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BUDGET TIME

Time to farewell the freeze, p3

INSIDE

AMA

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In this issue

Cover pic: AMA President Dr Michael Gannon and Health Minister Greg Hunt in discussions ahead of the Budget.

Hoping for a healthy Budget

The Federal Budget will be handed down by Treasurer Scott Morrison in Parliament House, Canberra on Tuesday May 9.

The AMA will be searching the Budget's contents to learn just how the nation's health budget will be impacted by the new fiscal direction of the Government of Prime Minister Malcolm Turnbull.

Health Minister Greg Hunt has consulted extensively with the AMA and is in no doubt of the issues important to doctors and patients across Australia.

His language has been positive and there exists an apparent goodwill and willingness to do the right thing in prioritising health in the nation's budget.

Just how persuasive Minister Hunt has been inside Cabinet, will be seen once the Budget is handed down.

There have been good signs real progress will be made.

Unwinding the Medicare rebate freeze is one topic on which the Minister has been sending positive messages.

"The Prime Minister has said and I have said that is an item that we would be willing to review and we are willing to review subject to a very clear set of reforms that will help make the system stronger and better," Mr Hunt has recently said.

This was welcomed by the AMA, but the extent of any thawing of the freeze remains to be seen.

AMA President Michael Gannon said the Medicare rebate freeze, which has been in place since 2010, having first been introduced by the then Labor Government, had become a "barrier to reform" between the health sector and the Coalition.

And he said ending the freeze wasn't the only health policy and funding issue the Government needs to address.

In the AMA's Pre-Budget Submission, Dr Gannon argues that health is the best investment the Government can make.

"The AMA agrees with and supports budget responsibility. But we also believe that savings must be made in areas that do not directly negatively affect the health and wellbeing of Australian families," Dr Gannon said.

"Health must be seen as an investment, not a cost or a Budget saving.

"Any changes must be undertaken with close consultation with the medical profession, and with close consideration of any impact on patients, especially the most vulnerable – the poor, the elderly, working families with young children, and the chronically ill.

"The Government must not make long-term cuts for short-term gain. Patients will lose out.

"Primary care and prevention are areas where the Government can and should make greater investment. General practice, in particular, is cost-effective and proven to keep people well and away from more expensive hospital care.

"The Government must also fulfill its responsibilities – along with the States and Territories – to properly fund our public hospitals. So too, the Government must deliver on its commitments to improve the health of Indigenous Australians."

In an apparent genuine Budget leak to News Corp newspapers, Health reporter Sue Dunlevy suggested patients and taxpayers will pay less for hundreds of medicines as a result of the Budget.

The Federal Government will look to secure $1.8 billion in savings from big drug companies.

"However, many people will be pushed to switch to cheaper generic versions of their medicines under reforms to save the taxpayer money," she wrote.

"And the price of X-rays and scans could rise with the Government poised to abandon an election pledge to index the Medicare rebates for these services."

News Corp also revealed: (the points below are directly quoted from the article.)

- The Medicare rebate for bulk billed GP visits will rise for concession patients from July this year and from July 2018 for general patients;
- The price of two of the most expensive medicines on the drug subsidy scheme will be slashed by 25 per cent;
- Chemists will get taxpayer funding to compensate them for low prescription volumes and $600 million for in pharmacy diabetes checks;
- Pharmaceutical companies will suffer major price cuts for hundreds of their medicines; and
- A 2014 plan to raise the price of prescription drugs by $5 is expected to be abandoned.

Mr Hunt did not comment on the report except to say – through a spokesman – that the Government's goal was always to reduce the cost of medicines for Australian patients, and that any claim about restricting access to medicines was "completely false".

Shadow Health Minister Catherine King said the reports suggested the Government was attempting to pick and choose which parts of the Medicare freeze to fix.

"If the Government's six-year freeze on GPs, specialists' consultations and procedures, and allied health professionals is not immediately lifted on Budget night, it will be yet another blow to our hard-working medical professionals and more evidence of how little this Government listens," she said.

CHRIS JOHNSON

Welcome and concern for new visa system

The AMA has cautiously welcomed the Government's new visa arrangements while it waits for more information about the possible impact of the changes on medical workforce shortages.

In a surprise announcement in April, Prime Minister Malcolm Turnbull signalled the end of the current temporary skilled workers visas regime.

The 457 visas will be abolished from March next year and replaced with a new Temporary Skills Shortage Visa (TSS).

The new system will have tighter conditions and cater for a smaller number of eligible occupations.

It will also be harder to progress to permanent residency from the new visa class.

The AMA has been advised that doctors will still be eligible for the new visa, but there is little detail about medical specialties or groups.

Existing 457 visa holders will continue on the same conditions they have now, but it is important that doctors with these visas who have been working hard towards permanent residency are not disadvantaged.

AMA President Dr Michael Gannon said international medical graduates (IMGs) have made a huge contribution to the Australian medical workforce, especially in rural areas and during periods of chronic workforce shortages.

"Many communities would not have doctors if it were not for the excellent work of IMGs," Dr Gannon said.

"Australia is presently in the fortunate position of producing sufficient locally-trained medical graduates to meet current and predicted need.

"It is time to focus our energies on training the hundreds of Australian medical graduates seeking specialist training.

"But we still need to have the flexibility to ensure that under-supplied specialties and geographic locations can access suitably-qualified IMGs when locally trained ones cannot be recruited."

Dr Gannon said it was important to strike the right balance between filling vacancies with locally trained graduates and ensuring communities, especially in rural and remote Australia, have doctors in the right numbers and with the appropriate specialist skills and experience to meet patient needs.

