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# Dodgy deal

## Pathology rent cap plan duds practices, offers nothing to pathologists, p6

## INSIDE



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# In this issue

# Health Care Home truths

BY AMA PRESIDENT DR MICHAEL GANNON

With the Medicare rebate freeze, issues regarding bulk billing incentives for pathology and diagnostic imaging, and pathology rents in general practices at the centre of AMA advocacy, the Government is placing a lot of its health policy capital in the trial of the so-called Health Care Home.

Given recent media activity around the funding of this trial, I wish to provide members with an update of where things are with the concept.

As we all know, the population is ageing and the incidence of chronic and complex disease is rising.

Governments around the world are looking at new models of primary care to keep their populations healthy, and contain rising health costs.

The Federal Government, based on the recommendations of the Primary Health Care Advisory Group, embarked on a trial of the Medical Home in Australia – under the name of the Health Care Home. Appropriately, it will be built around general practice.

The concept of the Medical Home already exists in Australia, to some extent, in the form of a patient's usual GP.

Evidence suggests that patients with a usual GP or Medical Home have better health outcomes. Currently, 93 per cent of Australians have a usual general practice, and 66 per cent have their own GP.

The Medical Home concept has the potential to deliver improved support for GPs in providing well-coordinated and integrated multi-disciplinary care for patients with chronic and complex disease. So it makes sense for the Government to build on the proven arrangements we have in Australia.

When the Government announced its trial in April, the AMA welcomed the vision, but said the devil would be in the detail.

Critically, we emphasised that the Government needed to back its vision with additional funding. If GPs are expected to deliver enhanced care for patients, they need to be adequately supported to do so with increased funding.

The Government has had an enormous amount of goodwill from the profession for its trial, particularly with its recognition of general practice's pivotal role in the health care system.

The Government endorsed the specialised work of Australia's hardworking GPs, and the unique role they play in managing patients who need regular personalised care in a familiar environment. This restored some of the goodwill squandered through the co-payment saga and the Medicare rebate freeze.

Unfortunately, the Government's recent pronouncements on the Health Care Home have potentially undermined some of the remaining goodwill with the GP population.

Not only has the Government affirmed that the damaging MBS freeze is staying in place for the foreseeable future, no extra funding has been committed to help with the Health Care Home trial.

Patients are likely to be the losers in all this.

General practice has been the target of repeated funding cuts in recent years. It is little wonder that GPs feel that they are being taken for granted.

GPs were incensed when the Department of Health, in a bungled announcement of its call for expressions of interest in participation in the trial, stated that enrolled patients would be limited to five MBS-funded services for care not related to their chronic health condition.

Confusion about the five MBS services limit was allowed to run for 48 hours before the offending materials were subsequently withdrawn and taken down from the Department's website.

We now know there is (and are told was) no limit, but the error was symptomatic of the problems we see with the trial. It again fed the perception that the Government is more focused on limiting costs than providing enhanced care for patients - and that the roll-out is being rushed.

In their own words, the Health Care Home trial is the Government's signature health policy for this term of Government. It has the backing of the Health Minister and the Prime Minister, and its announcement followed the good work of the PHCAG, led by former AMA President, Dr Steve Hambleton.

With so much of the Government's agenda invested in the trial, it cannot afford to get it wrong. The former Labor Government's Diabetes Care Project faded into extinction. The Health Care Home policy could go the same way without a radical change of thinking from the Turnbull Government.

The AMA and other groups will support this trial if it is properly funded and supported, and there is genuine consultation along the way.

All eyes – especially those of Australia's GPs – will be on the 2017 Budget for signs of a restoration of goodwill and a commitment to meaningful engagement with the profession. To not fund it adequately will have wasted a great opportunity for meaningful health reform.

# Enough talking … time for action

BY **AMA VICE PRESIDENT DR TONY BARTONE**

Face-to-face workshops are being held across all states and territories during November and December to provide the sector opportunity to comment on the Federal Government's fifth draft of the National Mental Health Plan.

Mental health is one of the nine national health priority areas agreed to by governments. According to the Australian Bureau of Statistics, one in five Australians aged 16 to 85 years will experience a mental disorder each year, and almost half will experience a mental disorder in their lifetime. Furthermore, less than half of people living with mental health issues access treatment each year, with untreated mental illness incurring major personal suffering and economic costs.

> "Every day, patients experiencing a vast array of physical and mental health problems are seen by doctors. The help they receive is uneven, varied and not always coordinated…"

Every day, patients experiencing a vast array of physical and mental health problems are seen by doctors. The help they receive is uneven, varied and not always coordinated because GPs are working within a wider system that is under-resourced, including inadequately funded community-managed mental health services.

We know that our patients need specialised care and help, often for problems that are seen as being outside the traditional (and narrow) prism of health care, such as securing safe and affordable accommodation, finding and maintaining employment, or day-to-day support in managing their lives.

Sebastian Rosenberg from the Brain and Mind Centre at Sydney University says that "for people seeking mental health assistance, there are few alternatives between the GP's surgery and the hospital emergency department." Too often I have been caught in this situation.

Sometimes it is frightening, but most often it is putting the quality care of the patient at risk. I am not a trained psychiatrist and access to specialised assistance is not uniformly or equitably available.

This is a troubling and frustrating situation for GPs and their patients. Frustrating, because there have been more than 30 major reports and inquiries in the last decade into mental health in Australia, and they pretty much reach the same conclusions. That is, we have a system focused on crisis – putting people in general or psychiatric hospitals – and not one that builds pathways and referrals to community-managed mental health services. We need a system that helps GPs know where they can refer their patients, and be given information to do that.

As many have pointed out, the problem lies, in large part, to the health system in Australia.

In the current system, the Federal Government manages primary care and State and Territory governments manage the hospital system. This creates tensions, duplications and gaps, and also means community-managed mental health care is left in a 'no-man's land' between the two tiers of government.

Like most GPs, I have patients with comorbidities and experiencing episodic mental health problems. They shouldn't be in hospital, but they may need assistance and care managing at home or in the workplace. Many of the patients GPs see would benefit from 'psycho-social support', a term that describes the provision of care for the emotional and social needs of people. In mental health, this is the support I think it is critical to focus on.

GPs want to have the resources and referral pathways to help their patients stay out of hospital.

There are a variety of reforms occurring in mental health, and primary care mental health has been identified as a target group of the Health Care Homes model of care. The mental health money going to Primary Health Networks is also somewhere GPs should have a role, particularly as some of the program funding being transferred to the PHNs has been for programs that worked with, and through, GPs, such as the Mental Health Nurse Incentive Program.

PHNs will have a large role to play in implementing and providing the recommended National Mental Health Plan services GPs need. They will also have to identify service gaps, especially in rural and regional areas, and provide psychological therapy options where there is a barrier to accessing care.

# AMA at the table on health insurance reforms

BY **AMA SECRETARY GENERAL ANNE TRIMMER**

> "In total, these reductions are expected to deliver savings of $86 million to health funds in the first year, and $394 million over five years. The Minister has also announced moves towards a more transparent pricing model with open disclosure"

AThe Federal Government continues with its reforms to health care, shifting focus to the private health sector.

Health Minister Sussan Ley has recently established a Private Health Ministerial Advisory Committee (PHMAC) to develop recommendations across a range of policy areas relevant to private health.

The PHMAC follows on the work earlier in the year of an industry working group on reforms to the Prostheses List. The Prostheses List sets out the reimbursement amounts for thousands of prostheses used in the private health system.

The Minister has announced reductions in the benefit amounts for some prostheses to support a reduction in cost to private health insurers and a consequential reduction in private health insurance premiums for consumers.

The benefits for a small number of prostheses will be reduced from February 2017, including a:

- 10 per cent reduction across the cardiac devices category;
- 10 per cent reduction to the ophthalmic (intraocular lenses) category;
- 7.5 per cent reduction across the hip product category; and
- 7.5 per cent reduction across the knee product category.

In total, these reductions are expected to deliver savings of $86 million to health funds in the first year, and $394 million over five years. The Minister has also announced moves towards a more transparent pricing model with open disclosure.

The work of the PHMAC is now underway as the second part of the reforms.

The Committee's terms of reference include a closer examination of private health insurance (PHI) product design with simplified consumer products; standard product categories; the role of exclusions and restrictions; appropriate excess levels; and the scope of services covered by PHI.

The Committee will also look at consumer information; premium setting; second tier default benefits; risk equalization; single billing; lifetime health cover; and providing better value for rural and remote consumers.

The first meeting of the PHMAC considered some early thinking from the private health insurers on product design and a potential 'Gold/Silver/Bronze' product classification model.

These are all important areas for review.

The AMA has a strong interest in the work of the Committee and its outcomes.

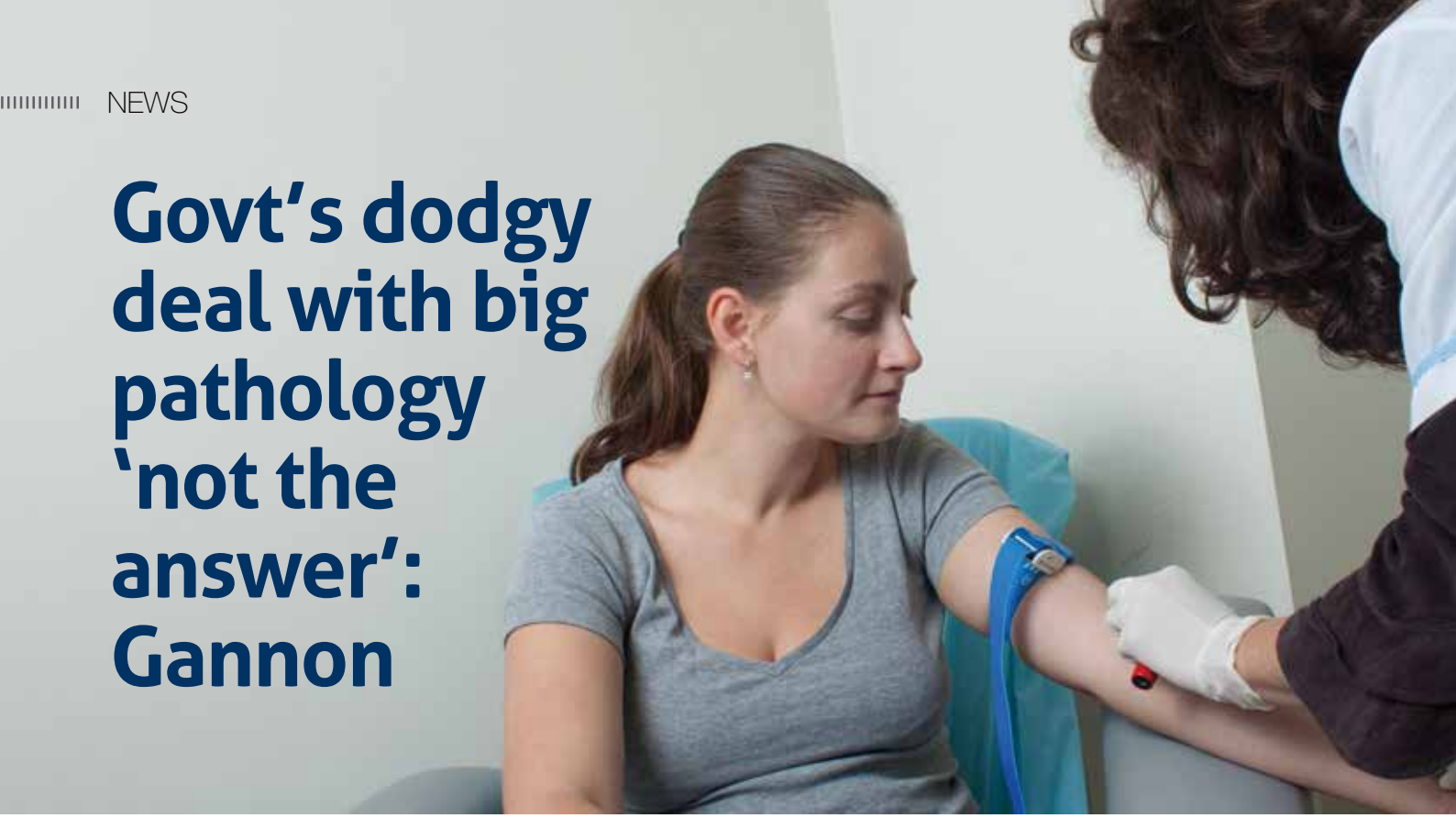
The AMA has a commitment to a viable private health sector and sees the work of the Committee as key to strengthening the sector and maintaining its relevance and attractiveness to patients into the future.

