senior support around the clock.

Taking advantage of remote intensive care unit (eICU) technology and the 14-hour time difference, the medical teams are essentially working the Atlanta night shift during the day in Sydney.

"We're in Australia because we are trying to look at a different model of care," Cheryl Hiddleson, the director of Emory's eICU Centre, told *Australian Medicine*.

"We were having our clinicians up all night while they were trying to do other things during the day – that's just what happens. We know that working the night shift is tough.

"This study is to look at our staff and see how the difference in the times that they are working makes to their performance and their health."

Under the trial, senior intensivists and critical care nurses from Emory are based in Sydney for six to eight week rotations.

They work at MQ Health at Macquarie University, using eICU technology developed by health technology maker Royal Philips, to provide continuous night-time critical care oversight to high-risk patients in Emory's six hospitals across the state of Georgia.

"We intensive care folk have one mission, and that's to deliver the right care for the right patients at the right time," Dr Timothy Buchman, the chief of Emory's Critical Care Services, said.

"Almost everything we do has to be done with both speed and care. That's easy in a big hospital at 10am on a Monday, but that task becomes a lot harder in a remote or rural hospital at unsocial hours – on weekends, holiday, or especially at night.

"There are fewer people, and less experienced people, and patients can become sicker around the clock. Patients and their

... from p14

families deserve the best care, and this is about bringing that senior support to the bedside."

The day before Dr Buchman spoke to *Australian Medicine*, he helped treat a patient who had been airlifted to one of Emory's Atlanta hospitals at 2am US time – 4pm in Sydney.

The patient was suffering severe pancreatitis and respiratory failure, and was being treated by a relatively junior doctor.

"I had a complete echo of the bedside monitor, and was able to guide the doctor through the treatment," Dr Buchman said.

"The attending physician would have been at home, probably asleep. But I was able to go in as if I was there and help implement care plans."

Two hours later, another patient came in from a smaller hospital, suffering post-operative haemorrhaging.

"She was deeply anaemic, but she was also a Jehovah's Witness and so was refusing blood products," Dr Buchman said.

"The other hospital said we needed experimental therapies, so we accepted her admission. I was able to evaluate her remotely and provide the level of care she needed. When I came in to work this morning, I was able to check on her condition again."

The previous night, just before 1am, the family of a terminally ill cancer patient, who had been intubated earlier in the day, requested a meeting to evaluate his care.

"I was able to talk to them – they could see me, I could see them – and they decided to shift from aggressive care to comfort," Dr Buchman said.

"The patient was able to die. His family were able to be there and it was able to occur in a timely fashion. The family had come to a decision and acceptance, and they could have that meeting when they needed it, instead of having to wait for hours."

Emory already uses the eICU to provide senior support to smaller and remote hospitals throughout Georgia. The time difference trial is intended to see if the technology can help keep senior clinicians in the workforce.

"People do function a lot better when they can do night work in day time," Dr Buchman said.

"This technology is important, but it is only an enabler. The people - the staff, the patients – are what is important, and this technology gives us the ability to use this accumulated wisdom during daylight for patients on the other side of the world who would not normally have access to this level of expertise."

MARIA HAWTHORNE

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Secure messaging – a real e-health payoff

Surgeon Dr Jill Tomlinson: "secure messaging provides real benefits"

Australian specialists are increasingly discovering the direct benefits for their practices and their patients of using secure message delivery (SMD) for communication with other health professionals.

While SMD has been overshadowed as an e-health development by the focus on the My Health Record, the AMA has long advocated for SMD to be supported and promoted as a key enabling technology.

SMD should fill a practical need for every medical practice that communicates clinical information with other health providers.

Communicating important clinical information by fax machine or hard copy letter can be time consuming, expensive and unreliable. Sending the same information electronically, directly and securely, to its destination has advantages all round; for the doctor, the receiving health service and for the patient.

The alternative to secure electronic communication for many medical practices is to cut and paste, transcribe or print information from the practice system into a paper-based letter or online form. The information is then sent via post, fax, online upload, or unsecured email, which involves extra time, cost, and lack of security.

Information from other health providers can arrive in hardcopy letters, faxes, reports and unsecured emails. This information must then be captured and added to the practice's clinical records using valuable practice resources. At each step there is the potential for information to be missed, added to the wrong record or otherwise corrupted.

There are direct and significant benefits if electronic communications with external healthcare providers and agencies are sent using secure messaging, including:

- secure exchange of private and confidential clinical information and documents;
- reduced paper correspondence to be managed in the practice, and reduced postage costs;
- improved workflow and reduced errors (less time chasing referrals and results, scanning, printing, filing, posting);
- improved patient privacy, consistent with data privacy principles;
- system notification of successful message delivery;
- the flagging of documents according to clinical urgency or requirements; and
- more timely receipt of clinical information

Dr Jill Tomlinson, surgeon and member of AMA Federal Council, is enthusiastic about the benefits SMD offers her practice.

"Secure messaging provides real benefits for my practice," Dr Tomlinson said. "It improves our administrative workflow and gets letters out fast. I've had times when I've left a phone message for a referring GP about a shared patient I've seen and by the time we connect via phone a few hours later they've already received the correspondence."

Implementing SMD within Dr Tomlinson's practice has required some administrative workflow changes.

"Getting the software installed was easy, but one of the slightly challenging elements was ensuring that every referring doctor that we added to our address book had their SMD details listed.

"Without this information in our address book, the administrative staff member had to look up the doctor in a separate directory. This meant we had to remember to 'think before you fax'."

Dr Tomlinson's experience suggests it's time that practices changed their letterhead, replacing their fax number with their SMD details.

"It makes sense for a medical practice to put their HealthLink, Argus or other SMD provider details on their letterhead, rather than their fax number.

"That tells other healthcare providers what your preferred system is, and enables receptionists to put the details in the practice's address book without having to search for them in one or more directories.

"Having your fax number on your letterhead, instead of your secure messaging details, perpetuates an archaic reliance on faxing.

"Easy access to your SMD details will support use of secure messaging, the way of the future."

MARTIN MULLANE, AMA SENIOR POLICY ADVISER

Better cancer care for all

Clinicians and bureaucrats hope to boost the survival rate of cancer sufferers following the adoption of national guides for the optimal treatment of 15 forms of the deadly disease.

In an effort to stamp out wide variations in the occurrence and outcomes of cancer in the community, the nation's health ministers have endorsed 11 tumour specific Optimal Cancer Care Pathways (OCP) to be used as guides for specialists, GPs, health administrators, other health professionals and consumer.

> "Altogether, pathways for 15 tumour types have been developed and adopted by the Australian Health Ministers' Advisory Council for implementation by all states and territories..."

Acting Commonwealth Chief Medical Officer Dr Anthony Hobbs said each pathway "maps the key steps in a cancer patient's journey, from diagnosis to survivorship or end-of-life care, and describes the key principles and expected standards of care at each stage".

Dr Hobbs said they had been developed by the National Cancer Expert Reference Group [NCERG], comprising clinical oncologists, GPs and consumers, in consultation with medical colleges and peak health organisations including the AMA, with the aim of reducing significant differences in outcomes for cancer sufferers according to their background, wealth and location.

"Outcomes for Australian cancer patients have improved dramatically over the past 30 years, with current survival rates now about 67 per cent overall," he said.

Dr Hobbs said this had been achieved through a combination of preventive action, cancer screening and action on early diagnosis.

"However despite the progress, Australia still has unacceptable variation in cancer rates and outcomes which differ by Indigenous status, geographical location and socioeconomic status. The NCERG's major focus has been on reducing this variation," he said.

