AUSTRALIAN

Medicine

The national news publication of the Australian Medical Association

Updates on Govt reviews

AMA brings Colleges, Associations and Societies together for briefings, p8

INSIDE

Vaccination debate heats up, p6

Prisoners and Medicare, p11

Revised Code of Ethics, p12

Labor health policy summit, p24

US doctors push back against Trump, p31

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AMA LEADERSHIP TEAM

President
Dr Michael Gannon

Vice President
Dr Tony Bartone

In this issue

National news 6-13

World news 30-31

Health on the hill 24-27

Research 28-29

Columns

3 PRESIDENT'S MESSAGE
4 VICE PRESIDENT'S MESSAGE
5 SECRETARY GENERAL'S REPORT
14 GENERAL PRACTICE
15 PUBLIC HEALTH OPINION
16 DOCTORS IN TRAINING
17 AMSA
18 MEDICAL WORKFORCE
19 RURAL HEALTH
20 INDIGENOUS TASKFORCE
21 PRIVATE SPECIALIST PRACTICE
22 FINANCE AND ECONOMICS
32 MUSIC
33 MOTORING
34 MEMBER SERVICES

Cover pic: Medicare Benefits Schedule Taskforce Review chair, Professor Bruce Robinson and AMA President Dr Michael Gannon at the Colleges, Associations and Societies briefings at AMA House, Canberra.

Valuing Private Health

BY AMA PRESIDENT DR MICHAEL GANNON

It happens every year around this time – the annual hand-wringing around the increase in private health insurance (PHI) premiums.

This year we had the new Health Minister Greg Hunt claiming that it was good news, as we had the lowest annual rise in a decade. We had the Shadow Health Minister Catherine King lamenting the rise and calling it another failure of the Turnbull Government.

The television cameras seek out healthy 20-somethings on comfortable, if modest, wages querying the diminishing value proposition of holding PHI. Here's a prediction – a variation on this story will happen again at the same time next year.

Health costs increase year on year. Health CPI outstrips real CPI every year. GPs and other specialists in private practice know this as they struggle under the weight of both sides of politics' lamentable decision to freeze patient rebates.

Bureaucrats running public hospitals in the States and Territories understand the inevitable increase in costs year on year. But rather than this annual mourn, let's consider the drivers of the increased health costs.

First, the bad news. Australia, like most countries around the planet, has seen an explosion in the rate of obesity in the past 40 years. Obese patients are more likely to get sick. They are more likely to have complications from any treatments. There is a near linear association with the risks of a whole variety of medical conditions including hypertension, hypercholesterolaemia, type 2 diabetes mellitus, cardiovascular disease and many cancers. This is just the tip of the iceberg. Obesity represents the public health emergency of our age.

Australia and Australians have a problem with alcohol. This drives increasing health costs. We are world leaders in tobacco control, but lamentably still 12-13 per cent of people daily undertake a behaviour that will kill half of them, and substantially reduce the quality of life of the other half.

We are dealing with a scourge of illegal drugs and the particular menace represented by methamphetamine use.

There is a little bit of good and bad in the ageing of the population. It represents success in our health system. It also represents opportunities to significantly improve care. Palliative care services are largely inadequate, and they drive the community's fear about dying - supporting sometimes very simplistic arguments in favour of euthanasia and assisted suicide.

If it is not next week, it will be the week after that Minister Hunt is making an announcement of an exciting new technology. Whether this is a new drug for treatment of cystic fibrosis, for hepatitis C, for metastatic malignant melanoma, or for something else, it will be exciting news for the sufferers and their loved ones.

Not a week goes by without tabloid newspapers making a case for PBS listing of medications, which typically cost in the tens of thousands of dollars for a treatment course. All of this money has to come from somewhere.

Next week on the news you will see another exciting new development in minimally invasive surgery, genomics, or another unforeseen piece of disruption or innovation. Every year, the manufacturers of implants and prostheses are looking for some benefit in terms of longer life span or reduced complication rates. All of this costs money.

An argument the AMA consistently makes to Government is that the costs in the health system should be regarded as investments. This is inevitably the case. We must look for things that are good value for money, and it is why we will never tire of reminding governments of the importance of good public health policy, other preventive measures, and the spectacular value for money that Australia's world-class general practice workforce represents.

However, it remains inevitable that patients will from time to time need to access public hospitals. These must be funded better.

Equally, many Australians will seek care in private hospitals and seek to use their private health insurance (PHI). Australians have an interesting relationship with their PHI. They don't lament the fact that they haven't cashed in their fire insurance or home insurance at the end of the year.

But there is an expectation that they will have used their PHI, even if it is for something as dubious as a Reiki session or a new set of gym shoes. If they are lucky, they might have had $150 off their dentist bill.

That culture is unlikely to change as the value proposition of PHI is inevitably benchmarked against the high quality care delivered in the public system.

So let's stop the annual hand-wringing exercise.

Health costs will inevitably increase year on year. I propose an intelligent public debate on how we support the private system - the system that offers Australians choice. The system that is responsible for over 70 per cent of operations and surgical procedures. The system that embraces innovation, efficiency, and contributes to universal health care and the blended system that is in so many ways the envy of the rest of the world.

Aged care system needs to evolve

BY AMA VICE PRESIDENT DR TONY BARTONE

A sometimes selectively ignored but ever burgeoning problem is access to appropriate continuity of care and access to quality residential aged care beds. The size of the problem cannot be ignored.

Fifteen per cent of the population is over 65 years of age and, as we all know, increasing longevity and the baby boomer led increase in population are creating an unprecedented demand on the system.

It is clear that the system will struggle to accommodate future needs. The Australian population is continuing to age, with an expected 1.8 million people over the age of 85 in 2050. The number of aged care beds in Australia increased by 27 per cent from 2005-2015, resulting in an additional 40,000 beds.

However, a forecast demand of 392,000 beds by 2025, while supply in the same year based on current growth is predicted to be 262,000, leaves us potentially some 130,000 beds short.

We all know that just like other areas of health, the aged care sector faces a significant lack of funding. Furthermore there is a serious workforce shortage looming.

Add to this a lack of GPs who regularly attend aged care facilities – made worse by the fact that, increasingly, new facilities are largely being developed on urban fringes. Throw technology issues into the mix with the lack of access to a GP's patient medical record, or interoperability of nursing home drug charts with clinic software, and you have a perfect setting of dwindling regular primary care access to a significant proportion of the community – arguably with very significant healthcare issues.

The scale of the problem is immense. Clearly inadequate funding needs to be addressed but appropriate recognition in this fiscal environment is unlikely to change in sufficient quantum in the short term.

However, talk to many in the industry and they will tell you that funding alone will not be sufficient to relieve the pressure. Advocacy is also paramount as any solution is likely to be multi-factorial and goes to the heart of the state of the health system.

Appropriate rebates are necessary for patients for visits by all doctors, including visiting geriatricians and psychiatrists. Recognising the appropriate skill and time commitment and the opportunity cost for the doctor and the downstream benefits for the government, Federal and State, is vital. Streamlining access "outreach" type hospital services in Residential Aged Care Facility environment, supported by streamlining availability to geriatrician psychiatrists and diagnostic imaging services, will go a long way to reducing the demand on other parts of the system and hopefully redirecting some funding back to the sector.

This is no better demonstrated than by the often unnecessary urgent transfer by ambulance of a resident to ED for a problem that could be handled in the facility if access to care was available.

Advanced care planning and appropriate ACDs in place is also a large part of the conversation.

The situation is different in rural areas where many places are mostly publicly funded, making choices limited. Often doctors are forced to treat residents with severe medical conditions in RACFs due to inadequate local hospital beds.

Different issues also arise in looking at Culturally and Linguistic Diverse Individuals, with some 32 per cent of the Australian population (5.8 million people) born overseas.

Obviously there is an infrastructure investment which also needs to be considered here.

But there are other challenges which need novel solutions. Soaring property values and housing pressures are forcing new facilities on to the fringe areas of suburbia, often translocating elderly patients from a long and established GP relationship just when continuity of care is at its most strategically necessary point. Workforce solutions are clearly another structural issue and unlikely to be overcome any time soon

Clearly the situation is complex and is not in reach of an easy solution. An ever increasing proportion of our patients are facing a lack of choice in their aged care requirement. It seems as if the system is deserting them just at the time they really need continuous care.

The aged care system needs to evolve in order to accommodate Australia's increasing ageing population, with the majority of issues in the lack of aged care staff and the absence of recognition in the role of the medical practitioner in effective aged care.

Policy front and centre

BY AMA SECRETARY GENERAL ANNE TRIMMER

> "While the Medicare freeze remains a focus, there are many other areas of health policy activity that are just as important."

With the start of the parliamentary year and a change in Minister for Health from Sussan Ley to Greg Hunt, it is clear that health policy will remain front and centre in 2017.

Minister Hunt is very outcomes-focused and he and his staff have been working closely with the AMA to address one of the pressing health issues – the ongoing impact of the Medicare freeze.

While the Medicare freeze remains a focus, there are many other areas of health policy activity that are just as important. The work of the Private Health Ministerial Advisory Committee, which is reviewing aspects of private health insurance and the private health system more widely, will continue through the year. Its first recommendations are likely to go to Minister Hunt mid-year with proposals for simplified private health insurance coverage into gold, silver and bronze categories, as promised by former Minister Ley during the 2016 Federal election.

The AMA launched its 2017 Public Hospital Report Card in February, again highlighting the need for continued investment in the public hospital system. This will come to the forefront at the time for renegotiation of the National Health Reform Agreement.

Pleasingly, Minister Hunt, who is also Minister for Sport, has expressed his personal support for, and interest in, preventive health and mental health – two policy areas in need of attention.

The Labor Party also continues to develop its health policies to take to the next election. Shadow Minister Catherine King convened a summit in early March with participation from numerous health advocacy bodies, including the AMA, to help shape those policies.

An interesting year ahead.

The Federal AMA Secretariat is working on the final details for this year's National Conference, which will be held in Melbourne from 26-28 May. As a consequence of the changes to the Constitution in 2014, this year is a non-election year with the President and Vice President continuing in their terms until 2018. This allows for a wider range of policy sessions – this year ranging from organ donation and external threats to a healthy Australia, to obesity and doctor health and wellbeing.

With subsequent further changes to the Constitution in 2016, delegates are now drawn from practice groups as well as the State and Territory branches and Federal Council. The practice groups (general practice, public hospital doctors, private specialists, rural doctors, and doctors in training) each have 12 delegates. Where there are vacancies in delegate numbers, I will be making a call out to members in the relevant practice groups for expressions of interest. Federal AMA is keen to provide an opportunity for members to participate in National Conference for the first time where there are vacancies.

In another first, the National Conference will offer a master class on 'Dealing with Bad News' to be held the day before official proceedings. The master class will be facilitated by Stewart Dunn, Professor of Psychological Medicine at Sydney Medical School Northern and Director of Pam McLean Centre. It is aimed at improving doctors' understanding and interpretation of human behaviour and the value of good communication within the health system.

I encourage members to attend National Conference. Details can be viewed at https://natcon.ama.com.au/.

Vaccinations debate gets shot in the arm

One Nation leader Pauline Hanson has sparked outrage and ignited a fresh debate over vaccinations by saying the Government was blackmailing parents into immunising their children.

Reinforcing her belief that vaccinations have links to autism and can cause other ill effects, Senator Hanson suggested parents have their children tested first to determine if they will react adversely to the shots.

“I've heard from parents and their concerns about it and what I have said is I advise parents to go out and do their own research with regards to this,” she told the ABC's *Insiders* program.

