AUSTRALIAN
Medicine
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Cover pic: "The Prime Minister and the Health Minister must stare down Treasury and Finance" - AMA President Dr Michael Gannon

Primary care must be primary priority

BY AMA PRESIDENT DR MICHAEL GANNON

The most recent report on Australia's medical workforce from the Australian Institute of Health and Welfare (AIHW) shows that, in 2015, there were 102,805 registered medical practitioners - with 88,040 of those actually employed in medicine, more than 95 per cent of them in clinical roles.

There are more women in the medical workforce than ever before (40.1 per cent), and a quarter the workforce is aged 55 or older.

It is interesting, but not surprising, that GPs now make up 33 per cent of the workforce and other specialists make up 35 per cent, with specialists in training making up another 18 per cent.

This trend has been around for a little while, and can be traced back to the early 2000s, when GP training numbers under the old Family Medicine Program were as low as 450 a year. They are currently around 1500. The AMA has called on the Government to lift the number to 1700.

There was a long period of time where we were not producing enough new, young, home-grown GPs. This corresponded with an ageing of the existing GP workforce. Like many areas in medical workforce, we are playing a game of 'catch up'.

The message is clear. The Government must use this term of Parliament to build a renewed focus on primary care, especially general practice. It makes workforce distribution sense. It makes economic sense. It makes political sense.

I made this argument the central theme of my recent speech to the National Press Club.

When people are sick, injured, or want health advice, they want to see their GP.

GPs are the first point of contact when most Australians feel unwell, and they manage 90 per cent of the problems they encounter.

General practice has been under sustained pressure for years. GPs have been treated poorly by both Coalition and Labor Governments. There has not been a decent investment in their work since 2004.

Over the last decade, GPs have delivered 35 million extra GP-patient visits – up 67 per cent, and delivered another 10 million minor procedures – up 66 per cent.

If GP services were performed in other areas of the health system, they would cost considerably more than when provided in general practice.

For example, GP services provided in a hospital emergency department would cost between $400 and $600 each, compared to the average cost of a GP visit of around $50.

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

Medicare spending on GP services represents just 6 per cent of total government health expenditure.

But GPs are caught in a diabolical squeeze. They are caring for increasingly sick patients while the Government tightens the financial screws in the name of budget repair. For too long, they have been the easy target in health.

GPs are now at breaking point. Unless there is substantial investment in general practice, there is no doubt that the quality of care will start to suffer - and patients will face growing out-of-pocket costs.

The Government is acutely aware that health policy – poor health decisions, cost cutting measures, and a lack of well-targeted health initiatives – cost them dearly at the election. The hits to health were most evident at the front door of the health system – general practice.

There is already evidence that the Prime Minister heard the warning and is taking action.

The Government's announcement of a Health Care Homes trial is a good start.

Patients whose care is well managed and coordinated by their GP are likely to have a better quality of life and make a positive contribution to the economy through improved workforce participation.

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.

This is potentially one of the biggest reforms to Medicare in decades, and the AMA wants to help make it work.

I have met with the Prime Minister, the Health Minister, and the Department, reminding them of our concerns about inadequate

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funding for the trial. We also advised that the Government must act quickly in good faith to win back the trust of GPs.

The good news is that there is a much more positive buzz around Parliament House that the Government wants to repair its reputation in health. Even the more conservative political commentators are telling the Government to steer clear of chasing further Budget savings in the health portfolio.

Even better is word from insiders that the Prime Minister is taking a very strong personal interest in health policy. He has made numerous public appearances alongside a revitalised Health Minister Sussan Ley in recent weeks.

The script so far has been very positive. The political priority is Health Care Homes, and the key words being used by the Prime Minister and the Minister have been primary care, general practice, GPs ... and the AMA. This is smart politics for the Coalition. It is good news for GPs and the AMA. I hope that we can turn into good news for patients. Stay tuned.

What should be expected of doctors

BY AMA SECRETARY GENERAL ANNE TRIMMER

Much has been written recently about the importance of culture in organisations. The issue came to prominence in the corporate context with a recent proposal by the Australian Securities and Investments Commission to regulate culture in the financial services sector. The proposal has been met with strong resistance from a number of leading bankers.