Altogether, pathways for 15 tumour types have been developed and adopted by the Australian Health Ministers' Advisory Council for implementation by all states and territories, and 11 have been endorsed by the COAG Health Council. The remaining four are due to be considered later this year. All have been endorsed by Cancer Australia and Cancer Council Australia.

The 15 tumour streams covered by the OCPs are: lung, colorectal, hepatocellular carcinoma, prostate, lymphoma, melanoma, pancreatic, ovarian, malignant glioma, head and neck, breast, oesophagogastric, basal cell and squamous cell carcinoma, endometrial and acute myeloid leukaemia.

Each Pathway is presented in three formats.

Detailed clinical pathways for cancer specialists, health professionals and administrators and quick reference guides for GPs and other primary providers can both be found at: http://www.cancer.org.au/health-professionals/optimal-cancer-care-pathways.html.

'What to expect' guides for patients and their carers can be found at: http://www.cancerpathways.org.au/optimal-care-pathways

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Health on the hill

POLITICAL NEWS FROM THE NATION'S CAPITAL

Hospitals could pay for mistakes

Public hospitals would be charged for mistakes that seriously harm or kill patients and penalised for avoidable readmissions under reforms being developed at the behest of Health Minister Sussan Ley.

Ms Ley has directed the Independent Hospital Pricing Authority (IHPA) to model how funding and pricing could be used to cut the cost to the Commonwealth of so-called sentinel events such as operating on the wrong body part, incompatible blood transfusions, deadly medication errors, sending a baby home with the wrong parents or patient suicide.

The Authority has also been asked to look at ways to penalise hospitals that exceed a predetermined rate for avoidable readmissions.

The move coincides with the release of draft Productivity Commission proposals to publicise treatment outcomes for individual hospitals and doctors as part of measures to boost competition and contestability in the provision of health care.

In a consultation paper released on 30 September, IHPA said that incorporating safety and quality measures into pricing and funding models signalled the value Government attached to high quality care.

"Financial incentives can encourage a strengthened focus on identifying and reviewing ways in which the safety and quality of public hospital care can be improved. This can ensure that pricing and funding approaches are aligned with other strategies to improve safety and quality," the Authority said.

It said activity-based funding was often criticised for emphasising the volume of services rather than their quality or appropriateness, and increasing attention on sentinel events and avoidable readmissions could counter this.

Ms Ley has asked IHPA to present its options to the COAG Health Council by 30 November.

This would mean they could be incorporated into a new funding model for sentinel events and preventable hospital-acquired conditions that has been foreshadowed to come into effect from 1 July next year.

But hospital funding remains a huge political football between the Federal and State levels of government.

Although a pledge by Prime Minister Malcolm Turnbull of an additional $2.9 billion in Commonwealth funding to 2020 helped mute hospital services as an issue during the Federal election, the Coalition's decision to abandon the Health Reform Agreement and withdraw billions in extra funding remains a point of great tension between the two levels of government.

It makes a challenging setting for preliminary Productivity Commission (PC) proposals to increase information disclosure by hospitals and doctors and greater contestability between human services, including public hospitals.

While Australian public hospitals performed well by international standards, "there is scope to improve", the PC said, including by matching domestic best practice and publicly disclosing more information.

"Public patients are often given little or no choice over who treats them or where. Overseas experience indicates that, when hospital patients are able to plan services in advance and access useful information to compare providers (doctors and hospitals), user choice can lead to improved service quality and efficiency," the PC said.

It said that any reforms to boost user choice would have to be supported by "user-oriented information", and suggested the English model in which increased choice is offered at the point where GPs refer patients to a specialist.

The Commission said experience in England had shown that patients given a choice of hospital and consultant-led team sought out better performing providers, and hospitals in locations where competition was most intense recorded the biggest improvements in service quality.

In order to exercise their choice, patients had access to web-based information enabling them to compare providers according to waiting times and mortality rates, and could use an online booking service.

"Greater competition, contestability and informed user choice could improve outcomes in many human services," the PC said. "Well-designed reform, underpinned by strong government stewardship, could improve the quality of services, increase access...and help people have a greater say over the services they use and who provides them."

Treasurer Scott Morrison said he had ordered the review to improve the efficiency and cost effectiveness of human services.

Health on the hill

POLITICAL NEWS FROM THE NATION'S CAPITAL

... from page 18

But Opposition leader Bill Shorten, reprising Labor's scare campaign during the Federal election on the privatisation of Medicare, said he feared it would be used to justify the wholesale handover of human services to the private sector.

"We've all seen this move before," Mr Shorten said. "When Malcolm Turnbull and the Liberal Party start talking about changing human services it means that poor people get it in the neck."

The Commission said that not all human services were amenable to increased competition, contestability and choice, but identified public hospitals and palliative care services among six priority areas targeted for reform.

The enormous variety of Australia's public hospitals, including big differences in the populations they serve, workforce arrangements and characteristics and the complexity of their links to the rest of the health system, militate against like-for-like competition – something the Commission admitted.

If such issues or political considerations made fostering direct competition unfeasible, the Commission instead suggested exerting pressure for improved performance by making the position of senior hospital managers more precarious.

"There have been difficulties in the past commissioning non-government providers, and lessons from these attempts should not be forgotten," it said. "As a result, it may be more feasible to implement contestability as a more transparent mechanism to replace an underperforming public hospital's management team (or board of the local health network) rather than switch to a non-government provider."

The PC's preliminary report is open for submissions until 27 October, and the Commission is due to deliver its final report by October 2017.

ADRIAN ROLLINS

Cancer registry privacy fears

The AMA has raised concerns sensitive patient information will be in the hands of a for-profit operator following the Federal Government's decision to award a $220 million contract to Telstra to build and operate a national cancer screening register.

The AMA has told a Senate Committee inquiring into the decision that although it did not have any in-principle objection to outsourcing clinical registries, it was worried by Telstra Health's lack of experience in the field, and the implications of giving a profit-making enterprise access to commercially valuable and highly sensitive personal information.

"Telstra Health does not have direct previous experience in operating registries of this kind," the AMA said in a submission to the Senate Standing Committee on Community Affairs.

Under the Government's plan, data from nine separate cancer screening registers will be consolidated into a single National Cancer Screening Register containing the bowel and cervical cancer screening records of all participating Australians. Information on the register will be used to support the expansion of bowel cancer screening to cover almost 10 million people, and cervical screening for 1.4 million women.

The AMA said it would be "more comfortable" if the registry, which will contain sensitive information about a person's cancer risk, medical procedures and health status, was in commercially disinterested hands.

"Given the potential commercial value of the data contained in the register, the AMA would be more comfortable with it being operated by Government, a tertiary institution, or not-for-profit entity that has little interest in how the data in the register might otherwise be used," it said. "This would go a long way to allaying concerns about the secondary use of data for commercial reasons."

The AMA's concerns were echoed by health policy expert Professor Lesley Russell, of the Menzies Centre for Health Policy.

"Telstra Health will have the ability to access data from the Australian Immunisation Register, from the Australian Institute of Health and Welfare, and from Medicare claims, and the registers will be integrated with GPs, specialists and pathology laboratories," Professor Russell said in a submission t the Senate Committee.

"Will the Australian population be comfortable with the fact that a for-profit business knows whether they have had a full or partial hysterectomy, if they are at risk of bowel cancer... and when they last had a colonoscopy?

"Will GPs, specialists and diagnostic labs be happy that Telstra Health can, at least potentially, scrutinise their diagnoses and treatment?"

Privacy Commission Timothy Pilgrim said the centralisation

Health on the hill

POLITICAL NEWS FROM THE NATION'S CAPITAL

... from p19

of such sensitive information in a database that can be accessed from many points posed "a number of security and privacy risks", and suggested the operation of the register be subject to additional requirements under the Privacy Act.