“Look, there is enough information out there. No-one is going to care any more about the child than the parents themselves. Make an informed decision.

“What I don't like about it is the blackmailing that's happening with the Government. Don't do that to people. That's a dictatorship. I think people have a right to investigate themselves. If having vaccinations and measles vaccinations is actually going to stop these diseases, fine, no problems.

“Some of these – parents are saying – vaccinations have an effect on some children. Go and have your tests first. You can have a test on your child first.

“Have a test and see if you don't have a reaction to it first. Then you can have the vaccination. I hear from so many parents. Where are their rights? Why aren't you prepared to listen to them? Why does it have to be one way?”

Senator Hanson did not stipulate what test she was referring to and some days later apologised, saying she was wrong about it.

She has also stated that her comments were only a personal opinion and admitted that she had had her own children vaccinated.

But she maintains her distaste for the current Government policy to withhold some welfare payments and childcare fee rebates from parents who don't fully immunise their children.

“I'm not saying to people don't get your children vaccinated. I'm not a medical professional,” she said while campaigning in the WA State election.

“I had my children vaccinated. I never told my children not to get their children vaccinated. All I'm saying is get your advice.”

Her initial remarks, however, have caused a backlash from a host of experts, commentators and politicians – including Prime Minister Malcolm Turnbull.

“If parents choose not to vaccinate their children, they are putting their children's health at risk and every other person's children's health at risk too,” Mr Turnbull said.

Health Minister Greg Hunt described Senator Hanson's comments as “incorrect in fact” and not what a Member of Parliament should be making.

He also acknowledged that the so-called No Jab, No Pay policy is a strong and tough policy, but one he backed 100 per cent.

“I take a very clear, strong view of this. Vaccination is fundamental to protecting not just our own children, but everybody else's children,” Mr Hunt said.

“There are decades and decades of different sources of evidence and practice and simply reduced incidences of conditions such as mumps and measles, rubella, whooping cough.

“So the evidence is clear, overwhelming and very broadly accepted.”

The AMA has provided much of that evidence over a long period of time.

Responding to Senator Hanson's controversial remarks, AMA President Dr Michael Gannon praised the national immunisation program.

“The false claims, the mistruths, the lies that you can find on the internet are of a great concern to doctors,” Dr Gannon said.

Vaccinations debate gets shot in the arm

... from p6

"The national immunisation program is a triumph. There is good news in this story - 95 per cent of one-year-olds in Australia are fully vaccinated, 93 per cent of five-year-olds are fully vaccinated.

"But we know that a lot of parents are doing this with some reservations, and that's of great concern.

"The person to give you the most accurate information about the benefits of vaccination to allay your concerns is your local immunisation provider. In many cases, that's your family GP.

"I can assure you that there is some absolutely galling rubbish available to parents on the internet.

"They need to be taught how to find credible sources of information. Anything which weakens this most important of public health measures really needs to be stepped on."

Meanwhile, a new national survey has claimed that health care providers are refusing to treat one in six children who are not up to date with their vaccinations.

The sixth Australian Child Health Poll was conducted and released by the Royal Children's Hospital Melbourne and published in March under the title *Vaccination: Perspectives of Australian Parents.*

It also found that 95 per cent of parents kept their children up to date with vaccines, but that almost a third of parents held concerns about vaccination safety.

Dr Gannon labelled it an interesting study.

"It refers to health care providers. I would be surprised if we were talking about doctors. It's not ethical to deny treatment to unvaccinated children," he said.

"I suspect we would hear many, many complaints if this was the fact, that these were doctors refusing to treat these kids.

"Certainly legally they can refuse treatment, but ethically they shouldn't. Parents who deny their children the individual benefits of vaccination against preventable and infectious disease are already doing their child a disservice. Doctors would not seek to enhance that disadvantage.

"This study is a good news story in many ways. It shows the overwhelming support that the vaccination program enjoys amongst Australian parents."

Director of the Child Health Poll, paediatrician Dr Anthea Rhodes, said the survey suggested a worrying pattern of practice not previously identified in Australia.

"All children, regardless of their vaccination status, have an equal right to health care," Dr Rhodes said.

CHRIS JOHNSON

INFORMATION FOR MEMBERS

Essential GP tools at the click of a button

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

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

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

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

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

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

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

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

Colleges, Associations and Societies briefed on Government reviews

AMA President Dr Michael Gannon opening the CAS briefings

The AMA brought together 75 representatives from Medical Colleges, Associations and Societies on March 9 to update them on Government reviews into Private Health and the Medicare Benefits Schedule.

The doctors and other representatives met at AMA House in Canberra and represented a full range of specialty groups.

AMA President Dr Michael Gannon thanked the doctors for taking time out of their own practices on behalf of their respective organisations, stressing it was important for the profession to come together regularly as the reviews progress.

"To begin, I think we should take stock of what is happening in the general environment," Dr Gannon said.

"The Government has undertaken a large task to review the health system. There is currently a lot of work being undertaken in this area with reviews of the Medicare Benefits Schedule, Prostheses List, and the Private Health sector.

"The AMA supports the need to review the health system, to provide a mechanism to refresh the current arrangements and also support innovation, while understanding the need to ensure the health system is sustainable.

"But we also believe that if savings, not quality care, are the driving motivator for change, there can be the potential to negatively affect the health and wellbeing of Australian families.

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

Colleges, Associations and Societies briefed on Government reviews

... from p8

Chair of Private Health Ministerial Advisory Committee, Dr Jeff Harmer AO

"We agree that there are greater efficiencies to be made in the health system and in the health budget, but any changes must be undertaken with meaningful 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."

Chair of the Private Health Ministerial Advisory Committee, Dr Jeff Harmer AO, told the gathering that the medical profession should take a leadership role in helping to control the out-of-pocket expenses, which are a growing concern to private health insurance customers.

He said private health coverage was continuing to drop, raising concerns within Government that long term viability is being impacted. The AMA has been advocating for a long time that the private health insurance product was too complicated and the value evaporates as patients find out that, at their time of need, their insurance does not cover services that they thought were covered. The consumer survey found that not paying benefits was of great concern to consumers.

"Consumers are very concerned that private health insurance does not offer value for money," Dr Harmer said.

"There is an opportunity for the profession to adopt a leadership role in this area.

Concerns raised from the floor centred on the profits of the insurers, the imbalance of the power relationship and the view that some insurers were trying to move towards a system of 'managed care'.

"They (private insurers) do have a lot of power. No doubt about that," Dr Harmer responded to one query.

"The bigger the insurer and the smaller the hospital, the greater the imbalance."

Medicare Benefits Schedule Taskforce Review chair, Professor Bruce Robinson, said progress had been slow to date, not least because of a change in Health Minister.

"But neither former Minister Sussan Ley nor Minister Greg Hunt have expressed to me in any way shape or form that this process is about saving money," Prof Robinson said.

Prof Robinson fielded a number of questions from the group regarding concerns with the review process, Government's handling of recommendations and make-up of the clinical committees.

The reviews have been off to a slow start, with Prof Robinson commenting the review was still evolving and processes open to change to ensure the best outcomes are achieved for the system overall.

Discussion from the floor covered a full range of issues over the course of an hour. The medical profession expressed concern with how some of the reviews had operated to date, and called for greater consultation with profession and the Colleges, Associations and Societies of the detail.

Concerns were also raised about how the review will deal with conflicting recommendations, the need to widen the membership of some of the committees, to recognise the history behind some of the current items, as well as the current and separate deliberations being held by the Department on MBS changes and the proposed abolition of the Medicare Claims Review Panel.

CHRIS JOHNSON

When psychosocial supports go, mental health needs increase

The management of mental health within the AMA Secretariat now resides within both Public Health and Medical Practice. This mirrors the realities facing most people experiencing mental health problems – that mental illness often requires a combination of clinical treatment and psychosocial supports. It's also a recognition that social determinants of health impact on mental and physical wellbeing.

At a recent meeting of mental health experts organised as part of the ALP's Health Summit, a recurring theme was the paucity and inconsistency of services that fit between the GP and the ED. This presents myriad challenges to mental health reform, an agenda that Minister Hunt has signalled as a priority.

The way Primary Health Networks (PHNs) will commission mental health services is critical to the reform process. Concerns have been expressed about PHNs not being able to purchase psychosocial services. These are services that coordinate supports, such as employment and housing, for people with severe and persistent mental health issues who have complex needs. As mental health funding is transferring to the PHNs, it is reasonable to expect that, at a minimum, PHNs provide both clinical and psychosocial care, as needed.

Further complicating the mental health landscape is the operation of the National Disability Insurance Scheme (NDIS). Three important mental health programs – Partners in Recovery (PIR), Day to Day Living (D2DL) and Personal Helpers and Mentors (PhaMs) – are being rolled into the NDIS. The concern here is that those people assessed as ineligible for the NDIS will now not be eligible for other forms of mental health care. This could see greater pressure on GPs, psychiatrists and hospitals from those who fall 'between the new cracks' and are left with few alternative options for help.

There is a strong argument that investment in community mental health services is needed; providing GPs with enhanced referral pathways, and service options, especially for those with low to moderate mental health problems or who need supports in managing their day-to-day activities. How many Australians with mental health conditions will now no longer be eligible for the NDIS if no evaluation is undertaken?

A widely held concern is that the NDIS may end up excluding people with mental health problems. Where these people go, who will treat them, where they will be treated, and what medical and psychosocial supports will be provided remain in the 'unknown' ledger. What can be predicted is that those with mental illness who are excluded from the NDIS may end up taking up time and energy of clinicians and other health providers in more costly health care.

The Productivity Commission has released an Issues Paper on the costs of the NDIS. The Commission is looking at the sustainability, costs and future cost pressures of the NDIS, and how it impacts on, and operates with, mainstream services. The current projection is that by 2019-20, there will be 460,000 participants at a cost of $22 billion per annum.

According to the Commission, "poorly defined boundaries between the NDIS and mainstream services can raise the risk of gaps in services, duplication of services and cost shifting ... particular concerns have been raised about the interface between the NDIS and mental health services."

Another challenge is workforce, and workforce distribution. The Productivity Commission identified the difficulties in recruiting qualified staff, the unequal workforce distribution and demand for carers as key issues. It's worth noting that at the March 2017 Senate Estimates hearing, the Department of Health said that, in relation to on-going funding to the Mental Health Nurse Incentive Program (MHNIP), it is "the whole picture" of a region that DoH looks at. Said one official: "If you look at, for example eastern Melbourne, it is very significant. There is a congregation of psychiatry and psychology services in that region."

The worry here is pressure points in mental health care will increase and worsen. Waiting times and bottlenecks are created because the supports for people with low to moderate mental health conditions, or people needing support in their day to day living, are no longer being provided for. This will directly increase the burden on psychiatry and public hospitals to meet a growing and unnecessary demand for care.

With the 5th National Mental Health Plan currently being drafted, and a number of inquiries and reviews of the NDIS underway, there is no doubt the Government is on the path towards substantial mental health reform. What is not yet clear yet is how these reviews will ensure that people experiencing mental health problems are able to access an integrated system that meets their needs.

SIMON TATZ, AMA, DIRECTOR, PUBLIC HEALTH

Prisoners could get Medicare without a heavy taxpayer burden

People subject to incarceration and youth detention in Australia are currently excluded from Medicare and the Pharmaceutical Benefits Scheme (PBS), but the AMA is hoping to see that changed.

The AMA, along with the Public Health Association of Australia, Royal Australian and New Zealand College of Psychiatrists, and Professor Stuart A Kinner, NHMRC Senior Research Fellow, Griffith University and University of Melbourne, recently wrote to Health Minister Greg Hunt and identified a mechanism by which this demonstrable inequity can be rectified, at modest cost to the Australian taxpayer.