"The AMA welcomes the emphasis of the new arrangements to better target recruitment and the mandatory requirement for

Welcome and concern for new visa system

... from p3

labour market testing, which the AMA has been calling for in light of the significant increases in locally-trained medical graduate numbers," he said.

"We also need to see the Government step up policy efforts to encourage local graduates to work in the areas and the specialties where they are needed.

"We need to see flexibility in the arrangements, so for those specialties or those areas of the workforce where genuine shortages remain, that we are able to get staff from overseas.

"But what we've seen too much of is this mechanism gamed. We need employers to be more honest about the needs for extra staff, and what we need to see is greater investment in training positions for those hundreds of locally trained doctors who are now lining up desperately trying to find specialist training.

"And then deploy them where they're needed, making sure that Australians in rural and regional areas continue to be well serviced by health professionals."

The AMA is calling for a third of all medical students to come from rural areas, and wants to see more positive experiences for junior doctors and medical students when they go to the regions.

"We know from evidence that that means they're more likely to go and work in the bush later," Dr Gannon said.

"There's a moral dimension to these changes. Every time Australia recruits a doctor from a Third World country, or from another country, they are taking those doctors away from populations that desperately need them.

"Australia's definitely reached self-sufficiency in terms of total numbers of medical graduates.

"We've got to make sure that the public hospitals, the private hospitals, the general practices, have the training positions so that we can get Australian-trained doctors out there and working."

The Australian Medical Students' Association (AMSA) also broadly supports the Government's new visa arrangements, but is concerned the impact on international medical students graduating in Australia has been overlooked.

AMSA is the peak representative body for Australia's 17,000 medical students; 2,550 of which are international students from USA, Canada, Singapore, Malaysia, UK and many other countries.

Under the new changes, international medical students wanting to stay in Australia may be forced to take a gamble on their career.

Following graduation, it will be a race against visa expiry to enter specialty training in order to meet eligibility requirements to stay in Australia.

The new TSS visa requires holders to have completed two years of work experience, which graduates can complete on a 485 visa.

However, since Resident Medical Officers (RMOs) are only on the short-term skilled occupational list (STSOL), graduates will only have two to four years to begin their vocational training.

This timeline does not allow flexibility for unforeseen circumstances. Further, the STSOL does not include a pathway into permanent residency, leaving many international students uncertain about the future.

Andreas Hendarto, an international medical student about to graduate from University of Melbourne said the information received was not yet complete, but he felt there was cause for concern.

"As a fresh graduate, I will have to apply for a short-term two-year visa under the new scheme, ensuring that at the end of that visa, I will have to renew it again for another two years and hope that by the time that expires, I will be a registrar in a medical specialty listed as eligible for the four-year medium-to-long-term visa, which will allow me to stay in the country – provided my specialty is still listed as part of the PR skilled occupation list," he said.

"If I fail at any stage of this process, I will receive no reprieve.

"I had been looking forward to graduating and contributing back to the Australian healthcare system, which kindly hosts and teaches many international medical students for up to seven years.

"What then, can I do? I have spent the best part of eight years in this country, and I look forward to spending many more.

"But this new TSS scheme means that after many more years of working hard, I might still be forced to take my hard-earned experience and knowledge in Australian health care elsewhere – simply because I was here at the wrong time."

CHRIS JOHNSON

Decentralisation push could hit health agencies

Federal Health Department agencies could be relocated if the Government's new push for decentralisation gets momentum.

Health Minister Greg Hunt, along with Aged Care and Indigenous Health Minister Ken Wyatt, may have to justify their department and agencies remaining in the nation's capital or offer up a business case for suitable relocations.

The Nationals – the Coalition's junior partner – are driving a push to decentralise as many government departments as possible in order to rejuvenate struggling regional centres.

Regional Development Minister Fiona Nash, who is also the Deputy Nationals Leader, announced during a speech to the National Press Club, that all Ministers would have to make the case for agencies within their portfolios to remain in Canberra.

Criteria to make the assessments over what agencies to move should be finalised mid-year, and Ministers will have until August to report on which of their departments could be suitable for a regional area.

They will have to provide solid reasons for claiming any agency is not suitable for relocation.

Senator Nash said regional areas deserved the jobs opportunities that decentralisation will offer.

She is supported in the push by Deputy Prime Minister and Nationals Leader Barnaby Joyce, who is already relocating the Australian Pesticides and Veterinary Medicines Authority to his own electorate of Armidale in northern NSW.

But the Opposition has described the move as "trying to rip apart the nation's capital".

"For a government which preaches efficiency and joined-up government it is immensely hypocritical that they are pursuing a policy that will make government more inefficient and more fragmented," said Labor MP Andrew Leigh whose electorate of Fenner is in Canberra.

Gai Brodtmann, the Federal Member for Canberra, also condemned the announcement.

"This is a blatant example of the Government's complete and utter disdain for Canberra," she said.

"How long has the Government been hatching this secret plan to essentially completely deconstruct Canberra, to deconstruct Sir Robert Menzies' legacy?"

The Labor MPs have been joined by their conservative colleagues in the capital city, who say their own Government's push is misguided.

The ACT's only federal Liberal, Senator Zed Seselja, said he was "extremely disappointed" by the announcement.

"I have been on the record and made it very clear that I support Canberra as the national capital and the centre of government," he said.

"If the Commonwealth wants to consider moving government departments they should be moved from Sydney or Melbourne rather than Canberra, which is a regional centre.

"The relocation of a small department like APVMA was difficult enough and resulted in the loss of a large proportion of highly trained specialist staff."

The leader of the Liberals in the ACT Assembly, Territory Opposition Leader Alistair Coe, said he too was concerned by the push.

"Canberra was designed and created to be the capital of Australia, and part of that capital means housing the public service," he said.