But Telstra Health said it was "uniquely placed" to provide the register, with the size, scale and expertise to ensure its secure and successful operation.

It said Telstra already manages "extremely sensitive" data for hospitals, financial institutions and Government, and all information contained in the register would be hosted in Australia and controlled by the Government.

"Telstra will build and operate the Register in accordance with strict data security requirements determined by the Australian Government. These are the same requirements that would apply to any Australian Government or not-for-profit agency."

Concerns have also been raised about how Telstra Health was awarded the job, and what might happen to the register and the data it contains when the five-year contract expires.

Telstra said it won the contract following an open tender, but the AMA is among those complaining the process has been opaque.

"There has been a lack of transparency around the process for awarding this contract," it said. "The awarding of such a contract to an entity that has hitherto had no direct role in establishing or operating a register of this kind sets a challenging and potentially troublesome precedent."

Professor Russell said the basis on which Telstra won the contract over other applicants had not been disclosed, and the Government had not explained why other entities such as the Department of Human Services, the AIHW and Cancer Australia had not been considered for the work.

"What happens when the Telstra Health contract expires in five years' time – will it automatically be renewed, will it be up for competitive bids? How will this contestability affect the continuity, ongoing resources and work needed for the registers?" she asked.

Shadow Health Minister Catherine King said "clearly there are questions that need to be answered about handing these records to a for-profit company with no experience in this area".

"This is sensitive, personal information about people's health – we need to get it right," she said.

ADRIAN ROLLINS

Medicare data breach prompts law change

The Federal Government has moved to tighten privacy laws after doctor provider numbers were disclosed in a breach of security around Medicare and Pharmaceutical Benefit Scheme data.

Attorney-General George Brandis has announced plans to amend the Privacy Act to make it a criminal offence to re-identify de-identified Government data following a discovery that encrypted MBS and PBS data published by the Health Department had been compromised.

The Department was alerted on 12 September to the worrying security lapse by Melbourne University Department of Computing and Information researchers Dr Chris Culnane, Dr Benjamin Rubinstein and Dr Vanessa Teague, who found they were able to decrypt some service provider ID numbers in the publicly available Medicare 10 per cent dataset. They immediately alerted the Department.

In a statement, the Department said no patient information had been compromised in the incident.

"The dataset does not include names and addresses of service providers, and no patient information was identified," the Department said. "However, as a result of the potential to extract some doctor and other service provider ID numbers, the Department of Health immediately removed the dataset from the website to ensure the security and integrity of the data is maintained."

But Shadow Health Minster Catherine King questioned why it had taken the Government 17 days to reveal the security breach, and voiced concerns that there may have been 1500 downloads of the dataset before it was withdrawn by the Department.

"The Government's 17 day delay in admitting to a breach of health data under their watch is unacceptable," Ms King said.

Notice of the breach came as a Senate inquiry heard concerns about data security surrounding the decision to award Telstra Health $220 million contract to design and operate the National Cancer Screening Registry, and follows the collapse of Australian Bureau of Statistics systems on census night.

The AMA said that although the data security breach was concerning, it should not result in governments

Health on the hill

POLITICAL NEWS FROM THE NATION'S CAPITAL

... from p20

withholding data from being available for research and policy development.

The Association said that although it was paramount that personal information be properly secured and protected, it was important that de-identified and encrypted data be made available by Government to help inform research and the analysis of health information.

Senator Brandis reassured that the Government remained committed to making valuable data publicly available.

"The publication of major datasets is an important part of twenty-first century government providing a great benefit to the community," the Attorney-General said. "It enables... policymakers, researchers and other interested persons to take full advantage of the opportunities that new technology creates to improve research and policy outcomes."

But Senator Brandis said that advances in technology had meant that methods used in the past to de-identify data "may become susceptible to re-identification in the future".

Under his proposed changes to the Privacy Act, it would be a criminal offence to re-identify de-identified Government data, encourage someone else to do it, or to publish or communicate such data.

The Health Department said it was conducting a "full, independent audit" of the process followed in compiling, reviewing and publishing the data, and promised that "this dataset will only be restored when concerns about its potential vulnerabilities are resolved".

The Office of the Australian Information Commission is undertaking a separate investigation.

ADRIAN ROLLINS

Do you know enough about online programs for mental health?

Stepped care in mental health means matching the intensity of treatment to the needs of the patient.

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Facing up to Australia's big problem

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

Obesity is beginning to rival smoking as the major cause of preventable death in Australia. Almost two-thirds (63 per cent) of Australian adults are overweight or obese, and we are seeing a definite increase in the number of Australians who are moderately and severely obese (defined as a body mass index of 35.9 or greater).

Earlier this year, the AMA Federal Council agreed that it was timely for the Association to review its policy on obesity. A working group was established to consider the latest evidence, and to amend and refine the AMA position. I agreed to Chair the Working Group, not only because of its broad public health implications, but also because it's an issue that affects many of my patients.

The vast majority of Australian adults (95 per cent), and even more Australian children (98 per cent), do not eat the recommended amount of fruit and vegetables. Instead, more than 30 per cent of our diets are made up of what is referred to as 'discretionary foods' (foods we don't need). Our preferences for cakes, biscuits, soft drink, chips and other take away foods appear to displace their more nutritious counterparts. Further, in addition to poor eating habits, well over half of the population do not move enough.

While the exact cost of obesity in Australia is difficult to determine, a recent conservative estimate places the cost at $8.6 billion. There can be no doubt that obesity is placing a strain on the health system. We need leadership on a number of fronts in order to have any real hope of addressing the problem.

While Federal, State, Territory and local governments need to implement measures that have an effect on the broader population, medical practitioners have a vital role to play with their patients.

Patients may not always be receptive to advice about their weight. In fact, the normalisation of overweight and obesity can mean that some patients are actively resistant to the notion that their health, or the health of a family member, can be improved by even a modest reduction in body weight. Nevertheless, we must take the opportunity to raise the issue with patients, particularly when it is undermining their health.

Recently I came across a piece in The Conversation that suggested health professionals lack the confidence required to engage with their patients about their weight. The evidence cited for this conclusion actually reinforced the fact that the information and advice provided by GPs is powerful to patients and can in fact be integral in convincing a patient to change.

Perhaps GPs are an easy target. The reality is that we know our patients intimately, and can use this knowledge to engage in sensitive and diplomatic discussions that seek realistic and achievable change.

Some patients will heed our advice and others will not. The latter may need more support in understanding why they should, and how they can reduce their health risk.

GPs may also play an important advocacy role within our local communities, in translating the latest evidence for prevention into community initiatives.

Primary Health Networks can also play a role in supporting GPs in their efforts to prevent and treat obesity by supporting access to programs that seek to improve dietary patterns or increase participation in physical activity.

By identifying and addressing relevant gaps in the health workforce, PHNs can help establish care pathways that meet community needs. This will give GPs greater confidence that their patients will be able to access referred services in a coordinated and timely manner.

The work of GPs, and all medical practitioners, can also be supported by broader population-wide measures.

Programs such as the Health Star Rating system are intended to help consumers make healthier choices when buying food.

We also need programs that increase nutritional literacy and get more people moving, more often.

It is also time to think about actively discouraging consumption of foods known to contribute to obesity. International experience shows that a tax on sugary drinks can decrease consumption.

The AMA will soon release an updated Position Statement on obesity. It will outline the broad range of measures the AMA believes are necessary to tackle obesity in Australia.

Prevent or perish – the choice is ours

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

HPV vaccine has transformed the prevention of cervical cancer. We eliminated smallpox and perhaps we will yet dispatch polio. The dreadful infectious diseases of childhood are much diminished, at least in affluent societies. These good news items about prevention are welcome.