Former Health Minister Sussan Ley had previously said that States and Territories may deliver in-prison health services through the employment of appropriately trained medical or allied-health officers, or the payment of healthcare professionals from the public or private sector. However, Ms Ley did not acknowledge the growing evidence that States and Territories are not providing in-prison health services in a manner equivalent to that available in the community, and that this has a significant impact on the health of the more than 50,000 Indigenous and non-Indigenous people released from prison to the community in Australia each year.

The situation is that prisoners and young people in detention are excluded from Medicare and PBS subsidies under Section 19(2) of the *Health Insurance Act 1973 (Commonwealth)*. In short, the intent of this clause was to avoid 'double dipping', however, this is premised on the notion that the States and Territories provide equivalent health services for people in custody. Indeed, Australia has committed to the provision of equivalent health care for people in prison and youth detention, by endorsing the United Nations Mandela Rules. Rule 24 states that:

1. *The provision of health care for prisoners is a State responsibility. Prisoners should enjoy the same standards of health care that are available in the community, and should have access to necessary healthcare services free of charge without discrimination on the grounds of their legal status.*
2. *Healthcare services should be organised in close relationship to the general public health administration and in a way that ensures continuity of treatment and care, including for HIV, tuberculosis and other infectious diseases, as well as for drug dependence*.

However, in practice there are many examples of inequity in prisoner and detainee health care. The most readily apparent of these is that, despite an extremely high prevalence of mental disorder in prisoners and detained youth, psychological therapy for mental disorder in these settings is almost non-existent.

Currently, most treatment is reliant on the prescription of psychiatric medications. This deviates from best practice and community standards and, because prisoners and detainees are excluded from the PBS, they are frequently prescribed psychiatric medications in a manner that would not attract a PBS subsidy in the community. As such, adherence to these medications after release from prison is likely to be poor, with the result being recurrence of psychiatric symptoms and, for some, an avoidable relapse to self-medication with illicit substances, and crime.

As the AMA highlighted in the *2015 Indigenous Health Report Card*, Aboriginal and Torres Strait Islander people are over-represented in Australia's prisons by a factor of 13 and in youth detention by a factor of 24. Policies that discriminate against people in custody will, therefore, disproportionately impact on the health and wellbeing of Aboriginal and Torres Strait Islander people.

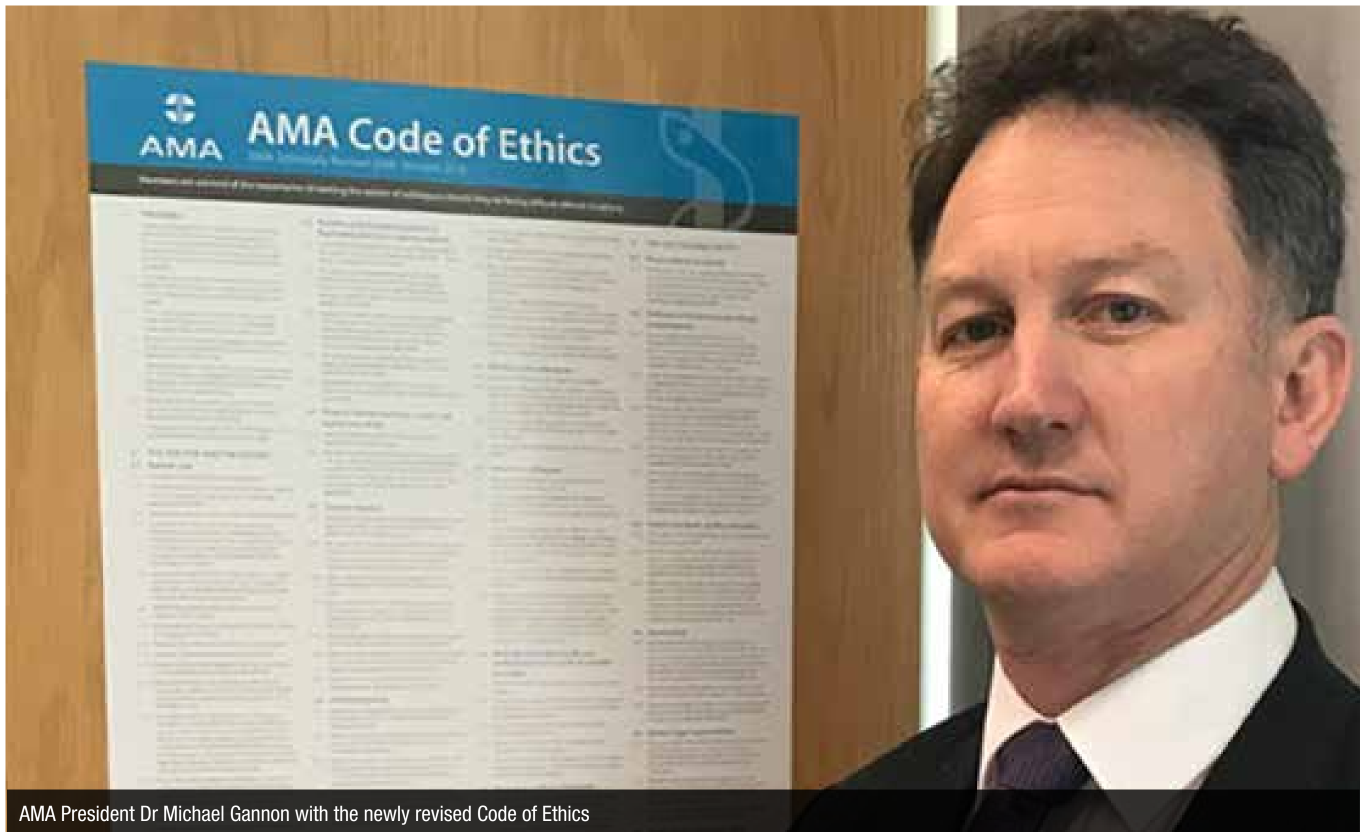
The letter to Minister Hunt pointed out that Parliamentary documents show that the Health Minister's power to waive the Medicare exclusion was explicitly included in s 19(2) of the *Health Insurance Act* so that governments could make amendments if the exclusion was deemed to cause disadvantage. In practice, the Commonwealth has been willing to grant exemptions in cases of clear and demonstrated need. These exceptions (to Commonwealth-funded ACCHSs and the Improving Access to Primary Care in Rural and Remote Areas (s 19[2] Exemptions) Initiative demonstrate the willingness of the Commonwealth to permit access to Medicare if the ability of a health service to adequately care for the needs of a community was curtailed by the exclusion; a situation that clearly exists in prisons.

The current exemptions all share a common theme: an expressed intention to ensure that all Australians have access to appropriate and quality health care, regardless of their circumstances.

Under the *Health Insurance Act,* the Health Minister has the power to grant an exemption to end prisoners' exclusion from Medicare, paving the way for rebates to be claimed for prison-based health care services in limited circumstances where demonstrable gaps exists in health service delivery. This would allow the prison system to retain the existing health service delivery model but to enhance this through access to selected Medicare items and PBS subsidies as outlined above. The costs incurred by Medicare would be minimal.

CHRIS JOHNSON AND SIMON TATZ

Code of Ethics revised and updated



AMA President Dr Michael Gannon with the newly revised Code of Ethics

The AMA has released its revised Code of Ethics, which was updated in 2016 and ratified by the AMA Federal Council at its November meeting.

For the first time since 2006, the Code has been substantially reviewed, culminating in the *Code of Ethics 2004. Editorially Revised 2006. Revised 2016.*

AMA President Dr Michael Gannon said a Code of Ethics was essential for setting and maintaining the expected standards of ethical behaviour within the medical profession.

"The AMA's Code of Ethics incorporates the values of the profession," Dr Gannon said.

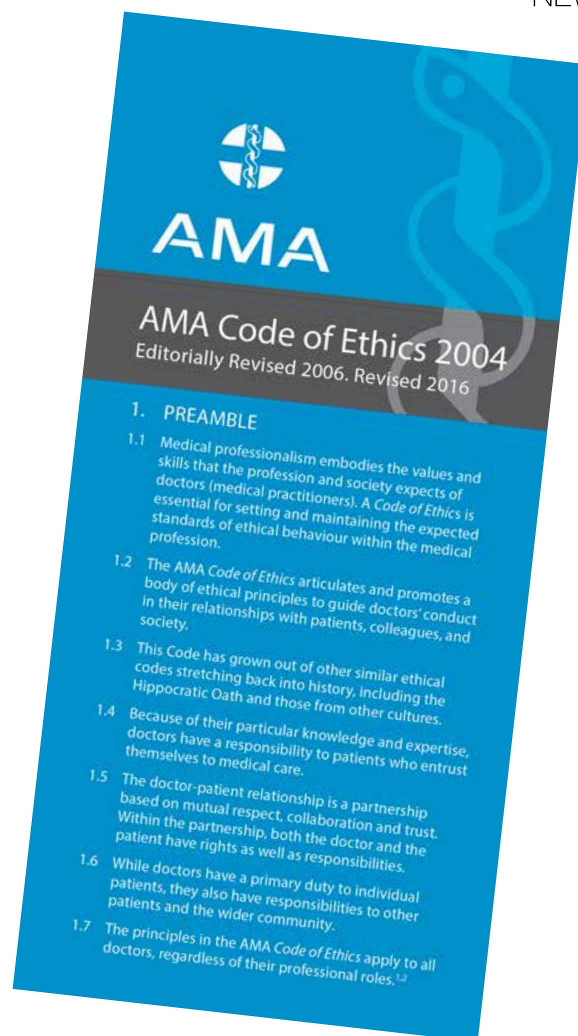
"The Code articulates and promotes a body of ethical principles to guide doctors' conduct in their relationships with patients, colleagues, and society.

"While the primary duty of doctors is to serve the health needs of individual patients, they have additional, and occasionally competing, duties in relation to other patients, patients' family members and carers, colleagues and other healthcare professionals, the wider health system, and the public health.

"The AMA places a very high priority on its Code of Ethics, and encourages all doctors to observe its values and principles," Dr Gannon said.

Code of Ethics revised and updated

... from p12



AMA

AMA Code of Ethics 2004

Editorially Revised 2006. Revised 2016

1. PREAMBLE

1.1 Medical professionalism embodies the values and skills that the profession and society expects of doctors (medical practitioners). A *Code of Ethics* is essential for setting and maintaining the expected standards of ethical behaviour within the medical profession.

1.2 The AMA *Code of Ethics* articulates and promotes a body of ethical principles to guide doctors' conduct in their relationships with patients, colleagues, and society.

1.3 This Code has grown out of other similar ethical codes stretching back into history, including the Hippocratic Oath and those from other cultures.

1.4 Because of their particular knowledge and expertise, doctors have a responsibility to patients who entrust themselves to medical care.

1.5 The doctor-patient relationship is a partnership based on mutual respect, collaboration and trust. Within the partnership, both the doctor and the patient have rights as well as responsibilities.

1.6 While doctors have a primary duty to individual patients, they also have responsibilities to other patients and the wider community.

1.7 The principles in the AMA *Code of Ethics* apply to all doctors, regardless of their professional roles.[1,2]

The updated AMA Code of Ethics for the first time addresses:

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

The updated Code also provides greater clarity on consent; conscientious objection; complaints; control of patient information; fees; professional boundaries; managing interests; stewardship; medico-legal responsibilities; and protecting others from harm.