"There really do need to be exceptional circumstances for any public service agency to be located outside of the ACT."

ACT Chief Minister, Labor's Andrew Barr, said the proposed changes could benefit Canberra if the decentralisation meant agencies located in NSW and Victoria were moved into the capital.

"Around 62 per cent of all Australian Government employment is located outside of the ACT," Mr Barr said.

"So there is plenty of scope for the decentralisation agenda to occur in the big states without undermining the core purpose of the national capital or the effectiveness of public administration."

Canberra's only daily newspaper, Fairfax's *Canberra Times*, responded with a front page headline screaming THE WAR ON CANBERRA following the announcement.

While it is expected the Department of Health itself – currently located in Canberra's Woden precinct – is not a target, it is by no means exempt from the push.

The relocation of some of its 17 operating portfolio agencies is a real possibility.

CHRIS JOHNSON

Clearing the air on pollution

AMA President Dr Michael Gannon has gone public to clear the air about the AMA's position on pollution and climate change following misinterpretation in some quarters of his comments about the closure of the Hazelwood power plant in Victoria.

Dr Gannon strongly promoted the AMA's long-held policies on pollution and climate change and health, and raised the need to be conscious of the health impacts of significant changes that affect local communities and families.

He said that, as a responsible health advocate, he raised the issue of care and concern for the people who lost their jobs because of the Hazelwood closure, and the broader impacts on their families and communities.

"I acknowledged the long-term effects of pollution in the Latrobe Valley, and cited the work of doctors, led by Doctors for the Environment Australia (DEA), in highlighting the health effects of pollution in other incidents, including the Morwell fire in 2014," Dr Gannon said.

"I raised the very real outcomes that stem from unemployment such as mental health, loss of self-esteem, alcohol and drug misuse, domestic violence, self-harm, suicide, and on it goes.

"These health effects are well documented in scientific studies around the world.

"I believe that governments and industry must be aware of, and make plans for, the impacts of transition – from employment to unemployment, from old energy sources to new energy sources, and for the ongoing impact of climate change on public health.

"It is a good thing for the AMA to responsibly point out the health impacts and societal impacts on many levels, at varying degrees, from situations like the Hazelwood closure. This is part of our job as a leading and respected health advocate.

"AMA advocacy is very broad and very deep. It has to be. No other medical or health organisation in the country can even come close to initiating or influencing change across the health system and society.

"We speak out on issues as diverse as workplace bullying and harassment, Indigenous health, women's health, men's health, end of life care, family and domestic violence, female genital mutilation, concussion in sport, and firearms.

"These issues cover many facets of society and many ideologies.

Some are regarded as progressive, some are conservative, but most are controversial – and therefore potentially divisive.

"We do this on top of our other core business – Medicare, the PBS, public hospital funding, the PSR, medical workforce, private health, rural health, doctors' health, and the broad range of public health issues.

"The AMA has to always tread a fine line, and we do that willingly. And so it is with contemporary issues like climate change, pollution, air quality, and renewable energy.

"The AMA believes that climate change poses a significant worldwide threat to health, and urgent action is required to reduce this potential harm.

"We have been vocal about the need for urgent government action, and have repeatedly called for the development of a National Strategy for Health and Climate Change.

"The AMA Position Statement on *Climate Change and Human Health 2015* is a very strong document. It was developed from the ground up, with input from AMA members at grassroots level around the country.

"The evidence is clear – we cannot sit back and do nothing," Dr Gannon said.

Dr Gannon urges AMA members and all doctors to visit the AMA website to stay abreast of the AMA's political advocacy and broad policy agenda.

JOHN FLANNERY

Indexation freeze hits veterans' health care

A recent survey of some AMA members has highlighted the impact of the Government's ongoing indexation freeze on access to Department of Veterans' Affairs (DVA) funded specialist services for veterans.

> "The AMA conducted the survey following anecdotal feedback from GP and other specialist members that veterans were facing increasing barriers to accessing specialist medical care."

The DVA Repatriation Medical Fee Schedule (RMFS) has been frozen since 2012.

The AMA conducted the survey following anecdotal feedback from GP and other specialist members that veterans were facing increasing barriers to accessing specialist medical care.

Running between March 3 and 10, the survey was sent to AMA specialist members (excluding general practice) across the country.

It attracted interest from most specialties, although surgery, medicine, anaesthesia, psychiatry and ophthalmology dominated the responses.

More than 98 per cent of the 557 participants said they treat or have treated veterans under DVA funded health care arrangements.

For the small number of members who said they did not, inadequate fees under the RMFS was nominated as the primary reason for refusing to accept DVA cards.

When asked, 79 per cent of respondents said they considered veteran patients generally had a higher level of co-morbidity or, for other reasons, required more time, attention and effort than other private patients.

According to the survey results, the indexation freeze is clearly having an impact on access to care for veterans and this will only get worse over time.

Table 1 highlights that only 71.3 per cent of specialists are currently continuing to treat all veterans under the DVA RMFS, with the remainder adopting a range of approaches including closing their books to new DVA funded patients or treating some as fully private or public patients.

Table 1

Which of the following statements best describes your response to the Government's freeze on fees for specialists providing medical services to veterans under the Repatriation Medical Fee Schedule (RMFS):

Answer Options	Response Percent
I am continuing to treat all veterans under the RMFS	71.3%
I am continuing to treat existing patients under the RMFS, but refuse to accept any more patients under the RMFS	9.9%
I am treating some veterans under the RMFS and the remainder either as fully private patients or public patients depending on an assessment of their circumstances	10.8%
I am providing some services to veterans under the RMFS (e.g. consultations) but not others (e.g. procedures)	5.6%
I no longer treat any veterans under the RMFS	2.4%

Indexation freeze hits veterans' health care

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If the indexation freeze continues, the survey confirmed that the access to care for veterans with a DVA card will become even more difficult.