The Australian Institute of Company Directors weighed in, expressing concern about the regulator's proposal to introduce corporate and personal liability for organisational culture.

A different position was taken by Dr Simon Longstaff of the St James Ethics Centre who welcomed the approach, commenting that "if boards are recklessly indifferent to the quality and character of corporate culture in the companies they govern, or if they encourage or support a culture of indifference to appropriate standards of law, then they should be held accountable".

Dr Longstaff's position is consistent with the positions taken by the Royal Australasian College of Surgeons and the AMA over the past year or so to address cultural issues in the medical profession. RACS and the AMA have taken significant steps to highlight the issue and provide guidance to members in supporting a shift in cultural behavior.

Most recently, AMA Victoria published a pledge which it is asking members to subscribe to as a way of acknowledging the need for an awareness of the impact of behaviour. This is to be commended. It follows a series of events hosted by the Victorian branch over the past few months that have brought together leaders in the profession and others to identify issues and agree on solutions.

Federal AMA is undertaking a review of its Code of Ethics over coming months. The present Code of Ethics was approved in 2006 with an express purpose to articulate and promote ethical principles to guide doctors' relationships with patients, colleagues, and society.

In keeping with its mission of leading Australia's doctors it is appropriate that the AMA accepts the responsibility for setting the standards of ethical behavior expected of doctors. To this end, the review of the Code of Ethics might consider some of the broader issues of behavior between colleagues that have been highlighted over the past year.

I look forward to the outcome of the review, which will be undertaken by the Ethics and Medico-legal Committee of Federal Council. Members with thoughts on the review of the Code of Ethics are invited to provide comments.

Listen to doctors to get e-health right

BY AMA VICE PRESIDENT DR TONY BARTONE

The introduction of the Australian Digital Health Agency is supposed to herald an opportunity for serious change. Time will tell if we are left bitterly disappointed.

For many years our position has been steady and strong. The AMA has always been supportive of e-health, but a lack of engagement and consultation with doctors has seen the Personally Controlled Electronic Health Record (PCEHR) so far fail in Australia.

Doctors treat patients most effectively when they have access to all the necessary clinical information regarding their patients. Patient safety and the quality of care will be improved if treating doctors can promptly and easily access and contribute to accurate, reliable and comprehensive electronic medical information about the patients they are treating.

The 2013 Royle review into the failings of the PCEHR found that the agency in charge of implementing the Government's e-health policy, the National E-health Transition Authority (NeHTA), did not have the confidence of the audience that it was attempting to represent.

It found that the board failed to reflect the objectives of the agency, and stakeholder ideas and concerns were prone to be overruled or lost in the bureaucracy of the organisation.

The Government revised its approach to e-health and abolished NeHTA, establishing in its stead a new agency responsible for all national digital health services and systems – Australian Digital Health Agency (ADHA). The board members were announced in April, and last month former NHS England Director for Patients and Information Tim Kelsey was appointed to run ADHA.

Kelsey quit the NHS after several years in charge of its highly controversial care.data program, a data sharing operation that was criticised as privacy-invasive.

In 2015, a Cambridge University study noted major care.data failings including, "mismanagement and miscommunications, inadequate protections for patient anonymity, and conflicts with doctors".

Care.data was officially abandoned in July after it was found it didn't have the confidence of patients. The failed system has so far cost the British taxpayer nearly £10 billion ($17.4 billion).

Sound familiar?

Kelsey has a lot of work to do, and only time will tell if he can engage constructively with doctors.

In addition to operating the Government's My Health Record, the new agency will also be involved closely with the trial and implementation of the $21 million Health Care Homes initiative, which forms part of the government's Healthier Medicare package that includes a clinician-led review of all 5700 items on the Medicare Benefits Schedule.

Recent data has shown that many medical practices and private hospitals are lagging well behind patients in registering with the My Health Record system, despite threats from the Government to withhold incentive payments from general practices that do not upload a minimum number of shared health summaries. However, in recent days the number of practices uploading records has been steadily increasing.

The Government needs to take a consultative approach and not jam the concept down GPs throats.