Prevention must be safe

But prevention can readily get a bad name. The controversy over statins – resolved in their favour only recently in a massive review of randomised trials published in the *Lancet* – illustrates how easily preventive strategies can be blown off course.

The late, great epidemiologist Geoffrey Rose pointed out that while taking a risk on a treatment and suffering side effects may be tolerable when you are ill, this is not so with prevention. Here, we are dealing with well people and if we place even one in 1000 in jeopardy by our preventive intervention, the red flag will be waved, publicity will follow and the intervention will likely be abandoned.

The anonymity of prevention

Prevention suffers further – from anonymity. A preventive intervention in the community, such as separating the drinking water supply from pollution or removing a 'black spot' intersection from a highway, will save lives. But who are the people whose lives have been saved? We will never know. The 'grateful patient' is not a person whose disease has been prevented, but rather one whose life has been saved through effective treatment.

The matter of anonymity goes further. Consider taking a drug that lowers blood pressure. Not everyone with elevated blood pressure who does not take the medicine will suffer a consequence. Not everyone whose blood pressure is lowered because of treatment will get a benefit. This muddle – some treated develop problems, many untreated don't – diminishes the credibility of prevention. We all know smokers who lived robust lives until they were 90 and we all know people who died before age 55 who were svelte, vegetarian, non-smokers who never sat down.

It is important to understand these attributes of prevention if we are to work out how to give it support. Simply put, there are few votes in prevention. Think suicide. Because prevention is anonymous and unpredictable and incomplete, it is unlike new surgical units, rescue helicopters and knee replacements. It is politically intangible.

But what to do about today's epidemics of chronic disease?

And yet. The perfectly reasonable question about our current and future disease profile is this. Given its magnitude and its clear association with where and how we live our lives, and the evidence that its incidence can change with changed environment, will we choose to offer health care endlessly to an ever-growing number of people who have succumbed to these chronic problems, or will we move our investment in health care, and lend our political weight, to programs that seek to prevent these problems?

I recently printed three documents about obesity. They weighed 1.8 kilograms. Two were prepared by consultancies – McKinsey and PwC – and the other came from the World Health Organisation. McKinsey, after a thoroughgoing analysis of the prevention literature, argued pragmatically that we should develop obesity preventive strategies that contain every intervention from childhood to dotage that has even a trace of evidence that it works. Put prenatal and early childhood interventions with adult cooking classes and food labelling and city planning and cycleways and readily available fresh food.

Social determinants

Sir Michael Marmot, an epidemiologist from London, has given this year's Boyer Lectures on the ABC. In them he urges us to look for the 'causes behind the causes'. A Sydney University graduate, he is now president of the World Medical Association and was previously, among many other things, President of the British Medical Association as well. He argues that the enemies of good healthcare are injustice and poverty, and to do nothing about them is a dereliction of medical duty.

The AMA strikes back

Before the last election the AMA called for a national strategy for prevention, a systematic approach to supporting efforts to reduce our dependence on the towing truck service of medicine in dealing with chronic and complex diseases and to favour prevention.

We need it – urgently.

As doctors we would do well to remember our roots. Long before we had effective remedies we were all public health physicians and much kudos helped develop the status of medicine because of our preventive agility and ability.

Lots to do here, and we need the help of the community and politicians in tackling 'the causes of the causes'.

Rural Health Commissioner, here is your to-do list

BY DR HIROWATARI, CHAIR, AMA COUNCIL OF RURAL DOCTORS

This is an open letter to the yet to be announced Rural Health Commissioner promised by the Turnbull government in June.

Dear new Rural Health Commissioner,

Congratulations on your new posting. There are a lot of souls out here in rural Australia who are eager for a unified, empathic, sensible approach to the health care issues out here.

The fact you are now in position is a breath of hope to us all - it means the Government is willing to listen. Good on them but, as you know, listening is not enough.

We sincerely hope you are given the mandate to act on your findings.

Go your thunder, ruffle a few feathers, argue, compromise, then make new projects and programs for us to benefit from your work. We may not agree with you, but we will be behind you.

As you know, that's how it works here.

You also are not alone in the current Government where, along with Sussan Ley, there are many other members of Parliament from rural areas.

Here is a little wishlist from us:

We need internet access.

This is not an urban area with 4G, hotspots and choices of providers.

We make ourselves humble to Telstra for all telecommunications.

It takes years to improve the signal. While we wait at dial-up speeds or with signal blackouts, out there is the world wide web.

As you know, health care requires medical software support, upskilling, teleconferencing and videoconferencing bandwidth.

Image and document uploading and retrieval is our way of communicating to our specialists.

Internet is cheaper than transporting a patient to a tertiary centre.

For our private needs, it is our sanity. To survive, we need social connections, the ability to shop, internet banking, and access to entertainment and news. It is our way of reaching out.

Increase the number and scope of rural GP and specialist training positions.

There are many ways to do this: increase the required clinical training time for medical students to a minimum threshold; grant specialist training in difficult-to-enter specialties if training is undertaken rurally; fund more rural training positions; and freeze funding on urban training positions.

Create more rural training positions by rewarding rural practices more for taking on a trainee, and promote and expand a National Rural Generalist Program which will create 'advanced specialty GPs' in anaesthetics, ED, obstetrics, mental health and Aboriginal health.

Expand support for rural grants.

For example, there are the rural infrastructure grants, rural procedural grants, and rural incentive programs.

In addition, we need visiting specialists and locum support to allow us to just take some time away from work. Our families and children need support with employment, recreational, educational and childcare opportunities.

Our country hospitals need to be fostered, not closed.

Visiting specialists have requirement to help them function when they visit. We need Rh negative blood in our EDs. Closing a maternity ward in a country hospital does not mean deliveries stop there: they still happen, and we need a fully functioning hospital to support us.

Recognise us. How about a Medal of the Order of Rural Australia?

I could go on and on, but you are a busy person.

We wish you well. Don't get too stressed. Come back to us after the Commission.

A voice from the rural doctors of Australia.

The drovers' doctor

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

Last year my partner floated the idea of moving to Darwin for a few years. In a fit of adventure I agreed, which led to one of the most beautiful drives one can do in Australia: Perth to Darwin via the coast.

It was then that I discovered that old Land Rover windscreens aren't as waterproof as you might think, and that losing your alternator in Broome over a

public holiday weekend is a genius way to get stuck in Matso's Brewery for four days.

I've driven from Perth to Hobart to Darwin and most places in between. All of this driving has served one extremely important purpose: you just can't appreciate the size of Australia from the seat of a plane. You need to see it from the ground level, and feel it in the hours that pass as you make your way around what is arguably one of the most beautiful countries in the world. And to those mad ones who ride their bicycles alongside road trains, I simultaneously salute you and constantly worry about the safety of your skulls.

Size matters, because you can't deliver healthcare in a country this large without factoring in the distances that you need to cover. Both patients and practitioners need to traverse large swathes of land to get what they need, only to have to make the same journey home again.

Some patients don't even have the privilege of having a home anymore, tethered to foreign cities by the bittersweet umbilicus of haemodialysis three times a week.

Service provision is a perpetual problem for regional communities.

It's not just a case of finding doctors to work in these communities. It's also about providing these communities with the resources and infrastructure to sustain these health services. It's about training a sizeable workforce that not only wants to work in the country, but wants to stay there.

And there's the rub: training.

Almost every single vocational training program across Australia cannot be completed in rural and regional settings. Apart from a few isolated local hospital networks, there are no uniform pathways for trainees to move from metropolitan settings to regional settings and vice versa.