It has also been drafted to be consistent with AMA policies on:

- advertising and endorsement;
- conscientious objection;
- Declaration of Geneva (pledge);
- Declaration of Tokyo (torture);
- doctors' health;
- ethics in custodial settings;
- independent medical assessments;
- medical certificates;
- medical professionalism;
- medical records;
- medical witnesses;
- patient examinations;
- patient follow-up;
- professional autonomy and clinical independence;
- professional boundaries;
- public health emergencies;
- relationships with industry; and
- regulations in times of armed conflict.

During the course of reviewing the Code, State and Territory AMAs were given the opportunity to suggest amendments on an earlier draft. Following incorporation of their suggestions, the draft was further updated and sent to MDA National and AVANT for their comments. This was to ensure it did not inadvertently conflict with their medico-legal advice. Staff at the Medical Board of Australia also reviewed it to ensure it did not conflict with *Good Medical Practice: A Code of Conduct for Doctors in Australia.*

The AMA Code of Ethics 2004. Editorially Revised 2006 is at: https://ama.com.au/position-statement/code-ethics-2004-editorially-revised-2006-revised-2016

CHRIS JOHNSON

Doctor as patient

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

> "During the morning I deteriorated, with worsening diarrhoea, vomiting and abdominal pain. I desperately needed a doctor and did not want a return visit to the ED."

In the week that the AMA released its 2017 Public Hospital Report Card, a dose of salmonella saw me experience first-hand the pressures that public hospitals are under, and appreciate the value of a GP home visit for urgent care in circumstances when you can't access your usual GP.

I had flown into Canberra for a weekend meeting of the AMA Council of General Practice, already feeling unwell with established symptoms of food poisoning. I was becoming sicker and more dehydrated. With abdominal pain and rebound tenderness, I found myself at the local emergency department at 10pm on the night of my arrival.

During the next eight hours I got to see my hospital colleagues dealing with the pressures of managing multiple patients in varying states of illness and distress, with limited resources and a bed capacity unable to keep up with demand.

Here it seems the world revolves around assessing and prioritising the steady stream through the door, although things can quickly change when a major incident happens. While I was there, the deluge of more than 80 patients affected by a local bushfire appeared to almost overwhelm available resources. The doctors, nurses and other staff worked diligently to ensure that patients were seen as soon as possible but, on a night like this, benchmark targets seemed to have very little relevance.

Sometime around 5am, with blood cultures taken and intravenous rehydration commenced, a long awaited physical examination revealed that my earlier rebound tenderness had resolved although there was still significant point tenderness. With no acute abdomen I was discharged around 6am Saturday.

During the morning I deteriorated, with worsening diarrhoea, vomiting and abdominal pain. I desperately needed a doctor and did not want a return visit to the ED. It was time to call one of the after-hours GP services, which sent a GP to see me in my hotel room. Following a comprehensive examination, which revealed marked lower abdominal tenderness and a positive Murphy's sign, I had a script for *ciprofloxacin*. Armed with this, some *ondansetron* and gastro-stop, I tried to make my flight home only to be bumped because I was too sick. Following a visit to the after-hours chemist and after commencing my *ciprofloxacin* I finally turned the corner, improving enough to fly home Monday morning.

I understand the health system better than most and know how daunting it can be to navigate – particularly at times when your usual GP is not there to guide. This experience was a timely reminder of the challenges our patients experience when seeking care, and why the AMA's advocacy for our profession and our patients is so important.

Besides getting a taste of what my patients experience when seeking care outside of surgery hours, this episode has also highlighted the importance of looking after our own health. I did try and soldier on for too long, not wanting to let my colleagues down.

We are not super human and we do get sick. When we are, perhaps we should consider what advice we would give a patient in the same situation. We need to be kind to ourselves and recognise when we need another's medical expertise.

The time is now to act on inequalities

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

An appropriate response from Australia and its new Health Minister to the health problems our country is confronting would start with a goal-based strategic approach to inequality and the injustice and health disadvantage that travels with it.

Many social and political analysts agree that inequality has manifested itself as an immense force in recent elections, including the vote on Brexit and the elevation of Donald Trump. The core temperature in the social volcano reached a critical level as workers' wages froze while top executives received ever more millions. Now the volcano has erupted. A period of prolonged social unrest and loss of confidence in political structures is predicted.

At the World Economic Forum in Davos, Switzerland last month, inequality received unusual attention. The Forum is traditionally for high-flying business magnates, princes of the financial world and others who have benefited immensely from recent decades of global economic progress. But this year the glitterati, as they checked their ski bindings, nervously added inequality to their agenda. Inequality they ranked as "the most important trend likely to determine development across the world over the next decade".

Now inequality may seem remote from us, our patients and the health of our communities but it may be closer than we think. Life expectancy and quality of health and life depend on life opportunities being relatively equal. Inequality is a powerful risk factor and as UK (nee Australian) epidemiologist Michael Marmot has shown and spoken forcefully in his 2016 ABC Boyer Lectures, can outweigh even smoking as a damage to health.

Hear the rumble in the mountain and be afraid

Voices urging health professionals to heed the rumbles deep in the mountain include those of Marmot and Flinders University's Professor Fran Baum. And thank goodness that to an extent we have done so. The Aussie "fair go" has contained the avarice of economic fundamentalists who would turn the torch of unfettered market forces on everything. And so Australia retains Medicare, public education and social welfare programs that mitigate potential catastrophes and life-long loss of opportunity. With the exception of Indigenous health, our social gradients in life expectancy are not savage although far from top drawer compared, say, with Scandinavia.

What to do?

We can analyse the statistics and note the extent of inequality and its effects, but it is quite another to work out what we might do about it.

A recent article in the *BMJ* by Kate E Pickett and Richard G Wilkinson, epidemiologists at York University, reflected on the agitation on the Davos ski slopes. Inequality, they observed, "during the 20th century in most rich countries fell almost continuously from the 1930s to the 1970s but then increased dramatically from the 1980s".

So presumably the deeply troubling levels of inequality that are driving current unrest can be undone. As John Kennedy observed, man-made problems are generally amenable to man-made solutions.

Pickett and Wilkinson remind us that the late Tony Atkinson, an economist and activist who spent his lifetime concerned about inequality, identified several actions relating to taxation and minimum wages that he calculated could help. So good minds have been at work.

Marmot has written extensively on what might be done about inequalities. His reports, built on a strong base of evidence, focus on six areas for action:

- Give every child the best start in life;
- Enable all children, young people and adults to maximise their capabilities and have control over their lives;
- Create fair employment and good work for all;
- Ensure healthy standard of living for all;
- Create and develop healthy and sustainable places and communities; and
- Strengthen the role and impact of ill-health prevention.

"Delivering these policy objectives," he writes, "will require action by central and local government, the [national health authority], and the private sectors and community groups. National policies will not work without effective local delivery systems focused on health equity in all policies."

Conceivably many of us can do a bit about several of these goals. A big challenge demands a big response and an imaginative and creative political push. It's ages since we had a national health policy that made you stop and think with its depth and challenge. Let's help make it happen.

The new normal

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

Something strange happened to me recently that reminded me of how badly calibrated our frames of reference can be. I'm a dual trainee, and with the new training year upon us, I was migrating from the calm and collected ivory tower of the intensive care unit, back down to the chaos and madness in the pit of the emergency department. It's clear that I like really sick people; I just can't seem to decide on the speed of sickness that I prefer. Fast or slow? I relished the change of pace. It was frenetic. We were getting things done. I was happy.

And then we had a teaching session. One of those beautifully peaceful moments when you leave the emergency floor and you enter the tranquillity of education. We discussed stroke management. I spoke about ultrasound. So far, so good. All normal. Our director of training asked us how we were going and he made specific mention of just how busy we'd been lately. I took note and thought "OK, so we've had a busy few days. Nothing new here". He kept probing and then the other trainees started talking about the pace. It then became abundantly clear to me that the last few weeks were not normal. They were chaos. The cubicle pressure, the acuity of the presentations, the backlog in the hospital… none of this was normal. Not by a long shot.

It might not sound much, but I was quite shocked by just how incorrect my frame of reference was. If you don't have a good frame of reference, you start to misjudge things that happen. What you explained away as a quirk of the system could quite easily become a serious medical error. And so, with this new calibration I started to re-hash the events of the past few weeks. What had I missed? If this pace wasn't normal, had I expected too much of my juniors at any point? Had I been too hasty with investigations, or documentation? What pressures had I placed on my nursing staff? Looking back with this new frame, I made my peace. Yes, things were fast. No, they hadn't been unsafe. But I remained shocked with this error of calibration. The compass was off, and a bad compass leads you to icebergs.

I've been a doctor for eight years now, and in that time, I've had to recalibrate on several occasions. I'm no expert and I'm certainly no source of truth, but here are some common "normalities" I've encountered along the way:

It's not normal to excel at every assessment along the way, and it's normal to fail. We've created this system of training in which hypercompetitive medical students vie for the "best" internship (whatever that is supposed to mean) and endlessly buff their CVs to achieve immortal greatness in the specialty of their choice, to the exclusion of all others. This type of system demands that doctors perform at 100 per cent of their operating capacity, at all times, which just isn't reasonable. I've spoken before about the green and red lights of assessment, and the dire lack of orange lights along the way. This isn't normal outside of medicine and it shouldn't be normal within it. We need systems of assessment that don't demand shiny whitewashed walls of achievement. The odd coffee stain isn't just acceptable, it should be encouraged. It should be a badge of honour, because stains draw attention, and they allow you to focus on how to improve yourself rather than improving at assessment. Use your frame of reference to improve, not to impress.

It's not normal to not see your loved ones for days at a time. My partner works shift work as well, and our training has meant that while I rode the escalator down into the pit of mayhem, she's taken the elevator to the top of the afore-mentioned tower. She relishes the opportunity to have a good laugh when I call from ED for ICU to please come and join the party. We're less jovial about our jobs when we're passing ships in the night, only seeing each other at the start and finish of shifts for a quick chat and a kiss goodnight. Now don't get me wrong, we've chosen this life and these rosters. However, no matter how you paint it, it isn't normal. We have had to take these runs as a sign to slow down and be sure to spend quality time with each other. If you're going to roster work, make sure you roster life.

It's not normal to be so close to death all the time. I've chosen two particularly bloody specialties, and death (often horrific death) is not uncommon. And yes, your temperament for death will be part of what guides you to your specialty. But death like this shouldn't ever be normalised. We need to remember to debrief with those around us, especially for new staff who might not be used to the abnormality of death on invasive organ support. To extend this further, I'd like to also point out that death of our colleagues is never, ever normal. It should be treated with the utmost of seriousness and should always result in an organisational response. We should never expect doctors to just get back to business as usual when they lose a peer.

It should be normal to enjoy your job. It should be normal to be proud of your profession. It should be normal to have a healthy workplace culture. Sometimes we hit these points of normality and at other times we don't. For my part I'm going to keep checking that compass. Pick up the deviations before we get lost, lest we run into icebergs.

Mixing it up

BY ROB THOMAS, PRESIDENT, AUSTRALIAN MEDICAL STUDENTS' ASSOCIATION

> "We take for granted that we did well in school, that we have a stable job and good support systems. We become complacent to our own self-worth, which can have damaging consequences."

The trouble with medicine (or should I say, one of the troubles) is that it tends to leave you with tunnel vision for that rotation, that class, the job, the title. Pituitary adenoma jokes aside, I'm saying that in short order, our entire life becomes medical.

I've already seen it since starting medical school – I study with other medical students; I relax with other medical students. And of course it is important to have a close group of colleagues to get you through the day, but it becomes hard to see outside of our world. When meeting up with close friends who have not chosen medicine as their career, we find it difficult to find common ground. Pretty soon we find ourselves talking about interesting cases we've heard of, or the best procrastination techniques we've come up with.