I am representing the AMA on the PHMAC, using a reference group of senior clinicians to provide advice in the lead in to each meeting.

The AMA will make available on its website the outcomes from each meeting (which are circulated for publication).

I welcome comment and input from members. The work of PHMAC will inform the shape of private health care funding for years to come. It is important that the AMA voice is heard.

# Govt's dodgy deal with big pathology 'not the answer': Gannon



AMA President Dr Michael Gannon has told pathologists that capping pathology collection centre rents is "simply not the answer" to the challenge the sector faces from almost 20 years of frozen Medicare rebates.

In a message to AMA pathologist members, Dr Gannon said the surprise deal struck between the Federal Government and Pathology Australia during the Federal election to impose a rent ceiling was a "poorly targeted" policy that would deliver a massive windfall for the big pathology companies at the expense of medical practices, and did nothing for individual pathologists.

"The Government's proposal goes too far, interfering with legitimate commercial arrangements that have been entered into by willing parties," he said. "It will unfairly damage medical practices that have made business decisions based on projected rental streams, including investment in infrastructure and staffing."

The AMA President said there was no guarantee from Pathology Australia, whose biggest member is Sonic Healthcare (which holds 43 per cent of the market), that any money pathology companies saved by cutting their collection centre rents would be re-invested in pathology services or the pathology workforce.

Instead, the rents deal controversy was overshadowing important issues such as the impact of the near 20-year rebate freeze for pathology services and the need for a much more sustainable funding base, he said.

In striking his deal with Pathology Australia, Prime Minister Malcolm Turnbull blindsided groups including the AMA and the Royal College of Pathologists of Australasia, who had been involved in discussions with the Government earlier this year on ways to improve transparency and strengthen compliance within the existing regulatory framework governing pathology collection centre (ACC) rents.

ACC rents have risen strongly since their deregulation in 2010, and there have been fears of a nexus between leases and the number of pathology tests a practice orders.

But the Health Department has reported in several different forums that it has not detected any such link, and told a roundtable meeting of stakeholders attended by the AMA on 27 April that it had found no evidence that rents were substantially above market value.

Instead, rents are being driven higher by intense competition for market share. Consolidation in the industry has intensified since deregulation, and the two big pathology companies, Sonic and Primary Health Care, between them now hold about 77 per cent of the market – a 12 per cent increase in five years.

Instead of addressing issues around the structure of the industry and how that was affecting competition and rents, Dr Gannon said the Government's unilateral move to cap rents was simply a "knee jerk reaction" to head-off a politically damaging campaign.

The Government struck the deal in the early days of the Federal election in order to get Pathology Australia to drop its threat to axe the bulk billing of pathology services following the abolition of the pathology bulk billing incentive.

The terms of the agreement were laid out in a Senate Estimates hearing last month by Health Department Deputy Secretary Andrew Stuart, who said the "nature of the deal between the Government and Pathology Australia is to work to bring rents

down to a more reasonable level and, at the same time or in some relationship to that, to continue with the Government's proposal to remove the bulk billing incentive".

Government Minister Senator Fiona Nash told the Estimates hearing the Coalition had received assurances from the pathology industry that "it is going to keep the bulk billing levels at its rates [and] we are taking it in good faith that that is exactly what they meant, and we expect they will do that".

Dr Gannon said that in rushing to strike its deal with Pathology Australia, the Government had failed to take into account the consequences for GPs.

The Government's plan went well beyond the intent of existing laws and gave pathology providers an unfair advantage in commercial negotiations with medical practices, he warned.

His concerns were borne out by the testimony of Mr Stuart, who admitted that the Department had not modelled the likely effect of the pathology rents cap on general practices, particularly when combined with the Medicare rebate freeze.

The senior health official, who made pointed reference to the fact the deal was "a Government negotiation, not a departmental negotiation", said details of the arrangement, especially regarding its implementation, were still being finalised.

Significantly, the deal leaves the contentious issue of what should be defined as 'market value' unresolved – something admitted by Health Department First Assistant Secretary Maria Jolly in her testimony to the Senate committee.

She said how the new arrangement would be introduced was also yet to be determined, including how existing leases would be treated, and how the new deal would relate to the current regime governing prohibited practices.

ADRIAN ROLLINS

# Pathology rent cap will cost patients, doctors

The AMA has warned that Federal Government proposals to cap pathology collection centre rents will likely drive up patient out-of-pocket costs and could force some medical practices out of business.

In a strongly worded letter, AMA President Dr Michael Gannon has appealed to the Small Business and Family Enterprise Ombudsman, Kate Carnell, to intervene and help try to convince the Government to drop its plan.

Dr Gannon said the proposal, announced during the Federal election, to change provisions in the Health Insurance Act would allow the two major pathology companies that dominate the market to unilaterally cut the rents they paid to medical practices for co-located collection centres (ACCs), delivering a big financial blow to small business already reeling under the effects of the Medicare rebate freeze.

"The proposed changes fundamentally alter the intent of the existing law…by imposing a blunt cap on the commercial rents that GPs and other specialists can receive for co-located ACCs," the AMA President said. "It delivers two major listed companies with an unwarranted and unfair advantage…estimated to save [them] between $100 million and $150 million per annum."

Under the deal, which was sprung on the medical profession without warning, the Government has promised to bring down rents in exchange for a promise from pathology companies that they will sustain bulk billing rates despite the loss of the bulk billing incentive.

Dr Gannon warned that the Government's proposed changes would have "a big impact" on medical practices.

"Medical practices are [already] feeling the impact of the current MBS indexation freeze, and policy changes like this will simply have a further negative impact on their cash flow and on practice viability," he said. "For those practices that have used this source of rental income to help keep them viable during the current extended freeze, it may it may mean higher costs to patients or simply selling their business."

Many, the AMA President said, had made decisions about hiring staff and purchasing equipment based on anticipated revenue streams from ACC rents, and the policy would put their finances under strain.

Dr Gannon said it was unlikely the Government comprehended the full impact of the "poorly targeted" policy when announcing it, including the massive windfall it would deliver to the big pathology providers and the hefty financial blow it would deliver to many medical practices.

ADRIAN ROLLINS

# Fees gap widens as costs rise but rebates dont

Patients face higher out-of-pocket costs as the medical profession struggles under pressure from the Federal Government's Medicare rebate freeze.

As a result of the Government's freeze, the gap between the Medicare rebate and the fee the AMA recommends GPs charge for a standard consultation will increase to $40.95 from 1 November, up from $38.95, continuing the steady devaluation of Medicare's contribution to the cost of care.

The increase comes on top of the effects of the Medicare rebate freeze, which is forcing an increasing number of medical practices to abandon or reduce bulk billing and begin charging patients in order to remain financially viable.

Medical centre operator Primary Healthcare, for one, has increased upfront charges for patients at a Canberra clinic to $100, and has flagged plans to roll out private billing in other centres.

Adding to the financial squeeze, the Government is considering changes that would cut the rents practices receive for co-located pathology collection centres that the AMA estimates would rip up to $150 million from general practice every year.

Under the changes recommended by the AMA, the fee for a standard Level B GP consultation will increase by $2 to $78, while the Medicare rebate remains fixed at just $37.05.

AMA Vice President Dr Tony Bartone said doctors had kept medical fee increases to a minimum, but Medicare indexation lagged well behind the cost of providing medical care.

"The MBS simply has not kept pace with the complexity or cost of providing high quality medical services," Dr Bartone said.

The rise is roughly in line with Reserve Bank of Australia forecasts for underlying inflation, currently at 1.5 per cent, to rise anywhere up to 2.5 per cent by the middle of next year, and reflects steady increases in medical practice costs.

Staff wages, rent and utility charges have all increased, as have professional indemnity insurance premiums, continuing professional education costs and accreditation fees.

While practice running costs are rising, the Government's contribution to the cost of care through Medicare has been frozen for more than two years, and in many cases far longer.

The Medicare rebate for GP services has not been indexed since mid-2014, while the last rebate increase for most other services was in November 2012. In the case of pathology and diagnostic imaging the rebate freeze is even longer, going back more than 15 years.

Dr Bartone said the rebate freeze was pushing up patient out-of-pocket costs.

"Many patients will pay more to see their doctor because of the Medicare freeze," he said. "The freeze is an enormous burden on hardworking GPs. Practices cannot continue absorbing the increasing costs of providing quality care year after year. It is inevitable that many GPs will need to review their decision to bulk bill some of their patients."

The AMA is pressing the Government to reverse the rebate freeze.

AMA President Dr Michael Gannon has raised the issue in regular meetings with Health Minster Sussan Ley, and Dr Bartone said the Association was committed to an immediate resumption of Medicare rebate indexation.

"Every day that the freeze remains...is another day that many doctors will make the decision that this is no longer sustainable, and they need to move from bulk billing all or some of their patients to a fee-for-service environment," the AMA Vice President said.

But Health Minister Sussan Ley has played down hopes that indexation will soon be reinstated, warning that there will not be a change of policy "any earlier than our financial circumstances permit".

The Government is trying to curb the Budget deficit and rein in ballooning debt.

It will provide its latest assessment of the Commonwealth's finances when it releases the Mid-Year Economic and Fiscal Outlook next month, but according to the Parliamentary Budget Office the fiscal deficit through to 2018-19 has increased by almost $9 billion to $105.1 billion, driven by a hefty $16.7 billion fall in revenue that is only partly offset by $4.5 billion of savings and a $3.2 billion drop in investment. As a result, Commonwealth net debt is projected to reach 19.2 per cent of GDP in 2017-18 before easing to $356 billion in 2018-19 (18.8 per cent of GDP).