In a workforce full of people vying for job security, the ability to train in rural Australia is quickly becoming a luxury that some trainees simply can't afford.

There are a number of key initiatives that the AMA has called for to increase rural training opportunities, such as the expansion of the Specialist Training Pathway program and increased targeted rural intakes for medical student enrolments.

One very important policy that we plan to focus on is our proposal for Regional Training Networks (RTNs). RTNs are vertically integrated networks of health services and regional training hubs of generalist and specialist prevocational and vocational training in regional areas. They allow for flexible entry, reciprocal links with metropolitan areas and targeted partnerships with regional communities and their healthcare needs.

Without programs like RTNs to organise regional training opportunities, we run the risk of isolating the most isolated parts of Australia even further.

The Council of Doctors in Training is continuing to develop RTNs, and will present these models to both Government and Opposition, in a concerted effort to turn policy into practice over these next two years.

To the metropolitan reader, this might just sound like a good idea to increase rural participation. I think it's much more than that. Regional communities can't exist without health systems to serve them, and without regional communities you lose the lifeblood of this amazing country of ours.

The red dirt and the blazing sun aren't just tourism ads.

They're the source of the food you buy so conveniently in your supermarket. They're places of immense history and significance for Indigenous Australians. They're places of serenity in a world obsessed with an endless stream of media.

If you're reading this in the middle of a major city, do me a favour. I want you to take the time to listen to Paul Kelly, Missy Higgins and Augie March covering one of Kev Carmody's most beautiful songs: *Droving Woman*.

If I can't convince you of the importance of regional training networks and regional healthcare needs, I'm certain that they can.

Bigger risk, no reward, in expanding pharmacist scope

BY DR ROBYN LANGHAM

The AMA is often accused of engaging in a 'turf war' when it warns against pharmacists and other healthcare practitioners expanding their scopes of practice – for example, into prescribing.

I expect we will attract similar criticisms following our submission to the Review of Pharmacy Remuneration and Regulation.

The Review is being conducted as part of the current Community Pharmacy Agreement (CPA) between the Government and the Pharmacy Guild of Australia. The CPA provides the framework for Government funding to medicine wholesalers and pharmacies in return for delivering and dispensing PBS and RPBS medicines to the public.

The Review is looking at whether there might be better ways to remunerate pharmacists and utilise their skills, and whether the regulations limiting the location of pharmacies should relaxed.

Our submission to the Review emphasises that the AMA fully supports pharmacists undertaking roles within their scope of practice. That means those activities and clinical services that are covered in their core education and training.

The AMA highly values the contribution pharmacists make to improving the quality use of medicines, such as by ensuring medication adherence, improving medication management, and providing education about patient safety.

We therefore support many of the community-based programs funded under the CPA, such as medicine reviews and Aboriginal and Torres Strait Islander services.

The AMA is also open to alternate models of funding that would encourage and reward a focus on professional, evidence-based interactions with patients. The AMA agrees that pharmacists' expertise and training are underutilised in a commercial pharmacy environment where they are distracted by retail imperatives.

With this is mind, the AMA has called for Government funding to support pharmacists working within a general practice to contribute to the delivery of high quality care for patients. You can see the full details of this proposal on our website.

However, over the last few years the Pharmacy Guild has pushed for a range of pharmacy services to be funded under the CPA as an extra source of income, which represents an expansion of pharmacists' scope of practice. This includes prescribing Schedule 4 medicines; providing advice on nutrition, weight loss, smoking cessation, pregnancy and baby care; and managing chronic diseases such as asthma and diabetes.

Under the Health Practitioner Regulation National Law Act governing the practice of registered health practitioners, the national boards are responsible for setting the accreditation standards for education and training for the knowledge, skills and professional attributes to practise.

By lobbying for these types of services to be funded under the CPA, the Pharmacy Guild – representing for-profit business owners – is trying to drive expansion of the scope of practice of a health practitioner. The Pharmacy Board of Australia has not been involved in any way.

This is not an appropriate way to design a health care system to meet the future needs of the community.

To ensure patient safety and cost-effectiveness for the health care system, the AMA maintains that any expanded scopes of practice by non-medical health practitioners should be underpinned by transparent and consistent processes which satisfy the following important questions:

- does the change in scope of practice introduce any new risks to patient safety?
- is the change to scope of practice rationally related to the practice of the profession and to the core qualifications and competencies of their profession?
- is the change in scope of practice consistent with the evolution of the health care system and the dynamics between health professionals who work in collaborative care models?
- are training opportunities for other health practitioner groups diminished?
- is the cost to the health care system lower than the current service offered, taking account supervision costs?

If, in the future, pharmacists' core education and training covers medical services, and pharmacists wish to have those services attract Government subsidies, then those services should be assessed for safety, efficacy and cost effectiveness in the same way as other health practitioner services. That means evaluated and funded under Medicare.

In the meantime, the AMA will continue to defend against profit-driven and unevaluated expanded scopes of practice.

Hospital funding outlook 'problematic'

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

As we approach the end of yet another year, it is timely to look back on some of the key issues that have affected public hospital doctors throughout 2016.

Rights of private practice in public hospitals

In the past few years the issue of doctors' right of private practice (RoPP) in public hospitals has been prominent. In Queensland, they have been investigated by the State's Auditor-General.

At the AMA, we comprehend that doctors and hospitals doing the sensible "thing" can have a productive relationship associated with RoPP. It is essentially designed to attract and retain staff to otherwise "unattractive" situations. However this practice is not without risks for doctors who are working at full capacity meeting their patient care obligations. Hospitals have a responsibility to ensure that doctors are readily able to comply with their obligations lawfully, without any fear of "accusations", and with patient care uppermost in their priorities.

I am pleased to report that both AMA and ASMOF are ready to release the *National Guide on Rights of Private Practice in Public Hospitals, 2016*. There are many different jurisdictional arrangements regarding RoPP, and no guide can ever be definitive, but this guide has been developed with a great deal of input from state industrial advisors and should serve as a profoundly authoritative guide for both our members and hospitals.

Safe Hours Audit

The AMA Safe Hours campaign has been running since the 1990s, with the AMA conducting Safe Hours Audits in 2001, 2006 and 2011.

The campaign has had an impact, with the number of hospital-based doctors in the significant risk and higher fatigue risk categories falling from 78 per cent in 2001 to 62 per cent in 2006 and 53 per cent in 2011.

Nonetheless, while the audits show that hours of work and levels of fatigue risk have come down, significant numbers of doctors continue to work extended hours.

The AMA is preparing once again to conduct a safe hours audit, likely in the latter part of this month. To support the audit, the AMA has updated its Safe Hours website, which will not only collect data, but also give individuals a report on their fatigue risk. A great initiative all round! Please watch for relevant updates.

COAG Hospital Funding Agreement

The medium term future of public hospital funding remains problematic, as a result of the July 2016 Federal election result. The Coalition campaigned on the basis of the Heads of Agreement reached at COAG on 1 April 2016.

The Heads of Agreement provides for public hospital funding from 1 July 2017 to 30 June 2020, with the Commonwealth providing an estimated additional $2.9 billion in funding, with growth currently capped at 6.5 per cent annually. Elements of the existing system, including activity based funding (ABF, not to be confused with the apparent reality of "funding-based activity") and the national efficient price (NEP), remain.

Ultimately, the states will continue to determine their overall contribution for their public hospital services and will meet the balance of costs above any Commonwealth contribution.

The COAG Heads of Agreement includes a commitment to develop an addendum to the National Health Reform Agreement (NHRA) for longer-term public hospital funding to commence on 1 July 2020. The Independent Hospital Pricing Authority (IHPA) will continue to develop the classification and costing of services under ABF.