It's important that we work hard to connect with people outside the medical profession, for a number of reasons. Firstly, it gives us perspective on our own challenges. Studying and working in such a high-functioning world, we begin to forget how lucky we have it. We take for granted that we did well in school, that we have a stable job and good support systems. We become complacent to our own self-worth, which can have damaging consequences.

Secondly, connecting with the general public helps us communicate with our patients. It's funny how many times I've seen doctors become frustrated with their patients not understanding medical jargon straight away. We forget that over many years doctors have learnt a new language – again, we take that for granted. The more we talk to the average human in a social setting, the better we can understand our patient when it really matters.

Third, although we enjoy our common goal in medical school – to finally graduate – we also must remember that in five to ten years we will all be choosing a path that is likely not the same as our peers. Our path will lead us to new challenges and eventually a consultancy that will be very unlikely to be with all of our current year group. Pushing yourself to make friends outside of medicine will continue to nourish you when your colleagues start to drift in different directions.

The other thing is, having something outside of medicine is important when things go wrong. Too often the stress of patient care, the normality of paying bills and the reality of exams thwack us into distress and burnout. This can all be alleviated by having something non-medical to concentrate on.

This may be a watching a sporting event, volunteering for meals on wheels, a weekly catch-up with high school friends, or exercising. Meeting with non-medical people may enhance your perspective and let you reframe your thinking from the heights of evidence-based medicine, journals and routines, appointments and rounds, and focus your thoughts on relating back to people.

It may seem ridiculous to add something to your plate when you're already incredibly busy, but it actually restores balance and leaves you feeling refreshed. You're forced to forget about your work and focus on something entirely unrelated to that world.

My advice to medical students is to not neglect their lives. Yes, it's important to make the most of your medical school experience, taking time to study and learn the necessary medical knowledge. However, it's just as important to learn to find balance – to exercise, to talk to non-medical people and to enjoy doing non-medical things. I guarantee it's worth it.

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Time to address the perennial problem of unequal distribution of the medical workforce

BY AMA VICE PRESIDENT DR TONY BARTONE

> "The MWC believes that unless there are more places for postgraduate training and in the undersupplied specialties, the problem of workforce shortages in rural areas will not go away over the longer term, no matter where the students are."

One of the questions I'm often asked as I travel across Australia is why can't we get enough doctors to the bush, especially with all the medical students we are graduating.

The unequal distribution of the medical workforce is one of the perennial problems that has weighed down Australia's health system. The reasons are many, as are the potential fixes offered.

Last year, we saw some positive signs that the Government has turned its gaze from funding more medical schools to addressing workforce shortages.

In this space, the issue du jour is the distribution of medical school places. As I write, a Government stocktake of the number and location of medical places, as well as the schools, campuses and clinical training sites is well underway.

The main focus is whether the distribution of medical Commonwealth-supported places should be changed. I understand that the recommendations that emerge from the review are likely to be considered by Federal Cabinet in April.

So would redistributing medical school places to universities with rural clinical schools, or to schools in rural areas ultimately get more doctors to the bush?

This question was given a great deal of thought by the AMA Medical Workforce Committee (MWC) at its recent meeting. As with many complex policy matters, there is no simple answer. But given the importance of the structure of medical training to Australia's future medical workforce, it is critical that we get this issue right.

The MWC believes that unless there are more places for postgraduate training and in the undersupplied specialties, the problem of workforce shortages in rural areas will not go away over the longer term, no matter where the students are.

Should the Government decide to redistribute medical school places, then we believe it should be guided by three important principles.

Firstly, overall student numbers must remain unchanged (until medical workforce modelling recommends otherwise). Unless you are a university trying to improve your bottom line or a nervous politician in a marginal seat, it is accepted that workforce projections are on the money and we do not need to train more doctors or open new medical schools.

Secondly, any decision to redistribute places has to be based on rock-solid information. What are the infrastructure requirements at the destination university or region; what criteria will be used; will quality supervision and appropriate resources for teaching be assured?

Thirdly, any change to the distribution of places must be linked to improved availability of downstream postgraduate training posts.

On this last point, the AMA has a number of innovative policy proposals worthy of consideration. These include our community residency program and regional training networks model for enabling medical graduates to complete most of their training in rural areas.

We now recruit almost a quarter of medical students with rural backgrounds and almost a quarter of Australian students go through rural clinical schools.

Though the AMA believes these allocations could be expanded, we nonetheless have a promising number of rural graduates. What we need now is a strategic approach to providing the training pathways that will give them the opportunity for rewarding careers in the bush.

In the end, it is about better medical services for local communities.

These ideas are outlined in our recent submission to the review. It is available online at (URL to be advised). I encourage you to take a look.

Will the bush ever have equitable broadband access?

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

> "Currently 68,000 Australians are connected to the Sky Muster service, which has undergone a range of fixes and improvements since it first began offering services on 28 April last year, and according to the nbn this has led to far fewer drop-outs than used to occur."

As some readers may know, the AMA released a Position Statement in January calling for better access to high speed broadband for regional, rural and remote health care. This Position Statement was developed in response to concerns by rural doctors that were highlighted in the findings of the AMA Rural Health Issues Survey conducted in April 2016.

The survey, which sought the views of rural doctors across Australia to identify key solutions to improving regional, rural and remote health care, found that access to high speed internet services was the number one priority for rural GPs and the second highest priority among all rural doctors.

The AMA Council of Rural Doctors, at its recent videoconference meeting in February, discussed this issue with representatives of the National Broadband Network Company (nbn) directly. We were told that at the time of the survey, the widely criticised Interim Satellite Service was providing internet services to regional and remote Australia. Since then, nbn has launched the first Sky Muster satellite, and will soon bring on board a second satellite that will offer business grade services around the second quarter of this year.

Currently 68,000 Australians are connected to the Sky Muster service, which has undergone a range of fixes and improvements since it first began offering services on 28 April last year, and according to the nbn this has led to far fewer drop-outs than used to occur. This is good news for those relying on satellite internet. The speed of these services will be either 12/1mbps (upload/download) or 25/5mbps, depending upon what plan you choose.

While these speeds are nowhere near the speeds available in the big cities that use fibre technology (up to 100/40mbps), they are sufficient for a range of uses, and should allow doctors, health services and hospitals to upload health summaries to the My Health record, undertake telemedicine via videoconference and exchange high resolution images. These speeds should also enable doctors to do business with Government, comply with Government requirements, participate in online continuing professional development and education activities, and reference online help such as clinical decision-making tools and other support.

Following our strong comments about data allowances, we understand that nbn is working on making eligible health centres, practices and large medical facilities Public Interest Premises. This will potentially afford them a higher data allowance (150GB per month).

Now comes the big HOWEVER. Will the data allowance be sufficient to do all this? There is much concern in the bush about the 'data drought'. I understand the satellite technology has inherent limitations that restrict the amount of data available. There is a real need for 'business style' plans to be made available, recognising the unique nature of the speeds and data allowances that businesses require.

So, while the nbn will clearly deliver improved broadband access for satellite users, it is hard to see how it can keep up with the needs of an increasingly digitally enabled health system. It's an area that the Government will need to give much greater thought to.

What I would also like to see happen over time is an extension wherever possible of the fibre and fixed wireless services into the satellite footprint and/or the introduction of alternative technologies to lessen the reliance on satellite for those living in rural and remote Australia. Maybe then, in time, we can say there is equitable access to broadband for all Australians.

Aboriginal and Torres Strait Islander People Have the Solutions to Close the Gap

BY AMA PRESIDENT DR MICHAEL GANNON

> "How much longer do Aboriginal and Torres Strait Islander people in Australia have to live in disadvantage? How much longer do they need to be sicker and die younger than their non-Indigenous peers? Australia must and can do better."

We continue to be handed myriad government reports on Indigenous affairs and hear well-meaning words spoken by our political leaders. But, in 2017, we still see governments fail to deliver on their commitments to improve the health and wellbeing of Aboriginal and Torres Strait Islander people.

The 9th Closing the Gap report, handed down in Parliament House by Prime Minister Malcolm Turnbull on 14 February, reflects the inadequacy of government performance against their own commitment to close the gap in health and life expectancy between Indigenous and non-Indigenous Australians. Whilst there have been some encouraging gains in health and educational outcomes over recent years, the gap in health and life expectancy between Indigenous and non-Indigenous remains wide.

Discouragingly, only one of the Government's seven Closing the Gap targets is on track to being met.

How much longer do Aboriginal and Torres Strait Islander people in Australia have to live in disadvantage? How much longer do they need to be sicker and die younger than their non-Indigenous peers? Australia must and can do better.

Positive progress can be made if governments work directly with Aboriginal and Torres Strait Islander people, and better understand the approaches that work in their own communities. Aboriginal and Torres Strait Islander people have long called for, and continue to call for, structured engagement with governments and involvement in decision-making. The AMA recognises the importance of self-determination and fully supports Aboriginal and Torres Strait Islander people in wanting to take charge of their own lives.

Governments must recognise and value the knowledge and expertise that Aboriginal and Torres Strait Islander people have. They must understand that Indigenous people have the solutions and the expertise to deliver. This was made clear in the lead-up to the release of the Closing the Gap report, when Aboriginal and Torres Strait Islander leaders presented the Prime Minister with the Redfern Statement – a statement that calls on governments to better engage with Aboriginal and Torres Strait Islander Australians, and contains the solutions to improving health and life outcomes for Indigenous people.

The AMA considers that the current Parliament has an unprecedented opportunity to work closely with Indigenous people and meaningfully address the disadvantage that Aboriginal and Torres Strait Islander experience. The AMA urges the Government, opposition and minor parties to take note of the Redfern Statement and ramp up their efforts to achieve health equality for Aboriginal and Torres Strait Islander people and take further steps in building on existing platforms.

The AMA, along with many others working in Indigenous health, has been campaigning for long-term funding and commitments from government to improve the health and wellbeing of Aboriginal and Torres Strait Islander people. We will continue our advocacy to help achieve this goal.

We must find a way to celebrate Indigenous advancement where there is evidence of real improvement. Some gaps remain because of equivalent improvements in the health of non-Indigenous Australians. It is important to avoid a nihilism about Aboriginal and Torres Strait Islander affairs. We must never consign these issues to the 'too hard' basket and we risk that if we do not carefully appraise measures that are working and acknowledge them.

But having only one single Closing the Gap target on track is truly disheartening, and frustrating for Aboriginal and Torres Strait Islander people when their solutions are being ignored. It is imperative that the Prime Minister and his Government act urgently so that we can finally begin to see genuine improvements in health and life outcomes for Aboriginal and Torres Strait Islander Australians.

Council of Private Specialist Practice created to respond to challenges

BY ASSOCIATE PROFESSOR JULIAN RAIT

The Council of Private Specialist Practice (CPSP) is the most recent of the Federal AMA's Councils – created in 2016 to recognise and respond to the key challenges that face private practitioners within the Australian health system. Our Terms of Reference provide for us to identify issues relating to private specialist medical practice and make recommendations to Federal Council, as well as develop and draft policy or position papers on key topics.

Private practices are an essential component of a sustainable Australian health system. The private system alleviates much of the demand on the public system – providing nearly 70 per cent of all elective surgical admissions.

And as with all other advanced economies, Australia requires both a strong private and public health system to meet the challenges that lie ahead – including an ageing population, rising health care costs and increasingly complex care.

The structure and format of private specialist practice is also changing – with solo and group practices competing with corporate entities.