As part of its strategy, the Government is increasingly pushing the cost of health care directly onto patients.

Australian Institute of Health and Welfare figures show the Commonwealth's share of the nation's health bill slipped down to 41 per cent in 2014-15, while patients' share has increased to almost 18 per cent, and Australians now pay some of the highest out-of-pocket costs for health care among Organisation for Economic Co-operation and Development countries.

ADRIAN ROLLINS

# THE COST OF HEALTH

## How AMA recommended fees compare with the frozen Medicare rebates

| Medical Service | AMA Fee (2015) | AMA Fee (2016) | MBS Schedule Fee (2016) |
|---|---|---|---|
| Level B GP consult (MBS item 23) | $76.00 | $78.00 | $37.05 |
| Level B OMP consult (MBS item 53) | $76.00 | $78.00 | $21.00 |
| Blood test for diabetes (MBS item 66542) | $48.00 | $49.00 | $18.95 |
| CT scan of the spine (MBS item 56219) | $990.00 | $1,055.00 | $326.20 |
| Specialist – initial attendance (MBS item 104) | $166.00 | $170.00 | $85.55 |
| Consultant Physician – initial attendance (MBS item 110) | $315.00 | $325.00 | $150.90 |
| Psychiatrist attendance (MBS item 306) | $350.00 | $355.00 | $183.65 |

# Penny pinching threatens chronic care reform

The Federal Government's landmark Health Care Homes reform is at risk of collapse because of a lack of funding, the AMA has warned.

Health Minister Sussan Ley has announced that $100 million will be provided to support the phase one trial of the reform, involving 65,000 patients and 200 medical practices in 10 regions across the country.

> "The allocations mean that patients on the lowest level of subsidy will be funded for just 16 visits to the doctor a year, rising to 48 visits a year for those deemed of highest need"

Under the Government's plans, practices will receive monthly bundled payments worth an average $1795 a year to manage patients with chronic and complex health conditions. Payments will vary from $591 for chronically ill patients who can largely self-manage their condition to $1267 for those who need more intensive care and $1795 for those with the most complex health demands.

The allocations mean that patients on the lowest level of subsidy will be funded for just 16 visits to the doctor a year, rising to 48 visits a year for those deemed of highest need.

Controversially, such patients would only be eligible for five extra Medicare-subsidised visits to the doctor for health issues that lie outside their chronic illness – a major change from the current system under which patients have uncapped access to GP care.

A spokesperson for Ms Ley told Fairfax that five-visit cap was only an "indicative figure for modelling and planning purposes", and said no patient would have their access to Medicare restricted or capped.

Ms Ley said Health Care Homes allowed for team-based, integrated care and would provide increased flexibility and coordination of services to tailor treatment to individual need.

But the details of the trial have reinforced suspicions that the Government is undertaking Health Care Homes primarily as a cost cutting exercise, and the AMA voiced concerns that if the reform was not adequately funded it could founder.

"The modelling is concerning and potentially leaves the whole program at risk of falling over because of being underfunded from the beginning," AMA Vice President Dr Tony Bartone told News Corporation.

Dr Bartone, a GP, is the AMA's representative on the Government's Health Care Home Implementation Advisory Group, which last met on 30 September.

He said that, if appropriately funded, Health Care Homes could support GPs to keep patients healthier and out of hospital, but added the Government needed the goodwill of general practitioners if its trial was to succeed.

"That goodwill will evaporate significantly if there is not the appropriate funding," he warned.

Earlier this year, AMA President Dr Michael Gannon warned that appropriate funding would be a "critical test" of the success or otherwise of the reform.

"BEACH data shows that GPs are managing more chronic disease. But they are under substantial financial pressure due to the Medicare freeze and a range of other funding cuts," Dr Gannon said.

"GPs cannot afford to deliver enhanced care to patients with no extra support. If the funding model is not right, GPs will not engage with the trial and the model will struggle to succeed."

ADRIAN ROLLINS

# Government targets quality in proposed PIP overhaul

The AMA has expressed concern that a proposed major shake-up of the Practice Incentives Program is not being supported by increased investment in general practice.

The Health Department has unveiled plans to "refresh" the 18-year-old PIP system by slashing the number of incentive payment categories on offer, reducing the administrative burden on practices and intensifying the focus on quality.

> "The AMA has welcomed the increased focus on quality, and is in consultation with the Department over the proposal to collapse the PIP payment categories"

Under the proposal, outlined in a discussion paper released by the Department, seven existing payments covering asthma, cervical screening, diabetes, aged care access, prescribing, Indigenous health and procedural GP incentives would be axed; four existing payments, covering rural loading, after hours services, teaching and e-health – would be maintained; and a new Quality Improvement Incentive payment would be introduced.

The AMA has welcomed the increased focus on quality, and is in consultation with the Department over the proposal to collapse the PIP payment categories.

But it voiced concern that the changes were not being supported by an increase in financial support for GPs, particularly given that many practices are being pushed to the financial brink by the Medicare rebate freeze and the prospect of cuts to pathology collection centre rents.

The Department has indicated that there will be no extra money injected in the PIP scheme.

It said the quality incentive payment would be used to "give general practices increased flexibility to improve their detection and management of a range of chronic conditions, and to focus on issues specific to their practice population".

The push to overhaul the PIP system comes at the same time the Government is launching the initial stage of its Health Care Home model of care and undertaking a comprehensive review of the 5700 services listed on the MBS.

The Department said the initiatives together would "take the health system towards services that are aligned with contemporary practice".

The case for changes to the PIP has been mounting in recent years, with a number of organisations including the Australian National Audit Office, the Organisation for Economic Co-operation and Development and the Grattan Institute all raising concerns that the system imposed an unduly heavy administrative burden on practices and was failing to keep up with evolving health needs and priorities.

The Department said the evidence showed that many existing incentives might be no longer appropriate, and that the more could be achieved by intensifying the focus on quality, including by making better use of data.

"Redesigning the PIP would enable it to move away from process-focused funding towards a simpler system that encourages quality improvement and innovation, and allows practices to see improvements in measures that are important to them," it said.

Precisely how this could be achieved was up for consultation and debate, the Department added.

It suggested two options. One would be to merge all five PIP items (including the new Quality Improvement Incentive) into a single payment administered by the Department of Humans Services – essentially building on and adapting existing arrangements. Eligible practices would receive sign-on and quarterly payments, to be used to make quality improvements of their choosing.

Under the second option, the Department would no longer directly fund practices. Instead, practices would use PIP funds to engage third-party providers to support their quality improvement work.

Whatever the option chosen, practices would be required to regularly share data to map quality improvements, individually, locally and nationally.

The Government is inviting submissions on the proposed PIP overhaul. The deadline is 30 November.

The Department's consultation paper can be downloaded at: https://consultations.health.gov.au/primary-healthcare-branch-phb/redesigning-the-practice-incentives-program/consult_view

ADRIAN ROLLINS

# E-health dream comes a step closer

The dream of a trustworthy, seamless and secure system for sending health information between providers, regardless of where they are or the platform they are using, is a step closer.

The Australian Digital Health Agency (ADHA), which began operations four months ago and has former AMA President Dr Steve Hambleton as a senior adviser, has launched a major program to realise the health potential of digital technology by developing a secure, fully interoperable sector-wide messaging system to enable practitioners to quickly and confidently send and receive vital medical information.

Years after many other industries have moved to predominantly digital communication, most healthcare providers continue to rely on fax machines because they do not have a way to securely send highly sensitive medical information or receive notification that it has been delivered or received, ADHA Chief Executive Tim Kelsey said.

"I keep hearing that our health professionals want to talk to each other routinely, securely, electronically – a situation that many currently find themselves unable to do," Mr Kelsey said. "One of the first priorities for the Agency will be to partner with [medical software] industry, jurisdictions and healthcare professionals to solve the daily challenge of not having a way to send electronic messages to others in the health sector in a seamless, secure way."

To keep the program on track and make sure it delivers the right outcomes for users, the Agency has appointed an external panel of advisers to lead it.

Designated as Senior Responsible Owners, the three experts, Dr Nathan Pinskier, Chair of the RACGP Expert Committee on E-health and Practice Systems, Dr Mal Thatcher, CEO of eHealth Queensland, and community representative Fiona Panagoulias, will "shape the direction of the program and hold the Agency to account for delivering a program that results in clear benefits for the community".

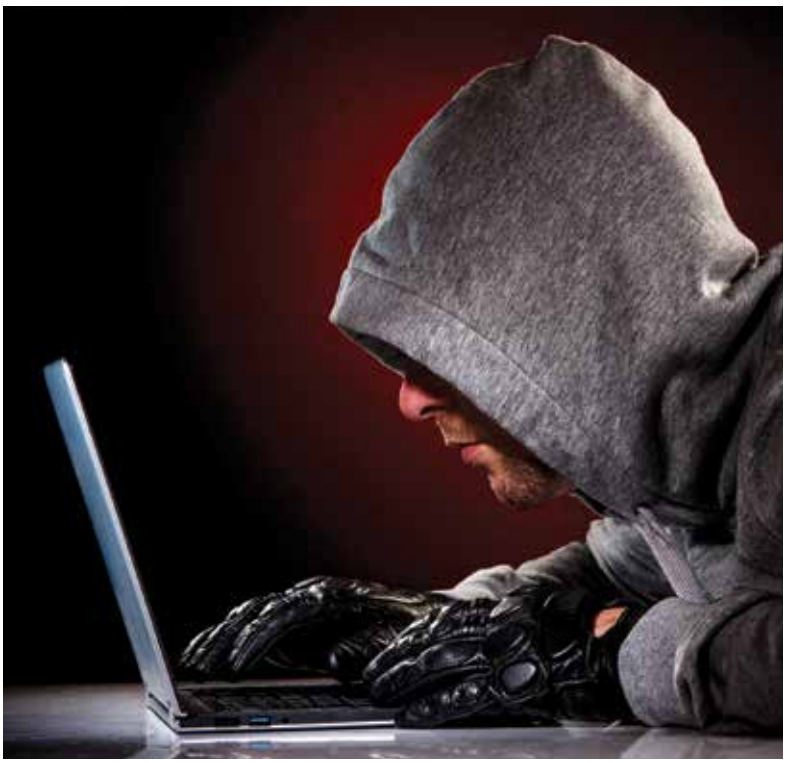
"The number one issue to be resolved in health care communications is the ability for healthcare providers to electronically communicate with each other directly, seamlessly and securely," Dr Pinksier said. "Solving the provider-to-provider secure messaging usability issue will create the potential to leverage these healthcare communications for other purposes, including uploads to the My Health Record. The interoperability solution is within our grasp."

The three experts will be supported by a Program Board comprising health providers and representatives from the technology industry, general practice, hospitals, Primary Health Networks and HealthDirect Australia.

No deadline for the work has been made public.