The prospects for securing significant additional hospital funding in this context would seem to be limited, but nonetheless the AMA will continue its advocacy in this absolutely vital area to combat traditional chronic under-funding.

This is my final article for the Council. I take this opportunity to thank everyone who has been involved in the CPHD and its predecessors for their help, advice, support and good judgment throughout 2016. I look forward to being in contact with many of you at our future meetings, and into 2017.

Best wishes for the Festive Season.

Ethics an essential guide to care

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

Medical ethics applies a moral code to the practice of medicine, guiding doctors to recognise moral issues arising out of patient care and dealing with them in a rational and principled manner.

As a core component of medical professionalism, medical ethics defines us as doctors. In return for the privilege of a significant level of professional autonomy and clinical independence, patients and the wider community trust us to develop, maintain and adhere to an ethical code that enshrines a high standard of behaviour and professional conduct.

> "It enshrines the core values of the profession, including respect for patients, their family members, colleagues and other health care workers, trust, compassion, altruism, integrity, advocacy and justice, accountability, leadership, collaboration and collegiality"

Medical associations around the world recognise 18 September as Medical Ethics Day. Established by the World Medical Association (WMA), the Day is a way for the global medical community to recognise and promote the important role of ethics in medicine. A central objective of the World Medical Association, which came into being on 18 September 1947, has been to establish and promote the highest possible standards of ethical behaviour and care by doctors.

The AMA plays an important role in promoting the highest standards of ethical behaviour expected of doctors in Australia, upholding the rights of doctors to fulfil their ethical obligations to patients and society, and advocating for a fair and just health system for all.

The AMA's *Code of Ethics* provides guidance to doctors in their relationships with patients, colleagues and society. It enshrines the core values of the profession, including respect for patients, their family members, colleagues and other health care workers, trust, compassion, altruism, integrity, advocacy and justice, accountability, leadership, collaboration and collegiality.

While the modern health care environment is one that evolves and changes over time, and is reflective of the current social, economic and political environment, doctors continue to have an ethical duty to ensure that the health needs of patients remain their primary focus, and to advocate that the health care environment remains patient-centred.

The *Code of Ethics* is currently being updated to ensure it continues to meet contemporary professional and societal expectations for ethical professional behaviour, and that it supports doctors in their commitment to the primacy of patient care. This will be the twelfth update of the Code since 1964, and the fourth since we entered the 21st century.

In addition to serving the medical profession and the wider community, the *Code of Ethics* establishes overarching ethical principles that underpin all AMA policies.

Further, we have developed a diverse range of ethics-focussed position statements and guidelines to support our members, and to advocate for patients and the wider health system, covering issues such as medical professionalism; professional conduct; patient care and safety; conscientious objection; reproductive health; end of life care; genetic issues; organ donation; public health emergencies; asylum seekers and refugees; aged care; custodial settings; and stewardship.

The AMA has also formally adopted a range of declarations from the World Medical Association, providing a sound basis for advocacy on issues including professional autonomy and clinical independence; the role of medical neutrality in times of armed conflict; and condemning medical participation in any form of torture, cruel or inhumane treatment or punishment.

We encourage all members to utilise the AMA's ethics-focussed position statements and guidelines which are publicly available in the Ethics & Professionalism section of the AMA's website at ama.com.au/advocacy/ethics-professionalism.

The current *Code of Ethics* is available at ama.com.au/ethics. We will keep members informed when the updated Code has been approved and becomes publicly available.

If you have any questions regarding the *Code of Ethics* or any other ethics-related position statements or guidelines, please send them to ethics@ama.com.au.

Research

Wrist action little help in weight loss

Fitbits and other wearable activity tracking devices could soon join exercise bikes and ab crunch machines in the list of fitness and weight loss technologies that fail to deliver.

While the devices are sure to find their way into many Christmas stockings this year, researchers at the University of Pittsburgh have questioned whether they really help to put people on a path to a leaner, fitter self.

They recruited 471 adults aged between 18 and 35 years with a body mass index of between 25 and 40. All were put on a low-calorie diet with prescribed increases in physical activity and group counselling sessions.

After six months, participants were randomly allocated to one of two groups. The first group began monitoring their diet and activity themselves, and recorded the data on a website, while the second group were given a wearable device and accompanying web technology.

While, over a two-year period, both groups recorded significant improvements in body composition, fitness, physical activity and diet, the group without the wearable devices lost an average of 5.9 kilograms, while those with the devices lost 3.5 kilograms.

The researchers admitted that the results could not be generalised to other age groups, and said the wearable technology used (attached to the upper arm) was different to more contemporary wrist-based devices.

But the results suggest people should be cautious in what benefit they expect such devices might confer in the battle against flab.

"Devices that monitor and provide feedback on physical activity may not offer an advantage over standard behavioural weight loss approaches," they said.

The study was published in the *Journal of the American Medical Association.*

ADRIAN ROLLINS

Nutting allergies out

Exposing babies to peanuts and eggs may head off a lifetime of unpleasant and potentially deadly allergies.

As researchers puzzle over the proliferation of food and other allergies in Western populations, a high-level analysis of results from 146 studies has found that parents could reduce the risk of allergic reactions in their child to eggs and peanuts later in life by introducing but foods at an early stage.

They found that children introduced to eggs at four to six months of age were less likely to develop an allergy, as were those exposed to peanuts between four and 11 months.

But this inuring effect did not necessarily apply to other foods and substances.

The researchers said there was low certainty that feeding fish to babies early on would result in "reduced allergic sensitisation and rhinitis".

Similarly, "there was high-certainty evidence that timing of gluten introduction was not associated with celiac disease risk, and timing of allergenic food introduction was not associated with other outcomes".

While the conclusions are based on the findings of a large number of studies, the researchers were cautious about drawing any definitive conclusions.

"Certainty of evidence was downgraded because of imprecision of effect estimates and indirectness of the populations and interventions studied," they said. "Timing of egg or peanut introduction was not associated with risk of allergy to other foods."

ADRIAN ROLLINS

Too much gluten a disease risk

High consumption of gluten is emerging as a risk factor in the development of coeliac disease.

While much attention to now has been focused on when gluten in introduced into a child's diet, a Swedish study suggests researchers should instead turn their attention to how much gluten they eat.

Sweden is considered a high-risk country for the development of coeliac disease – a gluten intolerance for which there is no known cure. The only effective treatment is to follow a gluten-free diet.

Lund University researcher Carin Andren Aronsson was keen to investigate why such gluten intolerance occurs, and examined the records of 8700 children across four countries (Sweden, Finland, Germany and the United States) who are part of The Environmental Determinants of Diabetes in the Young project.

"Our findings indicate that the amount of gluten triggers the disease," Ms Aronsson reported, adding that differences in

Research

... from p29

dietary habits between children from different countries should also be examined.

She found that Swedish children up to two years of age with a high gluten intake of more than five grams a day had twice the risk of developing coeliac disease compared with those who ate less.

Further, she discovered that Swedish children had a higher risk of developing the auto-immunity that gives rise to coeliac disease than children in other countries studied, including Finland, Germany and the United States.

But the researcher dismissed the idea that breast feeding, frequently a point of speculation, had a role to play.

"There was no apparent connection between the duration of the period of breast feeding and the risk of developing coeliac disease," Ms Aronsson said.

She were equally unequivocal that when gluten was introduced into a child's diet was not significant.

"The timing alone of the introduction of gluten in the diet is not an independent risk factor for subsequent development of gluten intolerance," she said.

Ms Aronsson said she intended to expand her study to include children from more countries, with data retrieved over a longer time span.