Two big "funders" of private health, the Commonwealth Government via the MBS, and the Private Health Insurers, continue to grapple with how best to fund the system in an era of escalating cost pressures. In response, they are seeking to drive down their costs, especially by curbing the growth in their outlays. This creates significant pressure on the private medical practitioner who is trying to deliver a high quality and economically viable service. Consequently, patients are incurring escalating out-of-pocket costs, prompting many to question the value of their private health insurance.

Private health is an area currently under extensive review, and subject to increasing scrutiny. We've seen the previous Health Minister announce the Private Health Ministerial Advisory Committee (PHMAC), and under this committee, a further number of working groups.

CPSP has been engaged, and supportive of the AMA's work in relation to PHMAC's deliberations– which clearly indicate that our Federal Government is considering various options in an attempt to make private health insurance a more attractive proposition for Australians. This includes considering clear categories of health insurance, reviewing of hospital contracting arrangements (and especially second tier funding provisions), while making polices easier to understand and removing impediments to policy portability for customers.

The reality is that a great deal of discussion will arise from the usual hot button media issues – with constraints on out-of-pocket costs and online rating sites being hailed as the 'answer' to make private health insurance "more attractive". Meanwhile, health insurers continue to record extraordinary profits and breathtaking returns on equity. For example, news outlets are reporting NIB recently received approval to lift its premiums by 4.48 per cent after announcing a 65 per cent increase in net profit (compared to the prior year) and scoring a return on equity of 32 per cent – with the latter result being double that of the Commonwealth Bank.

The CPSP has, and will continue to, be firm advocates for the profession on these issues. A little known fact among the broader population is that medical fees only account for 16 per cent of private health insurance benefits with 85.6 per cent of medical services having no gap, and 92.3 per cent of services having nil or a known gap charge . So you might agree that the gap fees of medical practitioners are not the leading cause of the PHI affordability challenge.

However, despite these modest figures, there is a perception that out-of-pocket costs are not being actively managed by the profession – a view apparently held by governments, consumers and mass media. The profession can no longer ignore the issue around significant or unexpected out-of-pocket costs without it being seen as a failure of the profession to self-regulate appropriately, and become the scapegoat for all the affordability problems of the system. Insurers and consumer groups have commenced research on the quantum and frequency patients experience these costs.

Moving beyond private health insurance reforms, we've also seen the Federal Government embark on changes to the medical indemnity insurance subsidy schemes. Many doctors would be aware that last year the Government included a funding

Public hospitals – funding needed, not competition

BY ASSOCIATE PROFESSOR SUSAN NEUHAUS, CHAIR, HEALTH FINANCING AND ECONOMICS COMMITTEE

Under its terms of reference, public hospital funding is a key focus for Health Financing and Economics' work. How funding arrangements affect the operation of public hospitals and their broader implications for the health system has always been an important consideration for HFE, and for Federal Council and the AMA overall.

The AMA Public Hospital Report Card is one of the most important and visible products for AMA advocacy in relation to public hospitals.

The 2017 Report Card was released by the AMA President on 17 February 2017. The launch and the Report Card received extensive media coverage.

The Report Card shows that, against key measures relating to bed numbers, and to emergency department and elective surgery waiting times and treatment times, the performance of our public hospitals is virtually stagnant, or even declining.

Inadequate and uncertain Commonwealth funding is choking public hospitals and their capacity to provide essential services.

The Commonwealth announced additional funding for public hospitals at the Council of Australian Governments (COAG) meeting in in April 2016. The additional funding of $2.9 billion over three years is welcome, but inadequate.

As the Report Card and the AMA President made very clear, public hospitals require sufficient and certain funding to deliver essential services.

"Sufficient and certain" funding is also the key point in the AMA's submission to the Productivity Commission's inquiry into Reforms to Human Services, in relation to public hospitals. The Commission is expected to report in October 2017.

Council of Private Specialist Practice created to respond to challenges

... from p21

cut of $36 million to one of these long-standing subsidies that underpin medical indemnity insurance in the Mid-Year Economic and Fiscal Outlook (MYEFO). Furthermore, they have announced a review into all the Government's indemnity support schemes – signalling that strong consideration is being given to future cuts to these important Government subsidies for the profession.

To that end, CPSP will be closely monitoring any proposed changes and the AMA will be participating in the forthcoming review.

The AMA has already written to the Government, reminding them of the truly disruptive crisis that brought about the current support schemes, and warning that any changes made without effective consultation with the profession, and their indemnity insurers, could lead to significant unintended consequences. CPSP has also discussed the importance of universal coverage arrangements (whereby no registered doctor can be denied insurance) – agreeing that any changes here need to be carefully considered.

Finally, there continues to be a number of reviews underway which may have impacts upon private practice. The Senate Community Affairs Committee has an inquiry into Prosthesis List Framework, the Australian Competition and Consumer Commission is calling for submissions on their annual report to the Senate on Private Health Insurance, and of course the MBS Review Taskforce continues. CPSP will be navigating all these reviews, ensuring that the private practitioner's voice continues to be well placed to advise the AMA on the implications of any changes.

The coming weeks will also see the release of the AMA's Private Health Insurance Report Card – a good chance to shine a light on the key issues facing private health, so please continue to be attentive to our initiatives.

Public hospitals – funding needed, not competition

... from p22

> "Public hospitals are not the same as a business entity that has full or even substantial autonomy over their customers and other inputs, processes, outputs, quality attributes, and outcomes."

As part of this inquiry, the Productivity Commission published an Issues Paper seeking views on how outcomes could be improved through greater competition, contestability and informed user choice.

While the AMA believes there is clearly potential to improve outcomes of public hospital services, its submission highlighted that there are significant characteristics of Australia's public hospitals that must be taken into account.

Health care is not simply a "product" in the same sense as some other goods and services. Public hospitals are not the same as a business entity that has full or even substantial autonomy over their customers and other inputs, processes, outputs, quality attributes, and outcomes.

Public hospitals work on a waiting list basis, usually defined by acuity of need, to manage demand for public hospital services. Private hospital services typically use price signals. There is limited scope to apply mechanisms for patient choice (such as choice of treating doctor) to access arrangements in public hospitals that are governed by waiting lists.

Public hospitals also operate within a highly developed framework of industrial entitlements for medical practitioners and other staff that are tightly integrated with State/Territory employment awards. These measures are intended to encourage recruitment and retention of medical practitioners to the public sector, offering stable employment conditions, continuity of service and portability of entitlements. They support teaching, training and research in the public sector as well as service delivery.

The freedom to choose between public and private hospital care, and the degree of choice available to patients in public hospitals as distinct from private patients, is an integral part of maintaining Australia's balanced health care system. The broad distinction between public and private health care is generally understood by the community as a basic feature of the health system and part of Medicare arrangements, even though detailed understanding of how this operates, including what they are actually covered for in specific situations, is often lacking for many people.

Introducing private choice and competition elements into public hospital care will tend to blur the distinction between public and private health care, and reduce the perceived value of choice as a key part of the incentive framework for people choosing private health care.

The Commission's Issues Paper proposes that increased competition will address equitable access for groups including in remote areas, benchmarking and matching of best practice, and greater accountability for performance. These are all worthwhile and important objectives in their own right. As such, they are already the focus of a range of initiatives.

Public hospitals are already subject to policies and requirements that address the same ends of improved efficiency, effectiveness and patient outcomes, including:

- Hospital pricing, now supported by a comprehensive, rigorous framework of activity based funding and the National Efficient Price;
- Safety and quality, supported by continuously developing standards, guidelines and reporting, including current initiatives to incorporate into pricing mechanisms;
- Improved data collection and feedback on performance including support for peer-based comparison.

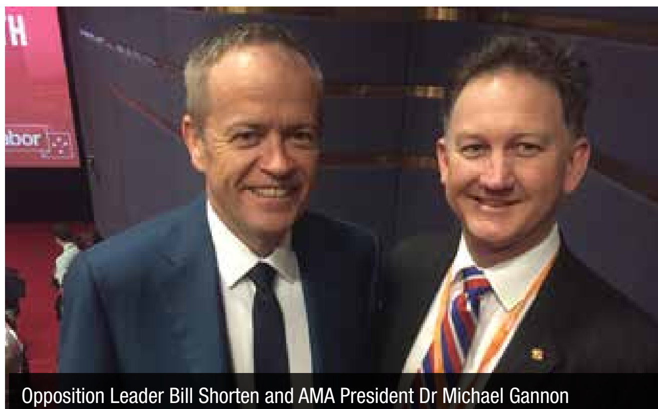
The single biggest factor that will increase the returns from such initiatives is the provision of sufficient and certain funding. Increased competition, contestability and user choice will not address this need.

The AMA Public Hospital Report Card 2017 is at https://ama.com.au/ama-public-hospital-report-card-2017

Health on the hill

POLITICAL NEWS FROM THE NATION'S CAPITAL

Experts gather at Labor Health Summit



Opposition Leader Bill Shorten and AMA President Dr Michael Gannon

AMA President Dr Michael Gannon was one of 160 hand-picked health sector leaders to participate in the Labor Party's National Health Policy Summit, hosted by Opposition Leader Bill Shorten at Parliament House in Canberra early this month.

Labor will use the Summit outcomes to help inform its health policies ahead of the next election.

There were sessions on Protection, Prevention, and Promotion; Primary, Secondary, and Community Care; Hospitals; Mental Health and Suicide Prevention; Ensuring Universal Access for all Australians; Designing our Health Workforce for the Future; Tackling Health Inequality and Other Whole-of-Government Challenges; and Innovation Across our Health System.

The Mental Health and Suicide Prevention session showed yet again that the mental health sector has a degree of fragmentation, with long-standing differences in how to approach funding, resources, and workforce.

Twenty eight countries have national mental health strategies, but not Australia. The experts want a strategy – soon.

There was universal support for the National Mental Health Commission, and some suggested that reform be driven through the Commission, rather than by government. Considerable time was focused on the need to invest in community mental health.

How Australia addresses our disproportionately high rates of suicide was canvassed. Importantly, it was recommended that suicide should not always be couched within the mental health framework as Indigenous suicide, in particular, is linked to intergenerational trauma and social determinants.

The Tackling Health Inequity session began with a focus on language: do we use the term 'social determinants of health'?

This session discussed how to manage chronic disease in a climate of disadvantage, especially in regard to Indigenous people. A whole-of-government approach to inequity is needed, and it was deemed imperative that this includes the labour market.

The current employment framework can further entrench inequity for single mothers, shift workers, and the like. One pertinent view was that the Government shouldn't be designing a health system that meets the needs of a 30-year old white male – it must be designed for the most at need, and then everyone will be cared for.

It was agreed that population data is critical to any attempts to reduce inequity. Housing, housing affordability, and transport – issues relevant to any discussion on inequity and health care – were raised by many delegates. So too, the problems with the NDIS, and problems accessing psychosocial supports.

The Hospitals session brought together key representatives from the Private Health Insurance (PHI) industry, private hospitals, public hospitals, as well as a range of stakeholders representing the staff and patients in the hospital sector.

There was a robust discussion on PHI and its role in supporting the wider hospital system.

Concerns centred in particular around private health insurance affordability – with many worried an increasingly unaffordable product will increase the strain on public hospitals, as people downgrade or cease their cover.

A strong view from the insurers was the issue of private

Health on the hill

POLITICAL NEWS FROM THE NATION'S CAPITAL

... from p24

patients being treated in public hospitals, but using their insurance to cover the treatment - a topical issue noting the recent media coverage of the growth of this practice in State-run facilities.

This discussion was balanced by some representatives highlighting that patients have a right to utilise their insurance, that there may be a number of reasons people choose to be treated in a public hospital, and a note that the insurers' increasing profits could be used to decrease premiums.