ADRIAN ROLLINS

# Health 'prime target' for cybercrime



The increasing adoption of electronic medical records and billing systems has made the health sector a prime soft target for cybercriminals, the World Medical Association has warned.

Delegates at the WMA's General Assembly in Taipei were told that cybercrime had become "a real threat", with some hospitals already being hacked on a regular basis – including, on occasion, being blackmailed for money.

"Cyber security threats are an unfortunate reality in an age of digital information and communication," the WMA said in a statement adopted by the Assembly. "Attacks on critical infrastructure and vital assets of public interest...are on the rise and pose a serious threat to the health and wellbeing of the general public."

It warned that the proliferation of electronic health records and billing systems meant the health sector was "especially susceptible to cyber intrusions and has become a prime soft target for cybercriminals".

Hospital information and practice management systems could become "gateways" for cybercriminals, putting the electronic medical and financial records of patients at risk and even opening the way to "increasingly sophisticated system breaches that could jeopardise the ability to provide care for patients and respond to health emergencies".

The WMA's warning echoes concerns about information security identified by the AMA in its Position Statement on Shared Electronic Medical Records issued earlier this year.

In the Position Statement, the AMA warned that the adoption of electronic medical records needed to be accompanied by measures to ensure their safety and security.

The WMA said current security procedures and strategies in the health sector had generally had not kept pace with the volume and magnitude of cyberattacks.

Despite the scale of the threat, many health care providers were devoting insufficient money and resources to the problem, and many lacked the expertise to detect a cyberattack, let alone prevent or address it.

The Association called on governments, policymakers and health providers to work with national cyber security authorities and collaborate internationally to anticipate and defend against such attacks.

It said providers should develop comprehensive systems to detect and prevent security breaches and, where they occurred, have a prepared and robust system of response that includes notification, remedial action and insurance.

Acknowledging that such an investment of time and resources may be beyond many smaller operators, the WMA said governments and provide bodies should provide support to overcome these limitations.

The AMA Position Statement on Shared Electronic Medical Records can be viewed at: https://ama.com.au/position-statement/shared-electronic-medical-records-revised-2016

The WMA statement can be viewed at: http://www.wma.net/en/30publications/10policies/c15/index.html

ADRIAN ROLLINS

# Shortcomings in asylum seeker care fire AMA concerns

The AMA has raised concerns that many asylum seekers and refugees detained on Nauru and Manus Island are being denied appropriate and timely health care for serious health problems.

The peak medical profession organisation has told a Senate inquiry that asylum seekers reportedly suffering serious illnesses or injuries including heart problems, head trauma, post-traumatic stress disorder and possible bowel cancer are receiving care below-standard care, putting their health at risk.

In a lengthy submission to the Senate Legal and Constitutional Affairs Committee, the AMA said it had been contacted by numerous asylum seekers and their advocates seeking help in ensuring they received adequate health care.

It provided details of the treatment of eight asylum seekers, including an elderly man hospitalised for seven months in Port Moresby with a heart condition and high blood pressure before being abruptly returned to Manus with his condition unresolved; a deeply traumatised woman exhibiting self-harm and at heightened suicide risk; a man hit over the head with a machete subsequently diagnosed with a mental illness and a man who suffered a head injury, the extent of which was undiagnosed.

Upon investigating their circumstances, the Association said it was "concerned that many asylum seekers are not receiving appropriate, timely and quality medical care".

"The AMA does not believe those detained on Manus and Nauru, either within detention facilities or within the community, are able to access a health care service of the same standard that a person in the Australian mainland would receive," it concluded.

Highlighting the secrecy and lack of transparency surrounding the operation of the detention centres, the AMA reported that in each instance it was told by the Department of Immigration and Border Protection it needed to obtain the written consent of asylum seekers for the release of their medical records before any information was provided.

It said the process of obtaining consent was "difficult and frustrating". In many cases, asylum seekers did not have access to computers and scanners and had to take a photo of a hand written consent form which was then sent by text to the AMA. In other instances, the Association reported it was unable to obtain the required consent and the wellbeing of the asylum seeker in question was unknown.

The AMA acknowledged that the information it obtained could not be independently verified, a fact that underlined its call for independent oversight of the health care provide to asylum seekers.

Ever since the Coalition abolished the Immigration Health Advisory Group in late 2013, the AMA has called for the establishment of an independent statutory body of clinical experts to investigate and report to Parliament on the health and welfare of asylum seekers.

AMA Vice President Dr Tony Bartone told Radio New Zealand that the appointment of such a body was vital to ensure cases of the kind investigated by the AMA were not allowed to continue.

"It's not the job of the AMA to advocate on behalf of detainees who are patients in the various offshore facilities," Dr Bartone said. "There should be an appropriate pathway which by there can be a review of the care that's being given and the outcomes that are being achieved."

The AMA Vice President said the problem did not lie with the health service provider, but the strictures within which they were required to work.

"They are operating under extremely difficult circumstances, often without enough detail or enough information to ensure the appropriate management," he said. "They're working towards a set of agreed requirements and they're probably hamstrung to deviate from that, we don't know whether a request has been made and not attended to or whether it is a failing at a much earlier level."

He said such uncertainty and lack of transparency reinforced the case for a statutory body of experts to oversee the treatment asylum seekers received.

In addition to this, the AMA has called for a moratorium on asylum seeker children who had been transferred to the Australian mainland for medical treatment to be return to offshore detention, and for all children being held in offshore and onshore centres to be immediately released.

The AMA's submission to the Senate inquiry can be downloaded at: http://www.aph.gov.au/Parliamentary_Business/Committees/Senate/Legal_and_Constitutional_Affairs/NauruandManusRPCs/Submissions

ADRIAN ROLLINS

# Whistleblower doctors exempt from jail threat

Doctors will no longer be threatened with imprisonment for speaking out about conditions in immigration detention after the Federal Government amended its controversial Australian Border Force Act.

Immigration Department Secretary Michael Pezzullo has confirmed that provisions of the Act have been changed so that secrecy and disclosure rules that threaten whistleblowers with up to two years' imprisonment no longer apply to health professionals including doctors, nurses, psychologists, pharmacists and dentists.

> "The operation of immigration detention centres, especially those located offshore on Nauru and Manus Island, has been surrounded by controversy amid claims of assault, self-harm, child abuse and substandard living conditions and medical services"

The backdown follows outcry by the AMA and many other medical groups and individuals against the Act's secrecy provisions, including the launch of a High Court challenge by the group Doctors for Refugees and the Fitzroy Legal Service.

Doctors for Refugees President Dr Barri Phatafod told the *Guardian* the decision was a "huge win for doctors and recognition that our code of ethics is paramount".

The provisions make it a criminal offence for those contracted to provide services to the Department of Immigration and Border Protection to record or disclose information obtained in the course of their work. The penalty is up to two years' imprisonment.

The operation of immigration detention centres, especially those located offshore on Nauru and Manus Island, has been surrounded by controversy amid claims of assault, self-harm, child abuse and substandard living conditions and medical services.

Groups including Amnesty International have condemned the detention regime, claiming it is causing enormous harm to the wellbeing of asylum seekers and refugees, particularly children.

The AMA has for several years called for the establishment of an independent medical panel empowered to investigate and report on detention centre conditions directly to Parliament.

Doctors have protested that the secrecy provisions in the ABF Act conflict with their ethical duties and their obligations under the Medical Board of Australia's Code of Conduct, most particularly their paramount obligation to the health of their patients.

These concerns have been magnified by a number of cases in which, it is claimed, authorities have sought to intervene in or override clinical advice on the transfer of detainees in need of medical attention, including the death of Omid Masoumali, who was medically evacuated to Australia from Nauru more than 24 hours after setting himself alight.

The Government denied the intention of the law was to prevent doctors from speaking up on behalf of their patients, and earlier this year Immigration Minister Peter Dutton said he thought it unlikely that health practitioners would be prosecuted under the Act.

But it was revealed that Dr Peter Young, who oversaw the mental health care of detainees for three years, was the subject of Australian Federal Police investigation, including access to his electronic communications and at its most recent National Conference, the AMA passed an urgency motion asking the Federal Council to "look into the matter" of AFP surveillance of doctors.

Dr Young told the *Guardian* the Government made the amendment because it wanted to avoid legal scrutiny of its policy.

"It's a big backdown from the Government, and they've made it because they didn't want to go to court, they knew they were going to lose, and they didn't want their planning and policies discoverable in an open court. That's what it's about," he said.

ADRIAN ROLLINS

# Revalidation: what's the problem?

The AMA has been working with the Medical Board of Australia to develop a suitable approach to revalidation. Australia has an extremely high standard of health care and the last thing the Australian health care system needs is to introduce layers of bureaucracy that don't actually improve the patient journey or make it safer. The AMA was very glad to see that the Board is not proposing a UK-style model.

One of the issues the Board appears to be grappling with is to clearly identify the problem that such a process would be set up to address, given that only a small proportion of doctors are the subject of formal complaints from patients or colleagues.

A discussion paper on options for revalidation, issued by the Medical Board, proposes that doctors undertake a 'strengthened' CPD program. This would include peer review of a doctors' performance. The plan could mean a review of doctor's medical records, and peer discussion of critical incidents and requirements to get feedback from multiple sources including medical colleagues, health practitioners and patients.

Simultaneously, there would be a 'proactive' screening process to identify and assess doctors who may be performing poorly and potentially pose a risk to patients. Under the Board's proposals, doctors deemed at risk would be formally assessed via a variety of methods. Doctors who were found to be underperforming through the Board's proactive screening program would be offered support and mediation to get them back on track.

The AMA would like the Board to outline the problem it wishes to address, and the proposed solutions, in greater detail.

Unfortunately, there is currently not enough detail in the Board's interim report to come to any conclusion about this. Likewise, the report notes that the costs of the proposed additional CPD and the system to identify and manage poor performance are unknown.

Of some comfort is that the report recommends guiding principles that should apply to all potential approaches:

- smarter not harder: strengthened CPD should increase effectiveness but not require more time and resources;
- integration: all recommended approaches should be integrated with, and draw upon, existing systems and avoid duplication of effort; and
- relevant, practical and proportionate: all recommended improvements should be relevant to the Australian healthcare environment, feasible and practical to implement and proportionate to public risk.

The Board's next steps are to finalise engagement and collaboration in 2016 and recommend an approach to pilot in 2017.

Consultations close on 30 November. You can have your say in a number of ways via the Board's consultation webpage http://www.medicalboard.gov.au/News/Current-Consultations.aspx

JODETTE KOTZ

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

INFORMATION FOR MEMBERS

# 1 NOVEMBER 2016 – AMA LIST OF MEDICAL SERVICES AND FEES

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

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

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

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

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

## Access the Fees List via the AMA website

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

## Access the AMA Fees List Online Database

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

## AMA Fees Indexation Calculator

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

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

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

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

# Gene tests on 'don't do' list

Medical experts have taken aim at 'direct to consumer' genetic testing services amid concerns that they are causing unnecessary expense and alarm.