The AMA has consistently warned the Government that the new system has significant shortcomings and that they need to provide sufficient support and education for GPs to use it. Furthermore, there should be an opportunity for the Practice Incentive Program Advisory Group (PIPAG) to review reasons given by practices as to why they are not able to participate. The Federal Government needs to ensure that any future changes to the PIP Digital Health Incentive are based on PIPAG advice.

In a recent AMA survey, many GP practices said that they would not be able to comply with the new rules and had multiple concerns about the technology, including:

- that My Health Record was not a reliable source of clinical information for GPs (65.1 per cent);
- there was no demand from patients (66.7 per cent);
- there was no financial support for the extra work involved in preparing and uploading shared health summaries (67.5 per cent);
- there were unresolved issues regarding the security of the My Health Record system (61.5 per cent); and
- other health providers were not using the My Health Record and GPs saw little value in using it (61.3 per cent).

Rushing ahead with the My Health Record and linking it to PIP incentives risks undermining the support of the medical profession and may do long-term damage to the goodwill of GPs, which is essential if a national e-health system is to be successfully rolled out.

Invest in health to avoid political disaster, Gannon tells Govt

"GPs are being caught in a diabolical squeeze": Dr Michael Gannon, National Press Club

The Federal Government must boost investment in general practice and public hospitals if it wants to avoid "a major Medicare headache" at the next election, AMA President Dr Michael Gannon has warned.

As the re-elected Turnbull Government pressures Parliament to support $6.5 billion of spending cuts, including in health, Dr Gannon has called for a change in the Coalition's mindset away from seeing health as a cost and instead view it as an investment, warning that the Government's political survival is at stake.

In his inaugural address to the National Press Club, the AMA President said the knife-edge result of the Federal election showed that Australians were "very comfortable with the state being in charge of their health and education" and did not like political parties messing with the system.

"There is no doubt that health was a game-changer in the election. It was very nearly a government-changer, too," Dr Gannon said. "Without a big re-think on the range of policies that affect general practice, the Government could have another major Medicare headache at the next election".

Prime Minister Malcolm Turnbull has acknowledged the political damage the Government inflicted on itself through its plans to introduce a co-payment for GP services and its cuts to public hospital funding, and has already had several meetings with Dr Gannon in an effort to try and improve his Government's relationship with the medical profession.

But Dr Gannon said that, while the more consultative approach was welcome, it had to result in better policy, reiterating the AMA's demands for an end to the Medicare rebate freeze, increased funding for public hospitals, the restoration of bulk billing incentives for pathology and diagnostic imaging tests and increased investment in preventive health.

The Government has so far shown no signs of budging on its decision to freeze Medicare rebates until 2020 as it tries to hold health expenditure down.

But Dr Gannon said the policy was a false economy because it was hurting GPs, who were providing the most cost-effective care in the health system. Furthermore, it would result in more patients deferring seeing their family doctor and eventually requiring much more expensive hospital care, and was undermining the goodwill of GPs, which would be needed for the successful implementation of the Health Care Homes initiative.

Just 6 per cent of the Government's health spending goes on GP services, and Dr Gannon said general practice represented "very, very good value for money".

But instead of getting support, GPs were being crushed in a "diabolical squeeze" as funding has been held down and cut even as demand for their services has continued to climb.

"GPs are now at breaking point," the AMA President said. "Unless there is substantial investment in general practice, there is no doubt that the quality of care will start to suffer - and patients will face growing out of pocket costs."

Stare down the bean counters

He warned that patients who are currently bulk billed may face out-of-pocket costs of $20 or more, and even a small charge would deter some from seeking treatment, potentially leading to more complex and expensive care later on.

The health budget had to be responsible and sustainable, he said, and doctors had a role to play in helping make sure health resources were used to greatest effect.

"[But] it must not involve funding cuts, especially not cuts to services that work. It must not involve taking money from one part of the health system to fund another part of the health system," Dr Gannon said.

The AMA President urged a change in the Government's mind-set toward seeing health as an investment, not a cost.