Table 2 shows that less than 45 per cent of specialists will continue to treat all veterans under the DVA RMFS while the remainder will reconsider their participation, either dropping out altogether or limiting the services provided to veterans under the RMFS.

Table 2

Which of the following statements best describes your likely response if the Government continues its freeze on fees for specialists providing medical services to veterans under the RMFS:	
Answer Options	**Response Percent**
I will continue to treat all veterans under the RMFS	43.8%
I will continue to treat existing patients under the RMFS, but refuse to accept any more patients under the RMFS	15.5%
I will treat some veterans under the RMFS and the remainder either as fully private patients or public patients depending on an assessment of their circumstances	21.1%
I will provide some services to veterans under the RMFS (e.g. consultations) but not others (e.g. procedures)	8.4%
I will no longer treat any veterans under the RMFS	11.2%

In 2006, a similar AMA survey found that 59 per cent of specialists would continue to treat all veteran patients under the RMFS.

There was significant pressure on DVA funded health care at the time, with many examples of veterans being forced interstate to seek treatment or being put on to public hospital waiting lists.

The Government was forced to respond in late 2006 with a $600m funding package to increase fees paid under the RMFS and, while the AMA welcomed the package at the time, it warned that inadequate fee indexation would quickly erode its value and undermine access to care.

In this latest survey, this figure appears likely to fall to 43.8 per cent – underlining the AMA's earlier warnings. The continuation of the indexation freeze puts a significant question mark over the future viability of the DVA funding arrangements and the continued access to quality specialist care for veterans.

The AMA continues to lobby strongly for the lifting of the indexation freeze across the Medicare Benefits Schedule and the RMFS, with these survey results provided to both DVA and the Health Minister's offices. The Government promotes the DVA health care arrangements as providing eligible veterans with access to free high quality health care and, if it is to keep this promise to the veterans' community, the AMA's latest survey shows that it clearly needs to address this issue with some urgency.

CHRIS JOHNSON

Serious issues discussed at World Congress of Public Health

An array of brilliant and captivating speakers held centre stage at the 15th World Congress of Public Health, discussing themes as diverse as tobacco, alcohol and illicit drugs, obesity, and maternal and infant health.

The AMA's Public Health secretariat attended much of the five-day Congress, which was held in Melbourne in April and which brought together national and international experts across a wide range of health areas.

The tobacco session canvassed policy levers to reduce smoking-related mortality, specifying that the most effective way to reduce tobacco consumption is through tobacco excise.

If you triple the price, consumption is halved and the tax yield is doubled. A 100 per cent increase in tobacco excise would reduce tobacco-related deaths by 20 per cent. We also heard about the growth of tobacco plantations, many using child labour, and the expansion of tobacco consumption in Asia.

Addressing obesity isn't so straight forward. Preventing obesity is complex and multi-layered, and it was said that single behavioural change is not enough.

A panel of experts discussed numerous approaches to ending the rise of obesity in a generation. One panellist posed the question: Who should be leading the policy, prevention and treatment agenda?

A somewhat controversial follow-up question was posed: Is health the right field to lead the drive to end obesity?

The health and medical profession is tasked with addressing obesity and the consequences of the high consumption of processed, sugary and high-fat products (and lack of exercise). But shouldn't the initiative to prevent obesity be driven by communities, families, workplaces, schools and those who are responsible for obesity?

The health sector knows what to do – or at least we broadly agree on most of the issues, factors, data, goals and targets – but the gap is in the action. The highest rates of obesity are also in the most disadvantaged quintile. This tells us where the problem is most acute. It was argued that it is time for the agricultural sector, food producers, primary industries, schools, wholesalers, retailers, advertisers and media to be held accountable.

Discussion turned to the frustration the health sector understands all too well – with so much evidence available world-wide about obesity, why is there still a lack of policy and legislative action? Australian governments have successfully initiated and implemented measures to reduce tobacco consumption (and sometimes alcohol and illicit drugs too) such as changing price, behaviours and policy settings, but this isn't being done with obesity.

It was interesting to hear from several different presenters that in relation to obesity, (and alcohol, tobacco and gambling) self-regulation hasn't worked. The message was told in different ways but essentially it was the same; that industry 'engagement' has not achieved the desired outcomes, and allowing the makers of foods and beverages, alcohol products, gambling or smoking 'alternatives' should not be involved in finding 'solutions'.

Delegates heard that these 'soft options', such as industry codes and industry-led campaigns, allow the makers and sellers (of tobacco, junk food, sugar sweetened beverages, alcohol products, gambling) to get away with proposals that favour their vested interests.

In short, commercial entities in these areas are resisters to good public health policies, legislation and stricter control. These industries cannot be trusted to make changes for the public good. Further, these industries seek to deflect, obfuscate and influence governments and the public through their own 'research' and 'engagement'.

The fact is, with all of these activities that are harmful and cause injury, illness and premature death, it is the health system that is left responsible for managing and caring for people. That's why many speakers argued that the true costs of these products should be carried by the manufacturers, not the health system.

A sugar tax has been introduced (or about to be) in Ireland, Mexico, Barbados, Chile, Hungry, UK, Philadelphia (USA) and some Pacific Islands. Interesting, one speaker argued it wasn't so much about changing behaviour, but rather that sugar-sweetened beverages are little more than water and chemicals and while the manufacturers reap in huge profits, the true costs of consumption are not reflected in the price.

The Congress was a very well organised event that showcased the latest research, initiatives and policies that are improving our knowledge and understanding of global public health.