Medical experts have warned that patients should not initiate genetic tests on their own, particularly for coeliac disease and for the genes MTHFR and APOE, which are, respectively, associated with levels of folate and susceptibility to Alzheimer's disease.

The Gastroenterological Society of Australia has recommended against genetic tests for coeliac disease because the relevant gene is present in about a third of the population and "a positive result does not make coeliac disease a certainty".

Similarly, Human Genetics Society of Australasia Clinical Professor Jack Goldblatt said variants of the MTHFR gene were "very common in the general population [and] having a variant in the gene does not generally cause health problems".

Additionally, Professor Goldblatt said that although the APOE gene was considered a risk factor for Alzheimer's, "having a test only shows a probability, so people undertaking [the test] can also risk being falsely reassured".

"Unnecessary genetic testing can lead to further unnecessary investigations, worry, ethical, social and legal issues," he said. "In particular, we caution people to not initiate testing on their own. Genetic tests are best performed in a clinical setting with the provision of personalised genetic counselling and professional interpretation of test results."

The recommendations are among 20 made by the Gastroenterological Society of Australia (GESA), the Royal Australian and New Zealand College of Radiologists (RANZCR), the Human Genetics Society of Australasia and the Australasian Chapter of Sexual Health Medicine, as part of program being coordinating by the Choosing Wisely Australia campaign to improve the use of medical tests and treatments.

The advice includes cautioning women against self-medicating for thrush, improved use of radiation therapy to treat cancer, and careful use of colonoscopies.

Professor Anne Duggan from GESA said colonoscopies had a "small but not insignificant risk of complications", and those undertaken for surveillance placed "a significant burden on endoscopy services".

Professor Duggan said surveillance colonoscopies should be targeted "at those most likely to benefit, at the minimum frequency required to provide adequate protection against the development of cancer".

The RANZCR said radiation treatment was "a powerful weapon" in the treatment of cancer, and half of those diagnosed with the disease would undergo radiation therapy.

But the College advised that such treatment should be provided within clinical decision-making guidelines, "where they exist".

In particular, it has recommended sparing use of radiation to treat prostate cancer.

Dean of the College's Faculty of Radiation Oncology, Dr Dion Forstner, radiation oncology might not be immediately required where prostate cancer is diagnosed.

"Patients with prostate cancer have options including radiation therapy and surgery, as well as monitoring without therapy in some cases," Dr Forstner said.

The College also advised that while whole-breast radiation therapy decreased the local recurrence of breast cancer and improved survival rates, recent research had shown that shorter four-week courses of therapy could be equally effective "in specific patient populations". It said patients and doctors should review such options.

The Chapter of Sexual Health Medicine made several recommendations, including advising against tests including herpes serology and ureaplasma in asymptomatic patients, and the use of serological tests to screen for chlamydia, because of frequent inaccuracy and the possibility of false-positive results.

In addition, it flagged concerns about the treatment of thrush.

Chapter President Dr Graham Neilsen said it was concerning that many women with recurrent and persistent yeast infections self-administered treatment, or were prescribed topical and oral anti-fungal treatments.

Dr Neilsen said it was important that patients had "good conversations" with clinicians about appropriate care.

"It is important to rule out other causes...such as genital herpes or bacterial vaginosis, so that other infection are not left untreated," he said. "As well as the importance of ruling out other causes before commencing anti-fungal agents, inappropriate use of antifungal drugs can lead to increased fungal resistance."

The 20 recommendations are the latest instalment in an ongoing program, coordinated by Choosing Wisely, in which 23 medical colleges and societies are working to improve the use of tests and treatments based on the latest evidence.

The process is separate from the Federal Government's MBS Review, which is examining all 5000 items on the Medicare Benefits Schedule.

ADRIAN ROLLINS

# Maximising My Health Record

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

There is no doubt the evolution of the shared electronic medical record, or the My Health Record as it is now known, has been a costly exercise, with more than $1 billion spent to date. Many observers would argue that is a lot of buck for little or no bang.

Certainly, the My Health Record is not yet perfect. But a recent demonstration of its use to the AMA Council of General Practice (AMACGP) was promising, and GPs who had previously dismissed it might consider taking a second look.

We all want the My Health Record to work. It has the potential to support much better patient care, particularly when your patients see another doctor or health care provider.

By uploading key medical information via a Shared Health Summary, you are making sure other doctors who may be treating your patient in an emergency situation, or while they are away on holiday, have the information they need to appropriately care for your patient, thereby reducing the likelihood of your patient experiencing an adverse medical event or unnecessary testing.

Of course, this is a two-way street. The investment you make in providing accurate and up-to-date medical information about your patient for other doctors and health care providers will be repaid when you benefit from the information they upload to another patient's My Health Record.

The vast majority of the Government's investment so far in e-health has funded the building blocks of the e-health system, such as the physical and governance infrastructures, enabling frameworks and privacy protections. To the GP on the ground, this does not mean much for day-to-day patient care.

However, there has been a lot of working going on in the background to make the My Health Record more useful and easy to use. The AMA sat on the Clinical Usability Group of the National eHealth Transition Authority (now Australian Digital Health Agency) and we have driven significant changes. The demonstration provided to the AMACGP highlighted how easy it is to access a My Health Record, as well as to create and upload a Shared Health Summary.

For most practices, the process for Assisted Registration of patients is also much simpler. As long as the patient is known to the practice or have their driver's licence with them, they can be easily registered for the My Health Record using the practice's existing clinical software. Patients do not have to be registered with MyGov to be registered this way for the My Health Record.

The My Health Record is now at a point where we can begin to realise the benefits of a shared electronic medical record.

These benefits will only come 'on scale' when there is a critical mass of registrants. A welcome sign has been Government's willingness to test 'opt-out' arrangements to increase uptake of the My Health Record. The current trials have seen very few patients opt out and, if this trend continues, they will prove the basis for the extension of those arrangements across the whole population.

The requirement to upload a minimum number of Shared Health Summaries under the revised PIP eHealth Incentive has provided a catalyst for more engagement. My patients willingly consent to having a SHS created for them, once they understand the information uploaded to their My Health Record will help facilitate their care, should they unexpectedly end up in hospital.

From the AMA perspective, the My Health Record should include core clinical information for all patients. This information should not be subject to patient access controls. I know that I will only be able to deliver the best care for patients when I have access to their full health record. This must include a current list of medications, allergies and adverse reactions, discharge summaries, recent test results and clinical observations, advanced care directives, advance care plans and resuscitation plans.

Provided the Government and the new Australian Digital Health Agency listens to the input of clinicians, we appear to be on the cusp of delivering a shared electronic health record that operates universally with optimum ease of use and seamless integration across health care providers. Clearly, more work needs to be done to ensure GPs are properly funded to work with the My Health Record and that specialists, other health care professionals and hospitals start to adopt this important clinical tool.

I would not have been so positive 12 months ago, but having used the My Health Record in my own practice and seen the recent demonstrations, I am becoming increasingly optimistic about its future.

If you are not already participating in the My Health Record, a range of training resources have been made available to assist you. They can be viewed at: http://www.digitalhealth.gov.au/using-the-my-health-record-system/digital-health-training-resources/software-demonstrations

# Setting the limits on medical advocacy

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

When the Port Arthur massacre occurred in 1996, I was newly appointed as Dean of the Sydney Medical School.

Simon Chapman, one of our senior public health professionals well known for his anti-tobacco advocacy and campaigning, was strongly associated with the anti-gun backlash to the Tasmanian atrocity. We provided space in the School of Public Health to accommodate several members of the anti-gun advocacy group and a small grant to help them do research in relation to this matter. The treasurer of a charitable foundation associated with the faculty resigned, protesting that gun control had nothing to do with medicine or public health.

A colleague wrote to me recently saying, in the light of the asylum seeker controversy:

There seems to be a tension between the broader and narrower conceptions of the profession's responsibilities. It waxes and wanes between those who take a fairly straightened view of what should rightly fit within the field of medical profession advocacy, and those who think the ethical obligation of doctors requires that they advocate on a broad range. From a certain viewpoint, most things can have implications for health. But is it feasible (or effective) for doctors to speak out on many, or is there reason to focus attention and effort? If so, how is such a selection to be made?

I suspect that this will always remain a matter of personal judgment, but there are three signposts that may help. I feel like the Dalai Llama who, when visiting Westmead Hospital in June 2013, was asked a tricky ethical question and answered with a thoughtful smile, "I don't know. You'll have to work that out!" Three signposts may make the journey a little easier.

## Our duty of care

First, doctors have a duty of care to the patient in front of them that trumps everything else.

Our duty of care obliges us to do all that we can that is consistent with our patient's wishes to enable them to live a life that, as economist Amartya Sen says so elegantly, "they have reason to value".

We do not have a duty of anywhere near the strength of the duty of care to save money, or to consider where else the resources we are using might be applied. The patient comes first. This ethic leads doctors to do amazing and wonderful things such as Catherine and Reg Hamlin for women with fistulae in Ethiopia - both caring for them and advocating for prevention and justice for them.

## Advocacy for health beyond our individual patient

But second, beside our duty of care to individual patients there are other things that claim our attention and energy. We are at our strongest here when our advocacy is over matters closest to our professional competence. Services provided through committees, help to patient advocacy groups and other community agencies and consultancies are in this category.

Third, and here things become slippery, as senior members of society and of the small stratum of highly educated elite, we have several other responsibilities beside those to our individual patients.

## The slippery slope

Expressing views and advocating for things beyond our professional competence - as when medical groups wrote letters endorsing Hitler's rise to power - can be dangerous. You can hold whatever political or religious views you like and advocate for these as a citizen. But once the medical mantle is donned, the ethical coordinates are reset.

In a bright and interesting paper published recently in *The Lancet*, academics from Bristol and Southampton reviewed the history of medical lobbying. They stated that, in the light of the growing chronic disease burden due to behaviours that derive from unhealthy environments, lobbying is needed to combat the "large sums of [spent] marketing commodities such as sugar-laden drinks that add to that burden". Should we be lobbying and advocating for less sugar in our diet?

Two topics bring the contemporary debate about medical advocacy and how far we as doctors should go into focus - climate change and asylum seekers.

# Setting the limits on medical advocacy

## Climate change and asylum seekers

Feelings run strongly in both directions over climate change. There are doctors who hold the view that it is the largest future threat to human health and that they should advocate for all the measures that have been proposed to prevent or at least mitigate it.

The evidential base for concern about climate change derives from climate science, but not medical science, and so we are not on strong ground as medical practitioners when we join the debate. There is, however, an accumulating corpus of research data and modelling about health effects that can be used by medical and public health advocates.

Asylum seekers, whose management challenges us and many other countries at several ethical levels, have a special appeal to the medical profession because depression, anxiety, impaired development during childhood follow from the ghastly business of seeking asylum, made many times worse by hostile responses and incarceration in the countries where asylum is sought.

The recently revoked embargo on medical and other health professionals speaking out about what they have observed when treating patients in the Australian detention centres reminds us of the limits of power to medical advocacy.