ADRIAN ROLLINS

INFORMATION FOR MEMBERS

1 NOVEMBER 2016 – AMA LIST OF MEDICAL SERVICES AND FEES

The 1 November 2016 edition of the AMA Fees List will soon be available in hard copy and electronic formats.

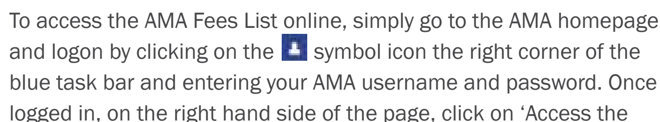
The hard copy book is for AMA members in private practice or with rights of private practice, and salaried members who have requested a book. Dispatch of the book will commence on 14th October 2016.

The AMA Fees List is available in the following electronic formats:

- **PDF** of the hard copy book
- **CSV** file for importing into practice software
- **Online database** where members can search for individual or groups of items and download the latest updates and electronic files.

PDF and CSV versions of the AMA Fees List will be available to all members via the Members Only area of the AMA website http://www.ama.com.au/resources/fees-list from 21st October 2016. The Fees List Online Database will be updated on 1st November 2016.

Access the Fees List via the AMA website



To access the AMA Fees List online, simply go to the AMA homepage and logon by clicking on the symbol icon the right corner of the blue task bar and entering your AMA username and password. Once logged in, on the right hand side of the page, click on 'Access the AMA Fees List'. From here you will find all electronic formats of the Fees List.

Access the AMA Fees List Online Database

The AMA Fees List Online Database is an easy-to-use online version of the AMA Fees List. To access the database follow the steps above or go to: https://ama.com.au/article/ama-fees-list-online

AMA Fees Indexation Calculator

Also available to members is the AMA Fees Indexation Calculator, this allows you to calculate your own fee increase based on your individual cost profile. To access the AMA Fees Indexation Calculator, follow these steps:

1) From the home page hover over **Resources** at the top of the page. A drop down box will appear. Under this, select **Fees List**.
2) Select AMA Fees Indexation Calculator (Members Only)

Members who do not currently have a username and password should email their name, address and AMA member services number to **memberservices@ama.com.au** requesting a username and password.

If you would like to request a copy of the AMA Fees List please contact the AMA on 02 6270 5400 or email feeslist@ama.com.au.

Superbugs could be 'worse than global financial crisis': World Bank

The rise of drug-resistant superbugs could cost more than US$1 trillion a year in extra health costs, plunge millions into extreme poverty and inflict greater economic damage than the global financial crisis if left unchecked, the World Bank has warned.

As world leaders prepare to discuss the threat of antimicrobial resistance (AMR) at the UN General Assembly in New York, the World Bank has released projections showing that the current widespread and often indiscriminate use of antibiotics will have severe health and economic consequences unless urgent action is taken.

"The scale and nature of this economic threat could wipe out hard-fought development gains and take us away from our goals of ending extreme poverty and boosting shared prosperity," World Bank Group President Jim Yong Kim said.

Modelling by the global development agency indicates that without more careful use of antibiotics, AMR will have an increasing effect. Growing numbers of people, particularly in poorer countries, will succumb to infectious diseases; people will get sick more often; health costs will soar; livestock production will tumble and global trade will shrink.

Even in the best case scenario, the World Bank warns that without urgent action to curb AMR, by 2050 global economic growth would be 1.1 per cent lower, health costs will be up by US$300 million a year, global trade would be down by 1.1 per cent and an extra eight million people would be thrown into extreme poverty.

But the consequences could be much worse.

In its more pessimistic high-AMR scenario, the agency estimates that by 2050 global growth could be cut by 3.8 per cent, the number in extreme poverty would soar by an extra 28.3 million and countries would have to spend an extra US$1.3 trillion a year on health care.

"Drug-resistant infections, in both humans and animals, are on the rise globally," the World Bank said.

"If AMR spreads unchecked, many infectious diseases will again be untreatable. Without AMR containment, humanity may face a reversal of the massive public health gains of the past century, and the economic growth, development, and poverty reduction that they enabled.

"The annual costs could be as large as those of the global financial crisis that started in 2008."

The World Bank said these "immiserating" effects would fall hardest on low-income countries and would derail current progress toward the goal of eliminating extreme poverty by 2030.

The AMA has been at the forefront of efforts to curb the use of antibiotics, supporting campaigns such as the Choosing Wisely initiative to educate doctors and, more importantly, patients, about the appropriate application of such medications.

One of the biggest targets of these campaigns has been to educate patients, particularly parents, about the inappropriateness of prescribing antibiotics for the treatment of colds and other viral infections.

Sydney GP and former Chair of the AMA Council of General Practice Dr Brian Morton advised in 2014 that, "prudent use of antibiotics…includes not using them when their benefit is minimal. Patients…need to understand that the symptoms they are experiencing is their own immune system working to resolve the infection. They also need to understand that using antibiotics in such cases may actually do more harm than good. Not only can it contribute to the development and transfer of resistant bacteria but patients risk possible side effects, such as upsetting the balance of gut bacteria and rashes".

The World Bank has urged a holistic approach to tackling AMR, warning it cannot be treated as a discrete health problem.

"Drug-resistant diseases are very much like infectious diseases with pandemic potential: because there is "no cure," their spread can be hard to control. The surveillance, diagnostic, and control capacity to deal with the first group of diseases is the same capacity that is required to control of diseases in the second group," it said.

The World Bank said investing in core human and veterinary public health systems in low- and middle-income countries was fundamental to establishing the surveillance needed to identify and control AMR.

"Increased global cooperation is essential as AMR containment is a global public good. It will require coordinated efforts to monitor, regulate, and reduce the use of antibiotics and other antimicrobials," the agency said.

ADRIAN ROLLINS

NHS dispute leaves bitter divide

National Health Service trusts across England have begun phasing in a controversial employment contract for junior doctors in the latest setback for medical staff protesting the deal.

Less than a week after the British Medical Association's junior doctor committee abandoned plans for a series of five-day strikes, NHS employers began signing up staff to a single national contract to cover all 54,000 doctors below consultant level employed by the NHS.

> "Late last month a judicial review threw out claims by the group Justice for Health that Mr Hunt had acted beyond his powers by seeking to impose the contract despite its overwhelming rejection by junior doctors"

The move came after a last-ditch bid to have the actions of British Health Secretary Jeremy Hunt in pushing forward the contract declared illegal failed.

Late last month a judicial review threw out claims by the group Justice for Health that Mr Hunt had acted beyond his powers by seeking to impose the contract despite its overwhelming rejection by junior doctors.

Within days, the BMA dumped plans for a rolling series of stoppages, but junior doctor committee chair Dr Ellen McCourt vowed that the fight was not over.

Dr McCourt said the BMA had not accepted the contract and was considering a range of options to force changes to address outstanding concerns.

The dispute flared last year when Mr Hunt announced plans to introduce a single national contract for NHS junior doctors that included a controversial clause for round-the-clock seven-day roster without any additional compensation.

The contract was overwhelmingly rejected by junior doctors in a vote late last year, which they followed up with an unprecedented series of strikes in the first half of 2016.

Following negotiations, a compromise deal that had the backing of the BMA leadership was also rejected by the junior doctors, and Mr Hunt declared an end to talks, instead moving to impose the contract.

But, even though the threat of five-day strikes has receded, the dispute has created enormous ill-will, according to Dr McCourt.

"Morale among junior doctors is at an all-time low," she told *The Guardian.* "[There is] a deep sense of anger and mistrust that has built up towards the Government over the last year."

There are concerns the dispute will speed the exodus of younger doctors from the UK.