• *See also World News, p19*

SIMON TATZ, DIRECTOR, PUBLIC HEALTH

Doctors best to give flu vaccines

The AMA has expressed concern that pharmacists will be able to administer flu shots to adults this winter.

This is the first year pharmacists Australia-wide are allowed to give the vaccinations, but the practice has been permitted in some States and Territories for up to two years.

With winter and the 2017 flu season fast approaching, pharmacists across Australia are preparing to administer the vaccines to adults.

But AMA Vice President Tony Bartone said getting the jabs from a local chemist was only a "second-best option".

He said while it might seem convenient to duck into a pharmacy, patients could lose out on vital consultations with their GPs.

"It is about ensuring the best possible standard of care is applied rather than an acceptable or passable standard of care," Dr Bartone said.

"If there was an adverse reaction in the retail space, it would be challenging at best and very problematic at worst.

"It is an extremely safe process, but we run the risk of overlooking and over-simplifying something that does carry a very low but inherent risk."

Dr Bartone added that some patients, especially men, might reduce regular visits to GPs if they can get their flu vaccinations at pharmacies.

He also expressed concern at how cheaply some pharmacies are offering the shots for (usually between $15 and $25, but as low as $10 in some cases), suggesting it was part of a marketing push by discount chain stores.

Anecdotal evidence suggests the cheaper the cost of the vaccination, the less privacy the patient receives, with some instances reported of pharmacists giving the shots on the shop floor by the counter and in full view of other customers.

The better pharmacies provide private rooms and health questionnaires before administering the shots.

They also have agreements with nearby medical centres in case of difficulties such as adverse reactions.

Up to one in ten adults are infected by influenza annually, while about three in ten children are infected.

It causes 1,500 to 3,500 deaths in Australia each year, usually from direct viral effects such as viral pneumonia or complications from secondary bacterial infections.

From 2016, the quadrivalent flu vaccine (QIV), which protects against four strains of flu, became publicly available and funded.

Prior to that, the trivalent vaccine (TIV), which protects against three strains of flu, was the vaccine used in Australia for many decades.

QIV and TIV were both available last year, but this year only QIV is on offer.

The Australian Influenza Vaccine Committee reviewed data relating to the flu strains circulating in Australia and the Southern Hemisphere in the 2016 winter and subsequently made new recommendations for vaccines.

They urged the Therapeutic Goods Administration to adopt the World Health Organization recommendations for the strains to be covered by the 2017 seasonal influenza vaccines.

While some health advocates support the wider availability of and access to flu shots, all agree that nothing should replace regular visits to the doctor.

CHRIS JOHNSON

Help improve online PBS authority approvals

The troubled online Pharmaceutical Benefits Scheme (PBS) authority approvals system is set for an overhaul, with the Department of Human Services asking for input from doctors.

Launched last year, the system promised Authority approvals for most PBS items online through Health Professional Online Services (HPOS), without prescribers having to ring the Approvals phone line.

However, the system turned out to be slow, clunky, and complex, and its inability to interface with doctors' desktop prescribing software meant that it is virtually unused.

The Department has advised the AMA that it is keen to improve the system, and is asking any doctor who prescribes PBS Authority medicines to complete a quick six-question survey.

The information collected will help the Department work with the medical software industry to develop products that allow access through existing prescribing software.

You can access the survey here: https://survey.websurveycreator.com/s.aspx?s=b38ea79f-050b-4563-b757-1e144f83f2c6

MARIA HAWTHORNE

1st Australasian Diagnostic Error in Medicine Conference

Local and world leaders in medical diagnosis will meet in Melbourne in May to explore ways to improve diagnosis and patient safety.

The theme of the 1st Australasian Diagnostic Error in Medicine Conference is "teamwork and collaboration for safer diagnosis", so it will bring together GPs, radiologists, pathologists, emergency department physicians and trainees, as well as nurses and other allied health workers.

Joined by leaders in diagnostic error, the safety sciences, health IT, medical indemnity providers, clinicians, cognitive psychologists, and advocates for patients, the attendees share a passion for making diagnosis more accurate, timely, and safe.

The language of diagnosis will be explored and the contribution that medical culture makes to diagnostic error, both positive and negative, will be examined.

The Conference is being held on 24-25 May (just before the AMA National Conference 2017 on 26-28 May, also in Melbourne) and more information can be found at https://improvediagnosis.site-ym.com/page/AusDEM17

MARIA HAWTHORNE

PM to address national conference

The Wide World of Health – Challenges, Threats, and Opportunities

Prime Minister Malcolm Turnbull will address the Saturday morning session of the AMA National Conference, as the event's keynote speaker.

Don't miss out on the opportunity to attend the 2017 AMA National Conference at the Sofitel on Collins, Melbourne, from 26– 28 May, for a rare and unique glimpse into medico-politics, global health issues and contentious contemporary health policies. The AMA National Conference provides a platform for Australia's leading doctors to share their ideas on the way ahead for Australia's health system and to discuss themes and events in global health.

This year's Conference agenda features a number of sessions that reach beyond the local horizon. We have a range of experts who will be presenting and debating 'big picture' factors that influence our health system and health systems around the world. These include:

- **Tackling Obesity** – experts will present a range of perspectives around the global obesity epidemic and possible solutions, with a special focus on how AMA policy can help the Government respond in a meaningful way.
- **Threats Beyond Borders** – an interactive panel discussion on potential infectious diseases and threats that cross our borders, and the possible role of a National Centre for Disease Control (CDC) in Australia.
- **Improving Australia's organ donation rate** – Australia is a world leader in achieving successful organ transplant outcomes, but our organ donation rate needs to increase to match world leaders. This session will examine the ethical and practical considerations related to Australia's lagging organ donation rate.
- **Doctors' Health and Wellbeing** – discuss initiatives and examine current and emerging issues related to doctors' health and wellbeing, during medical training and in their professional careers.