In this case, national political policies were held for a time to be superior to the duty of medical care to speak truth to power on behalf of our patients.

This unhappy event serves to remind us that medicine and health are players in a much larger game - that of national and international politics and economics.

Thank your lucky stars that we have the freedom that we do - and advocate for its preservation!

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

For example, general practice, general surgery – and all the surgical sub-specialities, paediatrics, pathology – and its sub specialities, 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.

# Gudjewg, The Wet

BY DR HIROWATARI, CHAIR, AMA COUNCIL OF RURAL DOCTORS

The Top End is getting ready. We are on the cusp of the Wet Season, or Gudjewg, one of the six Aboriginal seasons. Depending on who you ask, the season is from November to April or December to March.

Lightening will crack the skies. It is simultaneously hot and wet, therefore humid. Air conditioners strain, we conserve energy by settling for a "cool" 28-29 degrees. Cyclones are at the back of everyone's mind. This is the time to take pictures of the skies - the most dramatic sunsets in the world happen now.

For the animals out there it is a time of increase. Crocodiles make their nests, Aedes aegypti flourish, the horrible cane toads pop as you drive over them. In the trees, birds make their nests, predators steal the eggs. In the ocean, stingers, coral and other poisonous sea creatures are ready, as always, to sting swimmers. Kangaroos try to commit suicide via motor vehicle accidents with great dedication.

The land turns green and wild flowers appear - welcome colour after a winter of dry and dust.

The air appears to bring everything into sharp focus. The saturation of colours have inspired painters and photographers from around the world. The fruits come out, yum, and I know of four types of mangoes. We eat until our palms and lips turn yellow.

The rivers swell, the land is muddy, sticky, a trap for four wheel drives and gumboots. Tourist venues close - there are no croc tours in the wet, and they are not really needed anyway since the crocs are lining up trying to get on the road.

For rural doctors in these parts this is the time to think of dengue, arbovirus, meliodosis, leptospirosis and the post traumatic stress of Christmases past.

The workforce goes away on holidays so we may be asked to work impossible rosters.

When the local hospital is on one side, the airstrip on the other side of a flooded creek, how does one transport a patient for retrieval? One community I know has two ambulances; one for one side of the creek, the second for the other. And in between? Well, a trusted tinny.

Appointments to see specialists seem to go on hold for a whole month or more and the operating slate narrows to Cat 1 cases. Medical clinics, allied health services and admin offices downscale to minimum staffing levels and telephones ring for a long time.

Over in Canberra, the politicians try to sneak nasty laws like co-payment schemes into place while the country is on holiday.

From a survival point of view, one needs to have a cyclone plan, which includes enough food in stock to last two weeks. If the water backs up, be prepared to boil and sterilise the drinking water when the local store runs out of bottled water.

From a medical supplies point of view, it means having enough consumable supplies to make it through a dreaded multiple casualty event. And when will we get our O Neg? Point of care testing is essential because those tubes of blood will not make it to big city pathology in time.

Do you have any "wet" stories with a medical slant? I'd love to hear them. It is part of the lore of the rural medical profession. This season makes us hardy, at home with our limitations and humble.

INFORMATION FOR MEMBERS

## Food Standards Australia New Zealand – Board nominations

AMA members are invited to nominate for the Board of Food Standards Australia New Zealand.

FASNZ has invited the AMA to provide nominees for the consumer, science and/or public health positions on the GSANZ Board.

Nominees must have relevant expertise: good knowledge of consumer rights and consumer affairs policy for the consumer position; expertise in one or more of public health, food science, food allergy, nutrition, medical science, microbiology, food safety and biotechnology in the case of the public health/science position.

Nominations must be received by 30 November.

For more information, including selection criteria, please contact AMA Secretary General Anne Trimmer at ama@ama.com

# Nothing to fear, but internship itself

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

The turmoil of the Trump election has overshadowed one of the greatest things about the US presidential campaign: that it's now over. I'm fairly certain you're sick of hearing about it too, and you'll be glad to know this isn't an article about Donald. No, it's about fear and opinions becoming truths.

You see, Donald wants to build a giant wall, and he wants Mexico to pay for it. He'll be quite saddened to find that his wall will have the exact opposite of its intended effect, with more Mexicans presently leaving the US than entering it. A fitting outcome really, in a beautifully ironic serendipity.

I'm sure those closer to the reality are angrily exploding at their various newspaper headlines and television grabs with Donald continuing to espouse lies. But if you say something often enough, it doesn't need to be true; it just needs to be true enough.

This is the case with medical internships in Australia.

No, we don't want to build a wall to keep interns out. Yes, we do want to re-examine medical internship in Australia.

The greatest flashpoint of this discussion has been the COAG Health Council's Medical Intern Review. If you look at the terms of reference, the very first line says: "Australia has a high quality and well trained medical workforce". It doesn't exactly sound like the world is falling apart, does it?

But the implicit assumption in the discourse has been that internship is broken. Why commission such a review if it isn't?

In defence of the review, this was not the language that was used. It was the language that grew to occupy the new space that was created.

The AMA's position has always been that internship has room for improvement, but is not fundamentally broken.

However, since the review, every forum I've attended on prevocational training and education has worked off of the incorrect basis that internship is broken.

In a world where we "stop the boats", you shouldn't underestimate the power of language.

Despite no reliable evidence that internship is broken, this is now our baseline working point. And it's dangerous one, because it justifies truly crazy ideas, like moving internship into medical school.

It also comes with an opportunity cost. We're so busy talking about the unbroken internship that we don't discuss the increasingly broken prevocational space as a whole.

This is now more relevant than it has ever been before.

Internship is a protected space, with clear safeguards around training and education. Registrars are protected by their respective colleges and accreditation processes.

But what of the prevocational and non-vocational doctors?

When the sea of interns moves onwards, they'll soon find a lack of career pathways and, with minimal regulation over the prevocational space, it's a disaster waiting to happen.

Residents won't be doctors anymore; they'll be a poor excuse for a labour hire arrangement.

The AMA Council of Doctors in Training recently discussed a number of Position Statements around the pre-vocational space. We have always believed in quality teaching, appropriate learning opportunities and clear support structures, and we strengthened these calls in 2016.

We have always opposed early streaming, and we call for early choices to help develop a flexible workforce, for the health of Australia and for appropriate career opportunities.

We strongly believe that all prevocational positions should be accredited, to prevent exploitative employment practices in intellectually void terms and placements.

We call for the support of supervisors, to ensure teachers are free to teach. We believe that medical school should prepare you for internship, but we do not believe that internship belongs in medical school.

The AMA is often painted as a monolithic agent, resisting inevitable change.

I spend my time working with doctors in training from all states and territories to change the landscape of prevocational medicine in Australia for the better, so I resent that statement.

I take solace in the fact that the "half truthers" eventually get bored and move on, while the AMA remains on topic.

We're working for a brighter prevocational future, and we'll make it there.

# Exercising the script to fight the obesity epidemic

BY TABISH ALEEMULLAH, PUBLIC RELATIONS OFFICER, AUSTRALIAN MEDICAL STUDENTS' ASSOCIATION, AND FIFTH-YEAR MEDICAL STUDENT, UNIVERSITY OF NEW SOUTH WALES

Australia's doctors are at the frontline in the fight against the obesity epidemic, and our nation's medical students are the cavalry arriving to help.

However, in some ways, it is a battle our future doctors find themselves unequipped for, and it is our patients who will ultimately suffer.

> "Unfortunately, most doctors do not regularly assess or prescribe physical activity, and even fewer provide specific recommendations, often due to a lack of expertise and confidence"

Alarmingly, Australia remains one of the least physically active nations in the world. Almost 60 per cent of us don't move enough. The preventable result of this is tragic: more than 10 per cent die from causes associated with physical inactivity.

As a trusted source of health information, doctors play a vital role in promoting physical activity among individuals and communities at large, not just for patients who have chronic illnesses or are at risk of developing them, but those who are healthy as well.

Unfortunately, most doctors do not regularly assess or prescribe physical activity, and even fewer provide specific recommendations, often due to a lack of expertise and confidence.

To address this, it is crucial that medical students are adequately trained early on in their careers to advise on and engage in the subject of physical activity and, most importantly, in the counselling of exercise prescription to patients. This can ensure the doctors of tomorrow offer better support to everyday Australians fighting chronic disease; a fight they should never have to face on their own.

As it stands, medical curricula across Australia face considerable heterogeneity in their teaching of physical activity as a therapeutic treatment for obesity and chronic disease. Physical activity is often discussed as a means of prevention, rather than a significant component of the cure, and as a way of merely assessing a patient's behavioural attitude towards personal health. For many medical students, the combined scientific and clinical teaching of exercise prescription is insufficient. Often it is non-existent unless they undertake specialty training in areas such as primary care, sports and exercise medicine, orthopaedic sports surgery and public health.

In contrast, the evidence-based practice and positive value of smoking cessation advice has seen it become an inspiring cornerstone of medical education. Medical students around the country fulfil graduate capabilities in assessing tobacco smoking behaviours, delivering cessation counselling to patients and in competently knowing the treatment and support regimens they can provide, as part of a long-term management plan.

Herein lies a disconnect waiting to be resolved. When it comes to medical student education, isn't it now more important than ever to apply that same didactic rigour towards considering physical activity as a treatment?

The evidence for this is overwhelming.

A written prescription of exercise and lifestyle goals can increase physical activity in relatively inactive patients and signify exercise as a targeted therapy to reduce relative mortality risk. Evidence shows that physical activity can be just as effective as medical therapies in treating more than 25 different chronic diseases and, in special situations, can be more effective.

In terms of the effectiveness of physical activity counselling, the clinical effort needed to treat one person to achieve the recommended adult Australian guidelines of at least 150 minutes of moderate-to-vigorous activity per week is less than a quarter of that involved in achieving a comparable health benefit from encouraging a patient to quit smoking.

This year, the Canadian Medical Association passed a motion to support physical activity counselling training among its medical students nationwide. There has never been a more apt time for Australia to follow suit and make an equally significant and positive statement, to become a leader in the movement for movement and enhance medical education for the cavalry coming to the fight.

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# AMA policy on euthanasia and physician assisted suicide – an update

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

The issue of euthanasia remains very much to the fore in current media, and attempts to introduce euthanasia laws continue in several states.

In South Australia, a new voluntary euthanasia Bill is currently being considered by Parliament and will be voted on as soon as this month. Pro-euthanasia MPs in Tasmania and Western Australia have indicated they will introduce legislation in the near future. The Victorian Government is due to respond by year's end to a report on the Inquiry into End of Life Choices in Australia, which recommends the development of a legislative framework for assisted dying.

In the midst of this, the AMA's review of its own policy on euthanasia and physician assisted suicide continues to progress. The Federal Council held a special policy session on the issue at its meeting in August, where it considered information gained from a very wide-ranging and deliberate process of member consultation, including:

- the results of an AMA member survey on euthanasia and physician assisted suicide;
- issues raised through this year's AMA National Conference Q&A session on assisted dying;
- member responses to the current AMA policy (undertaken last year through *Australian Medicine*); and
- relevant background information on euthanasia and physician assisted suicide, including national and international legislative initiatives and professional and community attitudes.