"This will create tension within the Government. But the Prime Minister and the Health Minister must stare down Treasury and Finance to maintain health as a priority issue – and a political survival issue – for the Coalition," he warned.

Hospitals need care

While investing more in primary care and preventive health was vital, the AMA President said the Commonwealth must not shirk its responsibilities for public hospitals.

In 2014, the Abbott Government controversially walked away from the previous Labor Government's hospital funding agreement with the states, at a cost of $57 billion over 10 years.

Dr Gannon said public hospitals were "an everyday saviour for Australian families", but were failing to meet waiting time and treatment targets as "a direct consequence of the Commonwealth's failure to fund their share".

He said the States and Territories did not have the revenue base to increase their funding, and the "Commonwealth Government needs to step up".

ADRIAN ROLLINS

"He said it ...

What AMA President Dr Michael Gannon told the National Press Club

Near death

There is no doubt that health was a game-changer in the election. It was very nearly a government-changer, too. The take-home message for the Government was clear – health matters. Ignore health policy at your peril.

Smart investing

Australia does not currently have a 'health spending crisis'. It is not out of control, by any measure. Medicare spending on GP services only represents 6 per cent of total government health expenditure.

A matter of survival

The Prime Minister and the Health Minister must stare down Treasury and Finance to maintain health as a priority issue – and a political survival issue – for the Coalition.

Without a big re-think on the range of policies that affect general practice, the Government could have another major Medicare headache at the next election.

Health heroes

Public hospitals are [vital] to our health system. They are an everyday saviour for Australian families. The public hospitals, and the people who work in them, are national icons and heroes.

Skewed priorities

We are seeing behaviour by large private health insurers that reflects that their ultimate accountability is to their shareholders. Putting profits ahead of patients is not the Australian way.

Better choices

Preventive health is not about implementing a 'nanny state' or taking away people's 'choices'. Australians make bad choices about the foods they eat, the fluids they drink, and their level of physical activity every day. And that is before we even think about the latest dietary fad, flaky herbal remedy, unproven manipulation or anti-vaccination rant on the web.

Poor GP relations put 'essential' reform at risk

One of the boldest reforms to Medicare in decades could collapse if the Federal Government persists with the Medicare rebate freeze, AMA President Dr Michael Gannon has said.

Dr Gannon praised the Commonwealth's plan to establish a Health Care Home model of care for patients with chronic illness, but warned that its chances of success were being hobbled by inadequate investment and relentless Government attacks on general practice, particularly the rebate freeze.

"Unless the Government restores some goodwill by unravelling the freeze and invests the extra funding that is required for enhanced patient services, GPs will not engage with the trial, and will walk away from this essential reform," he said.

Under the model, also known as the Medical Home, patients suffering from complex and chronic health problems will be able to voluntarily enrol with a preferred general practice, with a particular GP to coordinate all care delivered.

Dr Gannon told the National Press Club the Health Care Home, if properly implemented, could deliver big improvements in quality of care, reduced hospital admissions and fewer emergency department visits.

"This is potentially one of the biggest reforms to Medicare in decades", the AMA President said, and the AMA was keen for it to succeed.

But he warned that it faced major obstacles without a change in approach by Government.

The Government has initiated a two-year trial of the Health Care Home model, involving 65,000 patients and 200 practices across 10 Primary Health Networks.

It has committed $21 million to pay for test infrastructure, training and evaluation, and has allocated more than $90 million in payments for patient services.

But the Dr Gannon said these funds were simply being shifting from other areas of health, and the Government must invest if the reform was to be a success.

"There is no new funding for the Health Care Homes trial," he said. "GPs are being asked to deliver enhanced care to patients with no extra support. This simply does not stack up."

Dr Gannon warned that "if the funding model is not right, GPs will not engage with the trial, and the model will struggle to succeed".

Adding to the Government's challenge, it is trying to recruit GP support for the policy while at the same time freezing the Medicare rebate and threatening to axe incentive payments to practices that do not upload enough health records to its My Health Record e-health system.

All this in addition to two aborted attempts to introduce a GP co-payment.

Dr Gannon said that these polices had damaged the relationship between the Government and GPs, and it would need to be repaired if Health Care Homes was to realise its potential.