Dealing with Bad Health News Masterclass – Limited Places Only

In conjunction with the 2017 AMA National Conference, the Pam McLean Centre will provide a pre-conference masterclass open to all doctors on Thursday 25 May, also held at the Sofitel on Collins, Melbourne.

The masterclass on '*Dealing with Bad Health News*' will be an interactive, evidence based full-day masterclass designed to provide a safe learning environment for participants to explore different communication approaches to help patients deal with bad health news.

Under the guidance of an expert facilitator, Professor Stewart Dunn (Director, Pam McLean Centre), participants will develop skills in interpreting human behaviour by improving the way they recognise, identify and respond to emotional reactions.

This is an accredited activity for RACGP Category 1 and ACRRM Core PDP points.

Pre-conference masterclass - details

- Time: 9:30 – 5:00
- Date: Thursday, May 25, 2017
- Venue: Sofitel, 25 Collins Street, Melbourne, VIC 3000
- Tickets: Conference attendees - $660, AMA members - $770, non-AMA members - $880

For more information and Conference registration log onto: https://natcon.ama.com.au/ or contact the Conference organisers at natcon@ama.com.au.

INFORMATION FOR MEMBERS

Specialty Training Pathways Guide – AMA Career Advice Service

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

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

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

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

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

Information on the new website includes:

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

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

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

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

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

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

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

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

Health on the Hill

POLITICAL NEWS FROM THE NATION'S CAPITAL

Close the Gap Parliamentary Friendship Group – an observation

The AMA joined the inaugural meeting of the Close the Gap Parliamentary Friendship Group, held on March 30 at Parliament House.

Convened by Greens Senator Rachel Siewart, ALP Senator Malarndirri McCarthy, and Liberal MP Lucy Wicks, the meeting aimed to raise awareness among key decision makers about the scourge of Rheumatic Heart Disease (RHD) on Aboriginal and Torres Strait Islander peoples.

Worldwide, RHD affects more than 30 million people, with Australia's Aboriginal and Torres Strait Islander people having among the highest rates of this debilitating disease.

The fact that RHD is occurring in Australia, and the fact that we need to reinforce to our political leaders that they need to do something about it, is symptomatic of consecutive government failures to listen and act. RHD is a disease of poverty and it should not be seen in Australia.

Yet Aboriginal and Torres Strait Islander people, particularly children, continue to suffer from RHD every day. Penny, a young patient advocate from Oenpelli in Arnhem Land, is one of those children. Penny was diagnosed with RHD at around ten years of age, and many of her family members are living with RHD as well – her mother, uncle, aunty, and cousin. While it is unacceptable that RHD is even occurring in Australia, it is intolerable that it is affecting whole families.

RHD can be usually resolved if it is detected early, but people are being treated for the condition when it is too late. Dr Bo Remenyi, a paediatric cardiologist in the Northern Territory described how she sees a new case of RHD being diagnosed among Indigenous children every second day – this is about 150 new cases per year.

RHD is no longer a public health problem in Australia. This issue was solved for the majority of Australians about 50 or 60 years ago with the introduction of penicillin and better living conditions. RHD is now a political problem.

In the words of Dr Remenyi: "We have a surgical solution for a political problem. Australia needs a paradigm shift – we need to move away from surgical solutions." We need to invest in prevention, and double the number of doctors and health workers on the ground – Aboriginal and Torres Strait Islander communities have the smallest health workforce in Australia. This is highly disproportionate, particularly when the health needs of Aboriginal and Torres Strait Islander people are two to three times higher than their non-Indigenous peers.

Part of the solution to addressing RHD is educating members of the community about skin infections, and how they can lead to Acute Rheumatic Fever, and then to RHD if they are not quickly treated. But most of all, there needs to be a strong will to put RHD in the history books.

The community, health professionals, people working laboratories, public servants and most of all, governments, are all responsible for helping to make this a reality. Our political leaders need to show leadership and take action to work with health professionals and communities to rid Australia of RHD.

ALYCE MERRITT, INDIGENOUS POLICY ADVISER AMA

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

Research

Domestic violence leading cause for women and girls hospitalised from assault

New data released by the Australian Institute of Health and Welfare (AIHW) shows that nearly 6,500 women and girls were hospitalised due to assault in Australia in 2013–14, with the violence usually perpetrated by a partner or spouse.

The statistics on the deaths and serious injuries resulting from family and domestic violence has been called a national epidemic, and one of Australia's biggest social, legal and health problems.

The AIHW examined cases of hospitalised assault against women during that period and it exposed that when place of occurrence was specified, 69 per cent of assaults against women and girls took place in the home.

"While women and girls are, overall, hospitalised as the result of assault at a rate that is less than half the equivalent rate for men (56 cases per 100,000 females compared to 121 cases per 100,000 males), the patterns of injury seen for females are different to that seen for males." AIHW spokesperson Professor James Harrison said.

AIHW data highlights:

- Nearly 60 per cent of hospitalised assaults against women and girls were perpetrated by a spouse or domestic partner.
- More than half (59 per cent or 3,685) of all women and girls hospitalised due to assault were victims of an assault by bodily force and a further quarter of all hospitalised assault cases against women and girls involved a blunt (17 per cent or 1,048 cases) or sharp object (9 per cent or 551 cases).
- Open wounds (22 per cent or 1,400 cases), fractures (22 per cent or 1,375) and superficial injuries (19 per cent or 1,194) accounted for almost two-thirds of the types of assault injuries sustained by women and girls.
- In the 15 years and older age group, 8 per cent of victims were pregnant at the time of the assault.