At its August meeting, Federal Council recognised the diversity of member views on euthanasia and physician assisted suicide and agreed that there was a need to consult further with State and Territory AMA offices on whether the AMA's current policy opposing doctor involvement in euthanasia and/or physician assisted suicide should be amended.

There were, however, several issues highlighted at the meeting over which there was no dispute:

- access to adequate palliative care and end of life care remains inadequate throughout the country;
- regardless of the final policy position, there must be appropriate funding of palliative care and greater clarity regarding legislative protections for doctors providing good end of life care for their patients; and
- irrespective of whether or not euthanasia and/or physician assisted suicide become legal in Australia, it is imperative that the medical profession articulates the message that end of life care is a central responsibility of doctors, and that we will always care for patients and the broader community.

The members of Federal Council are acutely aware that this issue is sensitive and controversial, and that any decision will have potential political ramifications and consequences for health care. It is an issue on which some members have very strong views, many of which have been expressed as heart-felt and compelling arguments during the current consultation process.

However, because this is a debate about something that is very much at the core of what it is to be a doctor - that is, whether doctors should be involved in actions with a specific intention to end life - there are times when those with opposing views maybe forget the need to genuinely listen to each other. This is unfortunate when it occurs, because what has become very clear during the consultation process is that all members, whatever their views, have shown a deep dedication to the care of their patients and the welfare of the community as a whole.

So, the Federal Council's mission is to be respectful of the views of all members, and to be understanding of the passion of those with opposing views, while seeking to find a position which is sensible and justifiable, but also reflects the unbreakable responsibility of doctors to always care for their patients.

Federal Council will continue its deliberations on a euthanasia and physician assisted suicide policy position at its upcoming meeting in November. We will keep members informed of the progress of this issue.

# Improving safety and quality of public hospital services – a case of less $$ to do more?

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

A key focus for Health Financing and Economics Committee (HFE) is the pricing and funding of public hospitals.

This work includes monitoring public hospital funding through the federal Budget and public hospital expenditure as reported by the Australian Institute of Health and Welfare.

> "The AMA has a direct and significant interest in the Pricing Framework for public hospital services as a critical element in the overall functioning of our hospital system"

HFE also takes a close interest in hospital pricing through the operation of Activity Based Funding (ABF) and the National Efficient Price (NEP), managed by the Independent Hospital Pricing Authority (IHPA). Each year, IHPA publishes a consultation paper to inform the Pricing Framework of ABF and the NEP to apply for the following financial year.

The AMA has a direct and significant interest in the Pricing Framework for public hospital services as a critical element in the overall functioning of our hospital system.

The major new element in the proposed Pricing Framework for 2017-18 relates to options for incorporating safety and quality into the pricing and funding of public hospital services.

For 2017-18, IHPA has been directed by Federal, State and Territory governments to undertake specific work to integrate quality and safety into hospital pricing and funding. IHPA has been tasked to advise on pricing and funding options for sentinel events, preventable hospital acquired conditions, and avoidable hospital readmissions.

IHPA's options are set out in its consultation paper on the Pricing Framework 2017-18.

The options involve reducing pricing and funding for services that do not meet safety and quality standards, for example, services that involve a preventable hospital acquired condition. The 'logic' appears to be that improved safety and quality will be achieved by imposing financial penalties and reducing hospital funding for poor safety and quality services.

At its October meeting, HFE was briefed by IHPA Chief Executive James Downie on hospital pricing issues and IHPA's safety and quality options. HFE drew on this discussion to consider and make input to the AMA's submission on the Pricing Framework.

The AMA has consistently advocated for the appropriate recognition of safety and quality in the ABF and NEP framework.

However, the AMA has significant concerns with how this longstanding gap in the framework is now to be addressed. Any approach that sets out to improve safety and quality by financially penalising hospitals that are already under-resourced to achieve safety and quality standards is misconceived.

Improving the safety and quality of public hospital services requires a framework of positive incentives for the achievement of relevant targets, supported by the full range of quality and safety mechanisms in place and available to public hospital system operators, doctors, nurses and other hospital staff.

These include improvements in data quality and information available to inform clinician practice, whole of system efforts to deliver improved patient outcomes, and incentives that work to the level of the clinical department to focus efforts and effect change, with local implementation, monitoring and information sharing needed.

An essential pre-condition for all such improvements is adequate funding for public hospitals.

Overall funding for public hospitals under the NEP has been, and continues to be, inadequate. This has direct consequences for the performance of public hospitals in key areas against the targets set by governments, as tracked and reported in the AMA Public Hospital Report Card.

# Health Care Homes must be tailored to Indigenous needs

BY AMA PRESIDENT DR MICHAEL GANNON

I am continuing the important tradition of chairing the Taskforce on Indigenous Health as AMA President. The taskforce acts to identify and recommend Indigenous health policy strategies for the AMA.

On 8 October 2016, it was my privilege to chair my first meeting of the Taskforce. A number of important issues were discussed, including the AMA's election priorities relating to Aboriginal and Torres Strait Islander health, the AMA's support for the establishment of an Academic Health Science Centre in Central Australia, as proposed by Baker IDI Heart and Diabetes Institute and its partners, and the Indigenous health focus of the Medicare Benefits Schedule (MBS) Review.

One issue that was raised as being of particular concern was how the proposed Health Care Homes initiative will affect health care for Aboriginal and Torres Strait Islander peoples. The AMA supports the concept of Health Care Homes – a policy announcement made by the Coalition prior to the 2016 election, and we are pleased that the Australian Government has committed to an extended trial of the concept.

The AMA has concerns about the Health Care Homes model in relation to Indigenous health, and we assert that the specific health needs of Aboriginal and Torres Strait Islander people must be addressed through the scheme.

The concept of the medical home is not new in Australia. For many Australians, their local general practice is already their Health Care Home, and their GP, their primary carer. Patients whose care is well managed and co-ordinated by their GP are likely to have a better quality of life and to make a positive contribution to the economy through improved workforce participation. Health Care Homes should mean more expensive downstream costs can be avoided. Chronic conditions, if treated early and effectively managed, are less likely to result in the patient requiring hospital care for the condition or any complications.

The Health Care Home model has worked overseas and the evidence is of significant reductions in avoidable hospital admissions, emergency department use, and overall costs.

The AMA sees Health Care Homes as potentially one of the biggest reforms to Medicare in decades.

However, we know that, for the Health Care Home model to succeed, the Government needs to engage with and win the support of general practice. We also need to see greater detail about how the Health Care Home model will operate in remote and Indigenous communities.

Indigenous communities face a range of unique health problems and chronic diseases uncommon in our cities. A high turnover of medical practitioners and support services in these areas means continuity of care and follow up treatment can be difficult to maintain.

Trust is a vital component of health care, especially for Aboriginal and Torres Strait Islander peoples, and knowing and trusting a GP is critical in the management of chronic conditions. How the Health Care Home model will deliver consistent, ongoing GP care and management of chronic health conditions is not known, and the AMA has been urging the Government to provide greater details about funding and operation.

There is a degree of anxiety among the Aboriginal Community Controlled Health Organisation (ACCHO) sector that any announcements made by the current Government will result in cuts to Indigenous health. There is a strong view that building up the ACCHO sector is the best model of care for Aboriginal and Torres Strait Islander peoples, particularly as ACCHOs are the preferred provider of Indigenous health services.

ACCHOs, like Health Care Homes, need to be built on existing relationships and investment in models that work. The Government must not rush the Health Care Homes trial and, if it is to be successful, it must be adequately funded.

As a model, it has the potential to help close the gaps in health outcomes between Aboriginal and Torres Strait Islanders and non-indigenous Australians. The AMA's position will be to closely monitor what works and what does not work, and work constructively with Government to ensure the necessary changes are made.

# Health on the hill

POLITICAL NEWS FROM THE NATION'S CAPITAL

## 'Obsolete' Medicare system to be replaced

The Federal Government has commenced work on replacing the ageing Medicare, health and aged care payments system in a move welcomed by the AMA.

Health Minister Sussan Ley and Human Services Minister Alan Tudge have announced that the process of identifying a new system to supplant the current 30-year-old structure has commenced.

"Australia's existing health and aged care payments system is 30 years old and is now obsolete," the Ministers said. "A process has commenced to identify solutions for this new payments system, which will be based on existing commercial technology."

But, seeking to prevent a repeat of Labor's damaging election campaign claim that such a move amounted to the privatisation of Medicare, the Ministers insisted the Government would retain ownership and control.

"The new system will support the Australian Government continuing to own, operate and deliver Medicare, PBS, aged care and related veterans' payments into the future," they said.

AMA President Dr Michael Gannon said the Government's move amounted to a modernisation rather than privatisation.

"The AMA made it very clear during the election campaign that replacing the backroom payment system for Medicare does not equate to the privatisation of Medicare," Dr Gannon said. "The current payment system is 30 years old. It is clunky and inefficient. Its many faults create inefficiency and inconvenience for doctors and patients."

The AMA President said medical practices had taken on much of the work of processing Medicare payments on behalf of the Government, costing them considerable time and effort.

The Government has promised to consult "extensively" with health providers and stakeholders in determining the final design of the new system.

Dr Gannon said such consultation was vital.

"It is critical the AMA is closely involved in the design of the new system to ensure it meets the needs of doctors and patients," he said, adding that medical practices must be properly supported to incorporate and implement the new system for the benefit of patients.

Consultations on the new system are due to be finalised in January 2017.

ADRIAN ROLLINS

## Mental health groups urged to boycott new plan

A prominent mental health advocate has blasted the Government's draft Fifth National Mental Health Plan as "rubbish", and called on mental health groups to boycott the consultation process.

The plan was released for consultation on 20 October, with Health Minister Sussan Ley describing it as "an important document" that was "focused on actions that will genuinely make a difference for consumers and carers".

"The Fifth Plan contains seven priority areas, which have been identified for action in close collaboration with the mental health sector," Ms Ley said in a statement.

But Professor John Mendoza, the former head of the Mental Health Council of Australia, said the plan would simply continue funding late-term intervention at the expense of prevention and early intervention.

Professor Mendoza called on colleagues at an international mental health conference in Brisbane that the consultation process should be boycotted.

"The plan does not reflect the Prime Minister's commitment at the election 'to leave no stone unturned when it comes to mental health'," Professor Mendoza told *The Australian*, adding that the plan was "mealy-mouthed rubbish" designed by bureaucrats with no institutional knowledge.

"The plan does not take us one step further in relation to the Government's announcements last November when it responded to the National Mental Health Commission report and it strongly endorsed the national commission's recommendations."

Professor Mendoza said that Prime Minister Malcolm Turnbull had used the words "we need to really embrace innovation, we have to focus on the mental wealth of the nation".