"For the Health Care Home model to succeed, the Government needs to engage with and win the support of general practice. To do this, it must first overcome the significant trust and goodwill deficit attached to the co-payment saga and the Medicare freeze," he said.

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Prevention key to contain costs

The nation is "going backwards" in tackling its obesity problem and facing a blowout in health care costs unless it ramps up its health prevention efforts, AMA President Dr Michael Gannon has warned.

Reiterating the AMA's support for a sugar tax as part of a range of measures to promote healthier eating, Dr Gannon said it was not about "demonising" particular foods like Coca Cola or McDonald's but a much broader approach to help people make more informed choices and help them live more active lives.

> "We can't just have a simple idea that this is the one solution. We need a whole-of-government, whole-of-society approach investing in public health campaigns, thinking about sport and recreation …"
>
> *- Dr Gannon*

The AMA President said that a sugar tax, on its own, would not "fix the problem".

"Too often…we hear the demonisation of Coca-Cola, we see the demonisation of McDonald's, when people make bad decisions about the food they put in their mouth every day, the food that they buy from supermarkets, the fact that we all eat so much processed foods," Dr Gannon told the National Press Club.

"We can't just have a simple idea that this is the one solution. We need a whole-of-government, whole-of-society approach investing in public health campaigns, thinking about sport and recreation, thinking about how we design our suburbs, looking at traffic-light systems for healthy foods, investing in some really decent public health campaigns so that people…are making informed choices."

Dr Gannon said the burden of health costs was being largely driven by patients being hospitalised for preventable health problems like obesity, and there needed to be much greater investment in public health campaigns to improve individual wellbeing and hold down the nation's health bill.

AMA President Dr Michael Gannon meets with Prime Minister Malcolm Turnbull and Health Minister Sussan Ley at Third Avenue Surgery, Mount Lawley, Perth

"We are going backwards in addressing obesity, and the effects are felt in almost every area of the health system," where morbidly obese patients are much more difficult and expensive to treat, he said.

To help contain this cost in the long term, Dr Gannon said the Government should lift its investment in preventive health.

He said health literacy levels were low, and every day people were making bad choices about what they ate, drink and did that would have consequences for their own health and for demand for health care.

"Preventive health is not about implementing a 'nanny state' or taking away people's 'choices'," Dr Gannon said. "There are not enough public health campaigns and we continue to fund, at tremendous expense, the consequences of failures to prevent chronic health conditions."

The AMA President told the National Press Club that Australia's spending on preventive health was woefully inadequate. Just 1.7 per cent of all health spending in 2011-12 went on health prevention, compared with 7 per cent in New Zealand and 6 per cent in Canada.

He said the success of action to curb smoking, including increased taxes, marketing restrictions, no smoking rules and tobacco plain packaging laws, showed what could be achieved, and it was time alcohol was taken out of the 'too hard' basket.

ADRIAN ROLLINS

Older male doctors face scrutiny

Older male doctors who have been the subject of several patient complaints could be targeted as part of proposals to "proactively" identify those most likely to pose a risk to patients.

Members of the medical profession would be profiled on their propensity to provide sub-standard care as part of a two-pronged process to support quality care and protect patients set out by a group of experts advising the Medical Board of Australia on the revalidation of doctor skills and knowledge.

A discussion paper on options for revalidation, issued by the Medical Board on 17 August, proposed that doctors undertake a 'strengthened' CPD [Continuing Professional Development] program. Simultaneously, there would be a "proactive" screening process to identify and assess doctors who may be performing poorly and pose a risk to patients.

"CPD alone, however rigorous, may not identify the practitioner who may be putting the public at risk. A regulatory approach, however thorough, cannot reliably, single-handedly improve the quality of care provided by most competent doctors," the Revalidation Expert Advisory Group said in a report which formed the basis for options canvassed in the discussion paper.

The expert group recommended that all practitioners undertake evidence-based, profession-led CPD activities that, in addition to attending conferences and workshops, would involve peer review of performance and medical records, feedback from patients, clinical audits and comparison of data with local, regional and national outcomes.