The ongoing issues of emergency wait times, and adequate access for rural and regional Australians was canvassed. The need to better integrate PHNs with hospital networks was a long topic of debate – with the view that much more can be done here to improve the system.

The session then moved to data, performance measurement and funding of the hospital system.

The 'Universal Access for All Australians' session started with the issue of specialist out-patient services and the disparity in wait times for public patients. The observation was made that out-patient clinics have been closed down over time for pubic patients and that there is really a 'hidden demand' for these services.

Many in the session questioned whether, in light of these issues and the fact we have 'two health systems', whether Australia has true universal access. The idea of a 'Medical Access Guarantee' was also raised.

It was noted that a key driver to the significant wait times some public patients experience, as well as the variability that is evident nationally in service delivery, is driven in part by workforce issues.

Without proper primary care access, a patient's conditions can worsen, and they present later to the acute care system. The end result is that the cost is higher and the outcomes will likely be worse, noting the person is now significantly sicker. Related to this issue was the concern about medication affordability, as well as their appropriate use.

The AMA stressed that stability in policy and funding, beyond a three to four year cycle, could have the potential to make the sector more efficient.

Dr Gannon and the AMA policy advisers who attended the Summit found it a worthwhile access – for networking, for highlighting AMA policy, getting a feel for the policy directions of other major health sector players, and for building closer political links with the alternative Government.

LUKE TOY AND SIMON TATZ

National e-health strategy – don't give us high level, give us down-to-earth, AMA says

The proposed national digital health strategy should be a simple, straightforward list of proposed projects and their benefits, rather than a high-level strategy document, Australia's peak doctors' body says.

In its submission to the Australian Digital Health Agency (ADHA), the AMA says it has long advocated for a strategic plan for digital health.

But it warns that clinicians must be involved in both the development of the proposed National Digital Health Strategy (NDHS) and its implementation, saying too many e-health projects around the world have failed because they were developed without consultation with the people who had to use them.

"The AMA is aware of the long track record, both locally and internationally, of e-health projects falling over for failing to consider the social aspects of development and implementation," the AMA says.

"If no other lessons have been learnt from Australia's approach to e-health, clearly a 'build it and they will come' approach, without coalface clinical involvement, will fail."

Clinician involvement must not stop at the 'strategy' level.

"There is a need for co-produced development and operational plans so providers can see where critical services are heading, over what time frame, and what this means for them," the AMA said.

"Many doctors and other healthcare providers have a level of scepticism about high level strategy documents, preferring instead to have access to a simple, clear, prioritised and costed list of projects, with tangible products and benefits able to be understood by the non-technocrat."

The AMA also said that the strategy should have a more balanced and complete coverage of all health practitioners' needs, compared to the historic over-emphasis on patient-controlled health records – the My Health Record (MyHR) - and support for e-health in general practice.

"This must include specific support for medical specialists other than GPs to take up digital health, including but not limited to the MyHR," it said.

"The NDHS should also clearly acknowledge that digital health has important and direct implications for the way health care is organised, for health financing and funding, and for existing payment models.

Health on the hill

POLITICAL NEWS FROM THE NATION'S CAPITAL

... from p25

"It should explicitly identify the need to carefully identify implications for payment models for clinicians of coming digital health initiatives.

"For example, under some initiatives, clinicians will be doing much if not most of the work of the inputting of data – work which is for the benefit of patients.

"In addition, digital health will likely involve clinicians doing a lot of work in communicating with a patient who is not present in the consulting room – eg communicating with the patient by secure messaging.

"Funding models – which currently don't even fund phone calls – will need to support this new clinical activity, including by dealing with and responding to new expectations, such as patients who may have an unreasonable expectation that they will be able to contact the doctor without having to see them, and without having to pay for their time and skills."

Submissions to the consultation closed on 31 January, 2017, with more than 1,050 online submissions received, and 3,100 people attending meetings, forums, workshops, webcasts and town halls.

More than 80 per cent of respondents agreed that digital technologies would transform and improve healthcare outcomes in Australia, and four times as many people want to access their personal health information on their smartphone than those who actually do.

MARIA HAWTHORNE

New genetic testing Framework needs funding to work

A new draft Framework on genetic testing could be relegated to nothing more than "a series of statements" if it is not accompanied by an implementation plan or funding, the AMA has warned.

The Commonwealth Department of Health has sought feedback on the draft National Health Genomics Policy Framework, which is a commitment between Commonwealth and States and Territories to work collaboratively to integrate genomics into the health system over time.

While the AMA supports the strategic priority areas in the Framework, and agrees with the issues and challenges identified, it is concerned by the lack of an implementation plan or funding to achieve its objectives.

"Both of these omissions risk relegating the Framework to only a series of statements without any impact on improving health outcomes," the AMA submission said.

The AMA also questioned the decision to restrict the Framework to guiding the genomics policies and activities of public hospitals.

"Limiting its scope in this way ignores the capacity for the private sector to contribute to, and complement, public health services," it said.

"Australia's health system is built on a complementary system of public and private services. There is potential to increase efficiencies, and reduce waiting lists, by better utilising capacity in the private sector.

"This is not possible while there are barriers to patients accessing a full range of services in the private sector, such as limited or no MBS rebates for the range of genomic health services now in use."

There is also no consistent, clear pathway for patients who start in the private sector but must move in and out of the public sector to fully benefit from access to genomic medicine.

"Clinical and testing services are primarily based in the public sector," the AMA said.

"This means that patients who have entered the public health system, referred by their general practitioner or private specialist, end up on long waiting lists to be seen in public hospital clinics, then wait again for public sector laboratory testing.

"Feedback to general practitioners is often slow and may be incomplete, despite the GP's responsibility to care for the patient and potentially track relatives of patients with newly-diagnosed genetic conditions."

Furthermore, genetic counsellors, who should be a critical member of multidisciplinary teams providing care to patients, are largely restricted to practising in the public sector as they do not have access to indemnity cover or MBS rebates for providing services in the private sector.

"Genetic counsellors should be facilitated to practise in the private sector so that they can support GPs and private practice specialists in treating their patients," the AMA said.

The AMA also called for more regulation of private operators who directly market genetic tests of dubious quality to people.

Health on the hill

POLITICAL NEWS FROM THE NATION'S CAPITAL

... from p26

"Not enough is being done from a regulatory perspective to protect vulnerable consumers who are embracing a level of genomics via direct-to-customer testing sales," it said.

"Most of these tests lack clinical utility and pose challenges in interpretation even to experts in the field."

The AMA called for a national approach to raising public awareness of the risks and benefits of genetic testing, including promoting reasonable expectations.

MARIA HAWTHORNE

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.

Research

New research reveals parents put too much faith in antibiotics

Bond University's Centre for Research in Evidence-Based Practice has found that parents grossly overestimate the benefit of antibiotics in reducing the duration of acute respiratory infections in their children.

The new research was published on March 14 in American journal *Annals of Family Medicine* and found most parents believed antibiotics provided substantial benefits for common paediatric respiratory infections, despite strong evidence that they offered only marginal improvements.

The study investigated the expectations and experiences of 401 parents of children aged one to 12 years, about using antibiotics for common acute respiratory infections, such as middle ear infection, sore throat and cough.

Bond University Professor of Clinical Epidemiology, Professor Tammy Hoffmann, who is the article's senior author, said antibiotics were being prescribed too often for acute respiratory infections, with the findings revealing a gap between expectations and actual benefits.

"Parents believed they were helping their children by using antibiotics. Their estimates of how much antibiotics can help were overly optimistic," Prof Hoffmann said.

"In the instance of middle ear infection, 92 per cent of parents believed antibiotics provided benefits.

"On average, parents estimated that taking antibiotics reduces the duration of the illness by three days. However, from many clinical trials we know the actual average reduction in illness duration is about half a day."

The study was the first that quantified parents' beliefs about antibiotic benefits and may help to explain why parents often requested antibiotics.

"While 78 per cent of parents recognised that antibiotics may cause harm, there were many inaccuracies in what harms they think can occur and confusion about what 'antibiotic resistance' actually is," Prof Hoffmann said.

"Less than half of the parents, just 44 per cent, recalled discussing benefits, harms and the option of forgoing antibiotic use with their clinician, during their last visit.

"Many of the parents, 75 per cent, indicated they wanted more involvement in future decisions regarding antibiotic use for their children."

The research highlights the opportunity for improving GP consultations by utilising shared decision making, in which GPs and patients discuss the benefits and harms of taking and not taking antibiotics, and together decide what is best for each patient.

"Collaborative decision making between GPs and their patients also provides the opportunity to discuss and address parents' overoptimistic expectations of antibiotics," Pof Hoffmann said.

The full report can be viewed www.annfammed.org/

CHRIS JOHNSON

Australian researchers work to speed up solutions for Motor Neuron Disease

A new urine test being developed with the help of researchers in South Australia could help expedite global efforts to develop better treatments, or possibly a cure, for Motor Neuron Disease (MND).

The cutting-edge test, under further development at Flinders University and the University of Miami, measures a key protein biomarker in the urine of MND sufferers as the condition progresses.

Eventually the test is expected to be used in clinical trials looking for improved treatments for the deadly neuro-degenerative disease.

Research

... from p28

The early promising findings will appear in the high-profile international journal *Neurology*, the medical journal of the American Academy of Neurology.

Currently there are no validated pharmaco-dynamic biomarkers for MND or Amotrophic Lateral Sclerosis (ALS), also known as Lou Gehrig's Disease.

Flinders University senior research fellow Dr Mary-Louise Rogers believes regular accurate and affordable testing of symptoms could lead to improved treatment and better interventions.

"A standardised, easy-to-collect urine test could be used as a more accurate progression and prognostic biomarker in clinical trials," Dr Rogers says.

"This will accelerate progress towards more rapid identification of improved treatments for MND and save time and money by faster exclusion of less effective or ineffective drugs.

"And in the future, it also could potentially be used to test people for early signs of pre-familial MND progression and used instead of patient questionnaires for regular testing of disease progress or drug suitability in existing MND cases," Dr Rogers adds.

As yet there is no cure for MND, or ALS, which causes the motor neurons or nerve cells that control muscle movements to slowly die.

Each day two Australians are diagnosed with MND and two people for.

With almost 1500 people suffering from the deadly disease, the cost to Australia's health care was $1.9 billion last year, according to Deloitte Access Economics.

ODETTE VISSER

Scientists discover method to starve out deadly malaria parasite

Victorian-based scientists have discovered a new way to fight malaria, one of the world's most infectious killer diseases.

The team from Deakin University's Centre for Molecular and Medical research says it has developed a way to starve the malaria parasite, which claimed more than 400,000 lives in 2015 from an estimated 212 million cases.

"Malaria parasites live inside a red blood cell," says senior researcher Professor Tania de Koning-Ward.

"They produce a group of proteins to change the permeability of the red blood cell, making it more porous, so they can absorb vital nutrients from plasma, and remove toxic waste products," Professor de Knoing-Ward added.

"What we've shown is that if you genetically block one of these parasite proteins, you can effectively starve the parasite and it dies.

"Scientists have long been unsure about how the parasite makes the red blood cell permeable, so it's exciting to now have the evidence that shows this protein plays an important part in allowing the malaria parasite to take hold."

It's feared half the world's population is at risk of contracting the disease and Professor de Koning-Ward said her team's finding was critical as the malaria parasites were becoming more resistant to current malaria medications.

"Obviously we'd like to prevent malaria in first place, but unfortunately we don't yet have a vaccine that works really well," she said.

Researchers say preventative measures such as mosquito nets can also be used, but even with these in place people will still get infected and will need to be treated with drugs.