"And he was stating that because it was clear to him that the economic drag on Australia now, through its focus on acute, late-intervention services rather than early intervention and prevention, means that we have hundreds of thousands of Australians who are unable to participate in work, who are unable to complete education, who are unable to sustain and maintain relationships, because they simply can't get access to the care they need," Professor Mendoza said.

"The Commission said this isn't good enough, we need fundamental reform. And the Government said that was what it was going to do.

# Health on the hill

POLITICAL NEWS FROM THE NATION'S CAPITAL

"Now, the Fifth Plan that's been released for consultation does nothing of the sort.

"It pays no attention to the Government's reform agenda, and it certainly doesn't marry up with what either the Queensland and NSW Governments [are doing] - two different sides of politics, both of them have articulated clear plans.

"This national plan is completely devoid of any specific actions, any measures, any targets."

The seven priority areas are:

- Integrated regional planning and service delivery;
- Coordinated treatment and support for people with severe and complex mental illness;
- Suicide prevention;
- Aboriginal and Torres Strait Islander mental health and suicide prevention;
- Physical health of people living with mental health issues;
- Stigma and discrimination reduction; and
- Safety and quality in mental health care.

The Department of Health and Mental Health Australia will hold consultation meetings in all capital cities, as well as Townsville and Alice Springs, in November and December.

The final plan will be considered by the Australian Health Ministers' Advisory Council and the COAG Health Ministers' Council early next year.

MARIA HAWTHORNE

INFORMATION FOR MEMBERS

# AMA Indigenous Peoples Medical Scholarship 2017

Applications for the AMA Indigenous Peoples Medical Scholarship 2017 are now open.

The Scholarship, open to Aboriginal and Torres Strait Islander people currently studying medicine, is worth $10,000 a year, and is provided for a full course of study.

The Scholarship commences no earlier than the second year of the recipient's medical degree.

To receive the Scholarship, the recipient must be enrolled at an Australian medical school at the time of application, and have successfully completed the first year of a medical degree (though first-year students can apply before completing the first year).

In awarding the Scholarship, preference will be given to applicants who do not already hold any other substantial scholarship. Applicants must be someone who is of Aboriginal or Torres Strait Islander descent, or who identifies as an Australian Aboriginal or Torres Strait Islander, and is accepted as such by the community in which he or she lives or has lived. Applicants will be asked to provide a letter from an Aboriginal and/or Torres Strait Islander community organisation supporting their claim.

The Scholarship will be awarded on the recommendation of an advisory committee appointed by the AMA's Indigenous Health Taskforce. Selection will be based on:

- academic performance;
- reports from referees familiar with applicant's work regarding their suitability for a career in medicine; and
- a statement provided by the applicant describing his or her aspirations, purpose in studying medicine, and the uses to which he or she hopes to put his or her medical training.

Each applicant will be asked to provide a curriculum vitae (maximum two pages) including employment history, the contact details of two referees, and a transcript of academic results.

The Scholarship will be awarded for a full course of study, subject to review at the end of each year.

If a Scholarship holder's performance in any semester is unsatisfactory in the opinion of the head of the medical faculty or institution, further payments under the Scholarship may be withheld or suspended.

The value of the Scholarship in 2017 will be $10,000 per annum, paid in a lump sum.

**Please note that it is the responsibility of applicants to seek advice from Centrelink on how the Scholarship payment may affect ABSTUDY or any other government payment.**

**Applications close 31 January 2017.**

The Application Form can be downloaded at:

https://ama.com.au/system/tdf/documents/Application%20Form_0.pdf?file=1&type=node&id=45143

Information on previous recipients can be found at https://ama.com.au/advocacy/indigenous-peoples-medical-scholarship

The Indigenous Peoples' Medical Scholarship Trust Fund was established in 1994 with a contribution from the Australian Government. The Trust is administered by the Australian Medical Association.

*The Australian Medical Association would like to acknowledge the contributions of the Reuben Pelerman Benevolent Foundation and also the late Beryl Jamieson's wishes for donations towards the Indigenous Peoples' Medical Scholarship.*

# The medical profession is under attack: WMA

The physical safety and professional autonomy of doctors around the world is under attack from governments, armed groups and individuals, hampering their work and putting the health of patients at serious risk, according to incoming World Medical Association President Dr Ketan Desai.

Speaking following a spate of deadly attacks on hospitals and medical centres in war-torn Syria, Yemen and Afghanistan, Dr Desai told the WMA annual assembly in Taiwan that increasingly the Geneva Convention was being "practised more in breach than observance, invariably ending up in flagrant violation of human rights".

UN Secretary-General Ban Ki-moon has condemned the sustained bombing of medical facilities in the besieged Syrian city of Aleppo as war crimes, amid claims that 95 per cent of pre-war medical personnel in the city have fled since the conflict began.

In Yemen, Saudi-led forces have been accused of targeting several health facilities, including a strike on a Medicins Sans Frontieres hospital in which 11 died and 19 were injured.

Dr Desai praised the dedication of doctors and health professionals working in these countries, and said they deserved protection: "To a physician, a patient is neither a friend nor an enemy. They legitimately need protection from violence while at work, whether in war or civil conflict situations".

Doctors also risked physical attack outside war zones.

The WMA President, who was elected to the post after serving as President of the Medical Council of India, said medical practitioners working in many parts of the world, particularly in Asia, were being assaulted, and hospitals and clinics ransacked and damaged, by angry patients and their families.

In addition to these physical threats, Dr Desai said that in countries as diverse as Turkey, India and the United Kingdom, governments were attempting to encroach on the independence and autonomy of the medical professional, to the detriment of patients.

"Regulation of clinical practice, framing evidence-based standard treatment guidelines, defining and checking professional malpractice and medical education all need vital professional independence and a democratic system based on meaningful participative decision-making," he said. "In many countries there are continued political attempts to undo or marginalise autonomy

AMA President Dr Michael Gannon (standing, second left) and AMA Secretary General Anne Trimmer (seated, far right) with outgoing WMA President Sir Michael Marmot (seated nex t to Ms Trimmer) and representatives of the Canadian, British and New Zealand Medical Associations at the General Assembly in Taipei

and self-governance of the medical profession, including mauling and trampling on the trinity of professional autonomy, clinical independence and self-governance."

Dr Desai said the WMA was alert to these threats and would continue to fight government efforts to make the medical profession subservient.

But he said part of this involved ensuring the medical profession acted with honesty and integrity, something that was at risk in many countries because physicians were prescribing and referring patients based on pecuniary self-interest or kickbacks.

In other developments, the WMA General Assembly:

- approved ethical guidelines on the collection and use of identifiable health data (the Declaration of Taipei);
- demanded an immediate and impartial inquiry into the bombing of hospitals in Aleppo;
- urged national medical associations and other health groups to divest fossil fuel stocks;
- called for greater focus on care of the elderly; and
- said doctors must be prepared to intervene to protect girls from undergoing female genital mutilation.

ADRIAN ROLLINS

# Holden Commodore SV6 "Driven to extinction"

BY **DR CLIVE FRASER**

Friday 6th October 2016 was a sad day for Ford fans all over Australia (and New Zealand).

It was the day that the very last Ford Falcon rolled off the production line at Broadmeadows, a blue Falcon XR6.

Ironically it was also the last Friday before the 2016 Bathurst 1000 race which would see Ford place third.

Ford has manufactured cars in Australia for 91 years and 4,356,628 vehicles have been built at Broadmeadows.

With the plant's closure 1200 jobs at Ford would go with probably another 8,000 jobs in the components industry also being lost.

Undoubtedly many tears will be shed over the loss of Australia's automotive manufacturing industry.

Though they have always been arch rivals Holden now has the locally-built six cylinder rear-wheel drive market all to itself at last.

So I decided to take a long last look at the soon to be extinct VF Holden Commodore with a trip from Sydney to Terrigal and on to Newcastle and the Hunter Valley.

For reasons too complicated to explain I made the journey twice so I covered 1,000 kilometres in three days.

No problems finding my SV6 Commodore in the airport parking lot.

Everyone complains that in the 21st Century all cars look the same, but the Commodore still stands out in the crowd, because it is so big.

That does provide a challenge fitting into those small parking spaces that beckon in Darlinghurst and Potts Point.

But all that bulk on the outside does translate into acres of space internally.

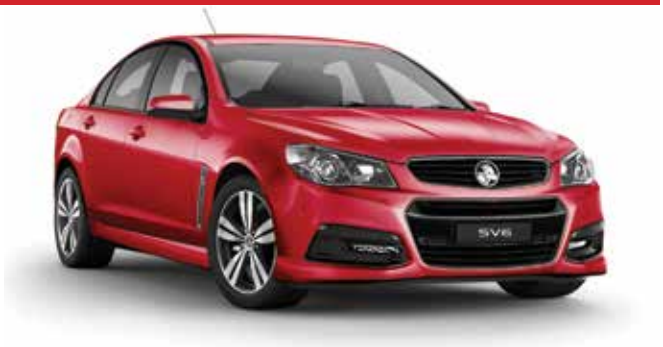
There is a rear seat that is living room size and really does fit three adults, though I can't remember the last time anyone sat in the back when I've been driving.

The Friday afternoon commute out of Sydney sees the Commodore crawling along with thousands of other commuters so it seems around town there really is no point in having a 3.6 litre V6 and 210 kW under the hood.

I wasn't disappointed once I hit the F1 Freeway as it's there that the Commodore can finally stretch its legs.

My last drive in a Commodore was in a VE which was 43 kg heavier than the VF.

The attractive styling of the VF also means that the coefficient of drag has dropped from 0.33 to 0.30, meaning that the VF




accelerates faster and also uses less fuel.

That's a combination that rev-heads and greenies will agree on.

On the open road the Commodore has effortless power and I can see just why sales reps have always preferred "family" cars when they spend all day on the road.

Commodore can forever claim bragging rights in the power race with the 6.2 litre V8 VF HSV GTS having power of 430 kW and 740 Nm of torque.

That makes that version of the VF the most powerful car ever produced for public sale in Australia.

In the United States General Motors sells this car as the Chevrolet SS and in the United Kingdom as the Vauxhall VXR8.

Whilst I loved the Commodore's driving experience I can't say I liked it's on-board MyLink entertainment centre.

Sydney drivers all know that 702 ABC Sydney doesn't have reception on the Central Coast.

I found the simple task of storing 1233 ABC Newcastle particularly confusing, and the operation of the radio was further complicated by the inadvertent pushing of the horizontally placed buttons below the touch screen.

One thousand kilometres in a Commodore is surprisingly pleasant.

My lumbar spine and gluteal region agreed that the seats were comfortable.

And I think that 7.8 litres per 100 km in a mixture of stop-start and freeway driving is commendable for a family-sized car.

Would I buy a VF Commodore?

Yes, because I've never owned one and I think it would satisfy my nostalgic cravings.

Safe motoring,

**Doctor Clive Fraser**
doctorclivefraser@hotmail.com

# AMA Member Benefits

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

AMA members requiring assistance can call AMA member services on

**1300 133 655** or **memberservices@ama.com.au**

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

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

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

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

Learning.doctorportal.com.au

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

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


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

www.ama.com.au/careers

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