The AIHW notes that the data used in their report probably underestimates the incidence of hospitalised assault resulting from domestic violence, as victims can be reluctant to report an incident to hospital personnel or to identify a perpetrator for hospital records.

The AMA believes the medical profession has key roles to play in early detection, intervention and provision of specialised treatment of those who suffer the consequences of family and domestic violence, whether it be physical, sexual or emotional.

Further the AMA advocates that medical practitioners must encourage attitudes and actions necessary to prevent family and domestic violence, identify women, men, families and children 'at risk', prevent further violence and assist patients to receive appropriate help and protection.

If you or someone you know is impacted by sexual assault or family violence, call 1800RESPECT on 1800 737 732 or visit www.1800RESPECT.org.au In an emergency, call 000.

MEREDITH HORNE

Liver research links genetics to treatment

The discovery by scientists at Sydney's Westmead Institute for Medical Research that the interferon lambda 3 (INLF3) protein causes liver fibrosis, has brought hope for the developments of new liver disease treatments.

The research also revealed a strong link between a patient's inherited genetic makeup and the amount of liver damage to improve techniques of identifying patients at risk of developing cirrhosis, and the development of new drug targets.

Currently liver transplantation is the only treatment for liver failure. No current treatments are available for a safe pharmacological therapy that prevent the progression of liver disease.

The lead author of the study, Professor Jacob George, says that the research will enable early interventions and lifestyle changes because it helps to predict risk of liver disease to individuals.

The Westmead Institute has developed a diagnostic tool based on their discoveries, which is available for all doctors to use, to aid in predicting liver fibrosis risk.

Research

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"This test will help to determine whether an individual is at high risk of developing liver fibrosis, or whether a patient's liver disease will progress rapidly or slowly, based on their genetic makeup," Professor George said.

Liver disease is now the fifth most common cause of death in Australia and affects 6 million Australians. Most forms of liver disease significantly increase the risk of liver cancer, which is the most rapidly increasing form of cancer worldwide.

Australia is a world leader for successful transplant outcomes with almost 3,000 Australian adults and children have undergone successful liver transplantation. However there are still many more people requiring transplants than donors.

MEREDITH HORNE

Mapping HIV virus for more effective treatment

Deakin University scientists, with support from CSIRO, have revealed for the first time the individual protein blocks that form the HIV virus.

It is hoped that the research will enable the development of effective and affordable new antivirals to treat millions of people living with HIV.

The exact way the virus formed had eluded scientist for the past 30 years so that current antivirals created only a partial understanding of how the pieces joined together.

"Inadequate supply of anti-HIV drugs in low- and middle-income countries has created an ideal breeding ground for the emergence of drug resistant HIV, which threatens the long-term effectiveness of patient care using existing anti-HIV agents," said senior researcher Professor Johnson Mak, from Deakin University's Centre for Molecular and Medical Research.

Professor Mak hoped his team's work would go on to inform the development of new drugs that work by interfering with the formation of infectious virus particles – essentially blocking HIV from taking a hold on patients.

HIV continues to be a major global public health issue. UNAIDs estimates in 2015, an estimated 36.7 million people were living with HIV, there were 2.1 million new infections worldwide and in the same year 1.1 million people died of AIDS-related illnesses.

The AMA this year launched its updated position statement on blood borne viruses (BBVs). The statement expressed the AMA's support for the availability of new, regularly evaluated treatments for BBVs.

Further, it acknowledged that prevention, treatment, and management of BBVs is a public health priority that requires a coordinated and strategic policy response, with national leadership driving actions to sustain improvements in their prevention, detection, and treatment. A copy of the statement can be found at: https://ama.com.au/position-statement/blood-borne-viruses-bbvs-2017

MEREDITH HORNE

UHT milk used to study age-related diseases

A new study on UHT milk jointly undertaken by ANU, CSIRO, University of Wollongong and international researchers is helping scientists to better understand Alzheimer's, Parkinson's and type 2 diabetes – opening the door to improved treatments for these age-related diseases.

The research examined how milk proteins changed structurally when heated briefly to around 140 degrees to produce UHT milk, causing the gelling phenomenon with long-term storage.

These proteins are the same type of protein clusters found in plaque deposits in cases of Alzheimer's and Parkinson's.

Fifty different diseases have been recognised as being associated with protein aggregation.

"Parkinson's, dementia and type 2 diabetes are big problems for the ageing population in Australia and many other countries around the world," said Professor John Carver from the ANU Research School of Chemistry.

"Any means we can understand these proteins, their structure and why they form amyloid fibrils has the potential for developing treatments."

Aging relating diseases affect about 500 million people worldwide and is set to increase over the next 20 to 30 years.

Population projections by the Australian Treasury forecasts the number of Australians aged 65 is increasing rapidly, from 2.5 million in 2002 to 6.2 million in 2042, or from 13 per cent of the population to 25 per cent.

The collaborative research was published in the published in the journal *Small*. The research does not suggest UHT milk can cause these age-related diseases.

MEREDITH HORNE

Cholera vaccination campaign focussing on Somalia

Women wait to have themselves and their children vaccinated against cholera at the Banadir hospital in Mogadishu, Somalia. Gavi, with funding from the government of Australia, has shipped nearly a million doses to support the campaign. Photo/Karel Prinsloo/Arete/Gavi

A second stage of a major vaccination campaign to halt the spread of cholera got underway in March and April in three drought-ravaged regions of Somalia.

Gavi, the Vaccine Alliance, delivered 953,000 doses of Oral Cholera Vaccine to the country to protect more than 450,000 people from the disease.