"But along the line the parasites have become resistant to drugs," Professor de Koning-Ward explains.

"The World Health Organisation has recommended artemisinin combination therapies for people with malaria but now people in South East Asia are developing resistance to that.

"If that resistance spreads, we lose our last anti-malarial drugs. So we are really desperate to find new strategies to combat malaria."

The work of the Deakin University scientists was recently published alongside two other papers from research groups in the UK and USA who used different approaches to also show the parasite protein, and another protein it interacts with, are critical for red blood cell permeability.

Their research was competed with support from the Burnet Institute and Monash Institute of Pharmacological Sciences.

ODETTE VISSER

Outstanding doctor from outstanding Israeli hospital visits Down Under

Internationally renowned Israeli doctor Nitza Heiman Newman is currently visiting Australia representing the Soroka Medical Centre, the only major medical centre in the entire Negev.

It is one of the largest and most advanced hospitals in Israel, serving a population of more than one million people, including 400,000 children, in a region that accounts for more than 60 per cent of the country's total land area.

> "We are one of the biggest medical centres in Israel and definitely as a trauma centre." - *Dr Newman*

Soroka also serves as a teaching hospital of the Ben-Gurion University Medical School.

But what makes Soroka even more unique in the region is that in a nation often embroiled in conflict, it caters for everyone.

"We treat people by the severity of the medical problems they have, not by any religion or culture," Dr Newman said.

"You can see in our wards, in the same room, Israelis, Jews, Arabs, Bedouin and more.

"And you can see the changes of the people in those wards. It can sometimes start out with – I wouldn't say with tension, but maybe with some suspicion amongst the patients and those who visit them. But within 24 hours they are getting along better and visitors are often bringing along cakes for everyone in the room."

Another thing making Soroka a standout facility is the way it is prepared for trauma. In a war zone, this is a necessity.

"What we see a lot of unfortunately is military trauma in our area. The last time there was a serious breakout two years ago our helipad was very, very busy and we were treating a constant flow of injured soldiers and civilians," Dr Newman said.

"We are one of the biggest medical centres in Israel and definitely as a trauma centre. But we are also a general hospital with more than a thousand beds.

"We do everything, including transplants. Our specialty is genetics and we also have the biggest delivery room in the country – delivering 55 new babies every day."

Dr Nitza Heiman Newman

Dr Newman says Soroka is an example to the world, which is part of her reason for being in Australia.

She is speaking at forums about the medical centre and also about the United Israel Appeal program called Professions for Life, which assists new immigrants to Israel to re-certify in their chosen professions.

"If you make the transition easier for new immigrants you make their lives easier and they integrate faster," she said.

"It makes life more enjoyable for them and for those who absorb them into the community."

Born in Israel, the only child of Holocaust survivors, Dr Newman served in a range of positions in the Israel Defense Forces, including as an officer in the Golani Brigade. Her last army position was as a company commander in a female officers' course.

She took a year off from medicine to direct a school in Be'er Sheva for gifted children, before taking a residency in pediatric surgery at Soroka Medical Center in Be'er Sheva.

She then did a year-long fellowship at Great Ormond Street Hospital in London in the field of pediatric oncology surgery, a field that she developed at the hospital.

Since 2005, Dr Newman has been responsible for the Dr. Gabi and Eng. Max Lichtenberg scientific program in surgery for outstanding staff at Ben-Gurion University.

From 2009-2013, she was a member of the Be'er Sheva city council and responsible for the health and environment portfolio.

Since 2010 she has been the deputy hospital director, in charge of medical personnel, children's division, maternity division, gynecology, psychiatry and now rehabilitation as well.

CHRIS JOHNSON

Doctors and Hospitals oppose Trump's plan to remove Obamacare

The American Medical Association has opposed the House Republicans' plan to replace the federal health care law enacted by the Obama administration.

US President Donald Trump is insistent on replacing Obamacare, but the powerful lobby group representing American doctors announced on March 8 that it was against the Republican legislation.

The groups said it was concerned the bill "would result in millions of Americans losing coverage and benefits".

The American Medical Association gave former President Barack Obama much-needed support to get his health care changes across the line in 2010.

Now the lobby group has written to the two House committees charged with drafting the Republicans' bill, called the American Health Care Act, to condemn it.

"As you consider this legislation over the coming days and weeks, we hope that you will keep upmost in your mind the potentially life altering impact your decisions will have on millions of Americans who may see their public, individual or even employer-provided health care coverage changed or eliminated," the group's chief executive Dr James Madara wrote.

The doctors are mostly concerned that the potential new laws aim to replace the subsidies millions of low-income Americans were given under Obamacare.

A flat tax credit to be adjusted by a person's age is instead proposed by the Republicans, but the doctors' lobby is insisting that any credit must be enough to enable low-income earners to afford quality health cover.

The Association has been joined in its opposition to the bill by the American Hospital Association and all of the nation's major hospitals.

The hospitals are concerned about planned changes to Medicaid – the US's government insurance program for people with limited resources – which became more expansive and inclusive under Obamacare.

They said changes would result in cuts to health care services.

The hospitals also wrote to Congress expressing their concerns that the House committees were considering a draft legislative proposal that could lead to "tremendous instability" for people seeking affordable health coverage.

Republicans are keen to pass the bill quickly, but the Congressional Budget Office is still to provide figures for the new legislation, including how many people it would cover.

CHRIS JOHNSON

Don't let her drink dirty water

World Vision

malaria, typhoid, dysentery, cholera, diarrhoea, intestinal worm infection, ... dirty water can kill.

6,000 children are dying every day – and it's because they don't have clean water. So they're forced to drink water that could make them sick with diarrhoea, cholera and typhoid.

The good news is, problems like dirty water can be solved. You can help children access clean water through World Vision's Water Health Life program by providing practical and effective solutions.

From $39 a month your support will help drill boreholes, protect water sources and provide health and hygiene training. You'll be helping communities to make long-term changes that ensure a clean water supply and basic sanitation.

Stop dirty water killing children,support Water Health Life:
visit **worldvision.com.au** or call **13 32 40.**

Water Health Life
Basic Needs. Permanent Solutions

Martha Wainwright back in town with new release

BY CHRIS JOHNSON

Everyone knows that music is good for your health. So along with our regular offerings on wine, motoring, travel, sport and books, *Australian Medicine* will now feature a music column – just to make you feel good. We will have album reviews, concert reviews and previews, and some snippets of musical history and trivia spanning most genres. But we also want to hear from you. What music do you like to listen to – at home or at work? Let us know what makes your spirits soar or your toes tap and we will endeavour to include it in upcoming editions. Send your music news and views to ausmed@ama.com.au

What better way of launching a new music column than to applaud a current tour and new album release of an international artist who pretty much (almost) calls Australia home. Martha Wainwright comes from music royalty. The daughter of American folk singer Loudon Wainwright III and Canadian folk singer the late Kate McGarrigle, she oozes musical ability, stagecraft and presence.

Currently touring Australia showcasing her new album *Goodnight City*, Wainwright is receiving rave reviews for her intimate and mesmerising concerts. Australian audiences love her and she is a frequent visitor to these shores. Having already played twilight concerts at Taronga and Melbourne zoos, as well as gigs in other Sydney venues, Perth and Canberra, there remains a handful of dates left on this tour. She had an outstanding recent appearance on the ABC's Q&A program.

More of a folk-rocker than either of her parents, Wainwright drifts between sublime, lush ballads and in-your-face spellbinding harsher numbers. Always with a voice to die for.

Refreshingly different, Martha Wainwright has been described by *Uncut Magazine* as "part Patti Smith, part Leonard Cohen" and by the *New York Times* as moving "amid prettily finger-picked folk-rock and more eccentric arrangements". *Spin Magazine* says "… her stage presence suggests several things at one time – defiant and strong, yet with an edge of sadness and vulnerability as well." While American online magazine *Pitchfork* describes Wainwright as "…taking music and wringing from it a startling wealth of shiver-inducing moments."

Which brings us to her new album. *Goodnight City* is riveting. Some are calling it her best yet. Her first release in four years, its 13 tracks are at once dynamic, impressionistic and confessional. A mix of originals and collaborations with the likes of contemporaries Beth Orton, Michael Ondaatje, Glen Hansard and her brother Rufus Wainwright, the album is compelling listening from start to finish.

She has played Carnegie Hall, appeared on the Late Show, the Tonight Show, Jools Holland and Australia's own Spicks and Specks and has now returned with a three-piece band to once captivate local audiences.

The remaining stops on her current Australian tour (at the time of writing) include Newcastle, Lismore, Brisbane, Hobart, Devonport and Bendigo.

The album can be obtained through https://Inertia.lnk.to/Martha

"London to Sydney - by any means"

BY DR CLIVE FRASER

The 1968 London to Sydney Marathon

It's been almost 50 years since an adventurous group of drivers in 98 cars set off from London on a long road race to the Antipodes (aka Sydney) on the other side of the world.

The idea for the race came from the owner of the *Daily Express* newspaper, who reasoned that the stagnant UK economy could be bolstered by the world-wide attention that the race would create.

He put up £10,000 in prize money and off they went.

The rules were simple. Go as fast as possible and try to get to Sydney first.

Repairs could be undertaken en route, but no one was allowed to touch their vehicle whenever it was being transported by boat.

The field was made up of a range of vehicles from Hillman Hunters to Falcon GTs and the drivers were as diverse as privateers and seasoned rally drivers such as Andrew Cowan.

I was 10 years old when the race was run and I recall being mesmerised as I followed the field across the globe.

After all, this was all before Apollo 11 and man setting foot on the Moon.

There were still remote places on Earth and National Geographic maps were still being used for navigation.

Unbeknown to me, a family from Australia were making the same trip from London to Sydney in a recently purchased Kombi van.

Their route would be more circuitous taking them first to Norway, across Scandinavia and down through Europe into Spain.

From there they were finally heading in an Easterly direction towards the Middle East and onwards.

I recently met the driver who is not far off becoming a Centenarian.

He has so many stories to tell and I had so many questions to ask.

For starters, "Did the Kombi break down?"

The answer being, "No, never."

"Did you have any dramas on the trip?"

The answer being, "Only in Afghanistan!"

No surprises there I thought, after all even today Afghanistan is still a remote and dangerous place.

"Oh no, not at all," I was told.

"We'd camped for the night in a field. We were just about asleep when there was a knock on the window. It was a police officer. He told us that there'd been some problems between a local tribe and another traveller recently. He thought it would be safer if we camped in the police station compound, which we did."

"What was the highlight of the trip?" I asked.

"The roads, how great the roads were, in … in Afghanistan," came the reply.

I thought I'd misheard the last sentence.

Afghanistan and great roads, could that be possible?

Well, yes.

Between 1960 and 1967 the US Army Corp of Engineers built 2,700 miles of paved highways in Afghanistan.

According to my research, the purpose of the regional transportation project was peaceful with no mention of the politics of the Cold War and the northern Russian neighbours.

The construction of just one highway between Kabul and Kandahar would shorten the journey from 10 days to six hours.

I'm not sure how many of the 50-year-old highways still remain, but since November 2016 they are being re-built again with the US stating that: "The most effective weapon America possesses in the war on terrorism may not be its military capacity, but rather rural roads and access to technology."

Andrew Cowan won the London to Sydney Marathon in a Hillman Hunter and that model continued production in Iran until 2005.

My almost Centenarian friend also got to Sydney and is still running his marathon.

Safe motoring,

Doctor Clive Fraser
doctorclivefraser@hotmail.com

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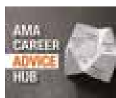

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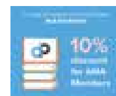

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