Medical Board Chair Dr Joanna Flynn said the intention was to keep the public safe and manage risk to patients, and "part of this involves making sure that medical practitioners keep their skills and knowledge up-to-date".

The recommendations come amid concerns that regular reports of misconduct by a small number of doctors are undermining public confidence and damaging the reputation of the medical profession.

In an interim report to the Medical Board, the Revalidation Expert Advisory Group said international evidence showed that only about 6 per cent of doctors provided sub-standard care.

The group said it was critical to "develop accurate and reliable indicators" so that practitioners who were performing poorly and posing a risk to their patients could be identified and helped before they harmed anyone.

"Prevention is better than cure," the group said in its interim report, setting out the characteristics international experience showed were most common in those likely to pose a risk to patients, including:

- being 35 years or older (with the risk increasing as age advances);
- being male;
- number of prior complaints; and
- time since last complaint.

The interim report said studies had identified a number of additional individual risk factors, including:

- doctors getting their primary medical qualification in certain countries (not specified);
- specialty;
- failing to respond to feedback;
- an unrecognised cognitive impairment;
- practising in isolation;
- few high quality CPD activities; and
- a change in the scope of practice.

"We propose that there is now enough evidence to trigger discussion and draw on insights available about how various risk factors might be used to proactively identify practitioners at risk of poor performance," the export group said.

Once groups of at-risk practitioners were identified, it was important to determine which individuals actually posed a threat to public safety.

Just because someone was in an at-risk group did not mean they were underperforming, the interim report said, emphasising that early detection and remediation was preventive and should not be punitive.

Those identified as underperforming would face a "tiered approach" of assessment, scaled to match the level of potential risk.

It would start with specialty-specific "multi-source feedback" involving input from colleagues, patients and co-workers – a process the expert group judged would be effective many cases in returning doctors to safe practice.

Doctors assessed as posing a greater threat could face peer review of their medical records, and practice and outcomes data.

Those determined to be the greatest risk to patients would face "extensive performance assessment".

The Medical Board said the proposed changes would not have

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"a significant impact" on doctors already undertaking effective CPD activities, though some would need to change their focus to include performance review, outcome measurement and validated educational activities.

It likened the profiling used to identify at-risk practitioners to disease screening tests.

"Most of the practitioners in the at-risk groups will be able to demonstrate that they are performing satisfactorily, just as most people who are screened in a public health intervention do not have the disease for which the screen program is testing," the Board said.

The Board has appointed a committee to conduct consultations with the medical profession and the broader community regarding the revalidation proposals.

Those interested are invited to participate in online discussions, take a short survey and provide written submissions. The deadline for feedback is 30 November this year,

The Revalidation Expert Advisory Group will provide a final report to the Board in mid-2017.

For further details, including copies of the discussion paper and interim report, go to: http://www.medicalboard.gov.au/News/Current-Consultations.aspx

ADRIAN ROLLINS

INFORMATION FOR MEMBERS

1 NOVEMBER 2016 – AMA LIST OF MEDICAL SERVICES AND FEES

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

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

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

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

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

Access the Fees List via the AMA website

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

Access the AMA Fees List Online Database

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

AMA Fees Indexation Calculator

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

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

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

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

Insurers pick wrong target in war on health costs

AMA President Dr Michael Gannon has accused the major private health funds of "squeezing" patients, doctors and hospitals in pursuit of ever-greater profits.

Hitting back at Medibank Private claims that "market failure" in the health system was driving up the cost of care, particularly some surgical procedures, Dr Gannon denied doctors were forcing up costs and instead blamed insurers for pushing more of the expense on to patients and providers.

"Insurers are trying to contain costs everywhere, and it's very difficult for the Government and the industry if the industry is in profit mode," the AMA President told *The Australian*. "They are looking to cut costs wherever it is possible and there are reasonable and appropriate ways in which they can do that, and there are other ways which involve squeezing doctors, squeezing hospitals and squeezing patients."

Dr Gannon said costs were being driven by a mix of factors including the cost of prostheses, rising wages, technological advances, soaring drug prices and an ageing population, which meant that patients were increasingly presenting with a complexity of health problems.

But he said there was little evidence that doctors were responsible for driving up costs.