The campaign took place in three of the worst-hit regions, Banadir, Kismayo and Beledweyne, with the vaccine being given in two doses to everyone over the age of one. The first round ran from 15-19 March and the second from 18-22 April.

The vaccines were procured, transported and stored at the appropriate temperature by UNICEF. They are being administered by the Government of Somalia with the support of World Health Organisation (WHO) and UNICEF; while UNICEF and others continue to improve water and sanitation infrastructure and promote behaviour change. As well as providing the vaccines, Gavi has provided US$550,000 to support the campaign.

Seth Berkley, CEO of Gavi, said the people of Somalia are going through unimaginable suffering.

“After years of conflict, a severe drought has brought the country to the brink of famine and now a suspected cholera outbreak threatens to become a nationwide epidemic,” he said.

“These lifesaving vaccines will play a vital role in slowing the spread of the disease, buying valuable time to put the right water, sanitation and hygiene infrastructure in place to stop the root causes of this outbreak.”

Dr Ghulam Popal, WHO Representative in Somalia, said cholera was a major health issue in Somalia.

“The current drought has worsened the situation for many. Therefore we’re very glad to have the support of Gavi to implement the first OCV campaign in Somalia,” Dr Popal said.

“We are very hopeful that the vaccination campaign will control outbreaks, and eventually save lives.”

The current severe drought in Somalia has forced communities to use contaminated water, helping cholera to spread. A total of 25,000 cases of Acute Watery Diarrhoea/cholera have been reported since the beginning of 2017, causing at least 524 deaths. Surveillance reports indicate that the epidemic is now spreading to areas inaccessible to aid workers.

UNICEF Somalia Representative, Steven Lauwerier said the vaccination campaign was an emergency measure.

“We need to continue to tackle the main cause of such outbreaks,” he said.

“UNICEF, donors, government and other stakeholders are making some progress in improving access to safe water and promoting good sanitation and hygiene practices and this needs to be scaled up urgently.”

Cholera vaccination campaign focussing on Somalia

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The oral cholera vaccine is taken in two doses a month apart, and offers protection against the disease for the majority of people who take it. Gavi, with funding from the government of Australia, has shipped nearly a million doses to support the campaign. Photo/Karel Prinsloo/Arete/Gavi

Gavi, the Vaccine Alliance is a public-private partnership committed to saving children's lives and protecting people's health by increasing equitable use of vaccines in lower-income countries.

The Vaccine Alliance brings together developing country and donor governments, the World Health Organization, UNICEF, the World Bank, the vaccine industry, technical agencies, civil society, the Bill & Melinda Gates Foundation and other private sector partners.

Gavi uses innovative finance mechanisms, including co-financing by recipient countries, to secure sustainable funding and adequate supply of quality vaccines. Since 2000, Gavi has contributed to the immunisation of nearly 580 million children and the prevention of approximately 8 million future deaths.

CHRIS JOHNSON

International spotlight on Indigenous public health equity

Prominent Maori health advocate Adrian Te Patu led a yarning circle at the 15th World Congress of Public Health, which unanimously supported the establishment of an Indigenous Working Group within the World Federation of Public Health Associations.

Mr Te Patu is the first Indigenous representative on the WFPHA Governing Council and is well-known throughout is homeland New Zealand and internationally for his campaigning on health issues.

He will now formalise the Indigenous Working Group, following its acceptance at the World Congress, which was held in Melbourne in April.

The Indigenous Working Group will provide an opportunity to bring to the global public health and civil society arena a visible and prominent Indigenous voice that privileges an Indigenous world view and narrative.

"We intend to create a platform for change with the aim to address the health inequities experience by Indigenous peoples worldwide," Mr Te Patu said.

The group was formed on the 50th anniversary of the WFPHA, at the 15th World Congress conference, when 40 Indigenous and non-Indigenous conference delegates of the yarning circle unanimously supported in principle its establishment.

The Public Health Association of Australia hosted the yarning circle that was led by Mr Te Patu.

A yarning circle, also known as a dialogue circle, comes from the traditional Aboriginal process of discussing issues in an inclusive and collaborative manner.

All participants are invited to have their say in a non-judgemental environment.

The WFPHA's function and mandate includes its link into the global health governance mechanisms such as the World Health Organisation.

CHRIS JOHNSON

AMA Member Benefits

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

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

Jobs Board: Whether you're seeking a new position, looking to expand your professional career, or looking to recruit staff to your practice, doctorportal Jobs can help you. Discounts apply for AMA members. jobs.doctorportal.com.au

MJA Events: AMA members are entitled to discounts on the registration cost for MJA CPD Events!

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

doctorportal Learning: AMA members can access a state of the art CPD tracker that allows CPD documentation uploads, provides guidance CPD requirements for medical colleges, can track points against almost any specialty and provides access to 24/7 mobile-friendly, medical learning.

Learning.doctorportal.com.au

MJA Journal: The Medical Journal of Australia is Australia's leading peer-reviewed general medical journal and is a FREE benefit for AMA members.

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

Career Advice Service and Resource Hub: This should be your "go-to" for expert advice, support and guidance to help you navigate through your medical career. Get professional tips on interview skills, CV building, reviews and more - all designed to give you the competitive edge to reach your career goals.

www.ama.com.au/careers

Amex: As an AMA member, receive no-fee and heavily discounted fee cards including free flights and travel insurance with range of Amex cards.*

Mentone Educational: AMA members receive a 10% discount on all Mentone Educational products, including high quality anatomical charts, models and training equipment.

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

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

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

Hertz 24/7: NEW! Exclusive to the AMA. AMA members can take advantage of a $50 credit when renting with Hertz 24/7.

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

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

MJA Bookshop: AMA members receive a 10% discount on all medical texts at the MJA Bookshop.