A survey of 420 doctors who have studied medicine in the past decade found 42 per cent intended to practise overseas, saying their current experience as a doctor was worse than they expected when they graduated. A further 16 per cent reported they had "taken a break" from medicine.

Dr McCourt told the *Daily Express* the findings were unsurprising.

"We have been saying for some time that morale amongst doctors is at an all-time low and these figures show, once again, that doctors are on a knife edge," she said. "They are reaching their limit, and if stretched any further, they will walk. Given the results of this study, it makes no sense for the Government to rush the implementation of the junior doctor contract, which will only make things worse."

The threat of an exodus of locally-trained doctors has been compounded by the prospect that Britain will find it harder to attract foreign doctors following the Brexit vote.

Mr Hunt has announced plans to add 1500 medical school places a year in an effort to make the NHS in England "self-sufficient" in doctors after Britain leaves the European Union.

ADRIAN ROLLINS

Brennan Wines – from a New York state of mind

BY DR MICHAEL RYAN

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Family enterprises always ooze passion with artistic flare, dutiful care of the end product and boundless enthusiasm.

The Brennans have excelled in these areas of winemaking since Murray Brennan, the father, purchased a landholding in 1994. Originally from the 'foreign region' of Auckland, and an oncologist, Murray had been smitten by the Central Otago's rugged beauty - particularly the wine potential of Gibston Valley.

There, the high quality fruit from the hand-planted, handpicked vineyards was sold to another high quality producer, Peregrine Wines. But then Murray travelled to the United States to expand his training in oncology. While there, he met and married a New Yorker and his son, Sean, was raised in the US. Eventually, in 2006, Murray returned from his overseas sojourn to take up the position of winemaker.

Sean had worked in wine retail in New York, and had also helped out with some in both the US and Australia. He gained his vinous university degree from Roseworthy in Adelaide. Two years of working in a relatively cool climate with significant grape diversity stood him in good stead for his Otago return.

The Otago vineyard is surrounded by some iconic yet collegiate neighbors. Vali Wines and Mt Rosa are a stone's throw away. The soils in the region are alluvial with glacial schist. These features can add minerality to already complex flavours.

Pinot Noir is dominant, taking up eight of the 10 hectares of planting. Other varieties include Pinot Grigio/Gris, Chardonnay, Riesling, Muscat, Gewürztraminer and Otago's only Tempranillo.

Sean is a fanatic in the vineyard. The "off season" is still a busy time, with attention to detail and maintenance that will give next vintage its best chance to shine. All grapes are handpicked and the sorting process begins in the vineyard as individual bunches are directed into different pathways that will ultimately result in a wine of high quality.

Having had a predominately New York upbringing, it is easy to sense the American influence. New York itself is about being big, not gross, individual but not gaudy, and full of confidence. In general, the wines have great fullness of fruit, rich flavors and robust structure.

The philosophy of slow but deliberate growth will steer Brennan Wines into a sound future. The first US exports have begun. A standalone Riesling will be released. Zinfandel is being planted - all inspired by that Hudson River line.

WINES TASTED

1. 2015 Brennan B2 Trio Gibston

Light green to yellow colour. White peach, some rose petals, grassy notes with hints of Chinese 5 spice. Fresh fruit flavor on the anterior plate with mid palate acid. Plush aromatic wine to have with white Castella.

2. 2015 Brennan B2 Pinot Noir Rose (70% Pinot Noir, 30% Tempranillo)

Spicy cherry notes with a hint of bramble. Fresh, smooth fruit flavors that ebb and flow. Supported by subtle tannins that allow the wine to pair with a range of foods such as chicken mushroom vol-au-vent.

3. 2015 Brennan Tempranillo

Dusky red in color. Youthful, flirtatious nose of dark cherry fruits, spicy plums and hints of earthy florals. Ample fruit flavors with white pepper spices. Medium tannin structure. Have with some mild Sopressa

4. 2015 Brennan B2 Pinot Noir

Dark red in color. Powerful bouquet of dark berry fruits, spicy savoury notes, with secondary floral herbal nuances. Powerful fruit ascends on the palate and is sustained by masculine grippy tannins. An excellent wine with duck and abalone risotto.

Whistleblowers are 'unreasonable' people - "Unsafe At Any Speed!"

BY DR CLIVE FRASER

It's been just over 50 years since a young lawyer from Connecticut named Ralph Nader published a book about the American automotive industry titled, *Unsafe At Any Speed : The Designed-In Dangers of the American Automobile*.

As a whistleblower, Nader should have been prepared for the retaliatory backlash from the politically conservative automotive giants because they would not be pleased by what he had to say in his book.

Nader was put under surveillance, his phone was tapped and prostitutes were hired by General Motors in an attempt to entrap the young man, apparently to no avail.

So why did General Motors go to such great lengths to discredit Nader?

One would only have to start by reading the first chapter in his book which was titled, "The Sporty Corvair – The One-Car Accident".

This chapter featured a discussion of the safety and handling characteristics of the 1960 to 1963 rear-engine Chevrolet Corvair.

It seems that the car was prone to dangerous over-steer because of its swing-axle configuration and the absence of $6 per car anti-sway stabilizers which were left out due to cost-cutting.

General Motors had even ignored the advice of its own engineer (George Caramagna) that the anti-sway bars should come as standard - though they were offered as an option.

A subsequent 1972 review by the National Highway Safety and Traffic Administration did eventually find that the 1963 Corvair was "no less safe" than its contemporary rivals, the Ford Falcon and Plymouth Valiant.

But the rest of Nader's book was still on fire about hood ornaments which might seem to be designed to impale unsuspecting pedestrians, non-standardized gear shift selectors which could inadvertently send the car backwards, shiny chrome-plated and non-padded dashboards that dazzled drivers' eyes, and sharp knobs and switches that speared passengers.

Manufacturers were obsessed with styling and horsepower and didn't think that safety would sell.

They believed that crashes were caused by bad drivers and bad driving.

The United States was falling way behind European manufacturers who were fitting radial-ply tyres and disc brakes which were actually saving people's lives.

Nader pointed out that Volvo could make a profit and sell cars with three-point seatbelts.

It really looked like Nader's book was going to be bad for business, with the final chapter suggesting that, "the automotive industry should be forced by government to pay greater attention to safety in the face of mounting evidence about preventable death and injury".

At the time about 1000 people per week were being killed in US traffic crashes.

The US Government did eventually take notice and on 9 September 1966 the National Traffic and Motor Vehicle Safety Act was enacted to empower the Federal Government to set and administer new safety standards for motor vehicles and road traffic safety.

In the 50 years since the US legislated safety standards automotive fatalities have reduced from 5.50 deaths per 100 million vehicle miles travelled to 1.07.

Unsafe At Any Speed was undoubtedly a public health success story.

So whatever happened to Ralph Nader?

His continued political activism has produced more legislation including the Freedom of Information Act, Foreign Corrupt Practices Act, Clean Water Act, Consumer Product Safety Act, and the Whistle-blower Protection Act

He has run for US president many times since 1972.

His candidacy in 2000 may have unwittingly granted George W Bush the top job when Al Gore fell 537 votes short in Florida on a split liberal/Democrat vote.

Nader has been affectionately described as "An Unreasonable Man".

According to George Bernard Shaw, "The reasonable man adapts himself to the world; the unreasonable one insists on trying to adapt the world to himself. Therefore, all progress depends on the unreasonable man".

Safe motoring,

Doctor Clive Fraser
doctorclivefraser@hotmail.com

PS Ralph Nader catches public transport and does not own a car.

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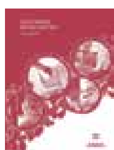

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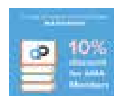

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