Medibank Private Executive General Manager Dr Andrew Wilson has used a three-year-old report showing that Australians were paying among the highest costs in the world for cataract surgery and knee and hip replacement as evidence of market failure that was making the nation's health system internationally uncompetitive.

Dr Gannon said that while international comparisons were important, and it was understandable that Medibank was looking to contain its costs, the fact was that the "vast majority" of operations were provided at no direct cost to the patient.

He said that 86 per cent of operations involved no gap payment, and a further 7 per cent included a known gap of less than $500. Doctor fees typically accounted for between 5 and 7 per cent of the cost of elective surgery in a private hospital.

"So, when we look at the increase in the costs year-on-year in private health care, the doctor's fee represents a very small part of that. The doctor's fee is very rarely the issue," he said.

Dr Wilson said patients were being denied access to the information needed to assess whether or not the prices they were being charged represented good value for money, such linking specialist fees with clinical outcomes.

"While such data undoubtedly exists, it is unavailable to consumers, leaving them with little information to make informed decisions on medical specialists – a classic example of market failure," the Medibank executive said.

But the same study, the *2013 Comparative Price Report* prepared by the International Federation of Health Plans (IFHP), showed for many common procedures such as childbirth, appendectomy and angioplasty, costs in Australia were comparable with those of most other developed economies, and well below those charged in the US.

It found that hospital costs per day in Australia were almost half of those charged in New Zealand and less than a third of the US cost, charges for MRIs and CT scans were moderate by international standards, while the normal delivery of a baby cost on average US$6623, compared with US$8307 in Switzerland and US$10,002 in the US.

Australian Private Hospitals Association Chief Executive Michael Roff accused Medibank of being "in a time warp" in its search for figures to justify Dr Wilson's claims.

Mr Roff said cost comparisons in 2013 had been distorted by the strength of the Australian dollar against the US currency, and more recent 2015 data showed "Australia is indeed competitive based on the IFHP analysis, and is not the most expensive country by any measure".

This included figures showing the cost of cataract surgery in Australia was 16 per cent cheaper than in the US last year, and was also lower than in the United Kingdom, he said.

Dr Gannon said all had an interest in ensuring the health system delivered value for money.

"It's in the interest of all of us to look at good stewardship, reduce complication rates, contain costs where possible, that's in the interests of everyone because ultimately it's the taxpayers of Australia that foot these bills," he said. "The doctor's fee is a small part of the issue, but we want to work with Government, with insurers, to make sure that Australian taxpayers and, especially those who put their hand in their pocket for private health insurance, get really good value for money."

ADRIAN ROLLINS

Bumper profits come at a heavy price

Medibank Private has headlined a year of bumper returns for private health insurers, announcing a 46 per cent surge in after-tax profits to reach $417.6 million, underlining concerns that the industry is pursuing financial returns at the expense of patients and service providers.

The latest snapshot of health fund finances shows that premium revenue across the industry surged by 6.4 per cent in the year to 30 June to reach $22 billion, far outstripping a 5.3 per cent increase in payouts ($19 billion), delivering insurers a healthy after-tax profit of $1.21 billion – up 8.8 per cent from the previous financial year.

The stunning results come amid widespread discontent about the behaviour of the health insurance, including large premium increases, complex and poorly explained health policies, arbitrary changes in coverage, routine attempts to contest and delay payouts, and aggressive negotiation tactics with hospitals and other providers.

The Federal Government has announced changes to improve the value of health policies, including mandating minimum levels of cover and banning junk public hospital-only policies, and in his speech to the National Press Club AMA President Dr Michael Gannon lambasted the sector for prioritising profits over patients.

"Increasingly, we are seeing behaviour by large private health insurers that reflects that their ultimate accountability is to their shareholders," Dr Gannon said. "If the actions of the funds continue unchecked and uncontested – especially their aggressive negotiations with hospitals and their attacks on the professionalism of doctors – we will inevitably see US-style managed care arrangements in place in Australia."

While Medibank attributes much of its strong profit result to unexpectedly low claims, it has also been aggressively cutting costs and undertaking "claim control" initiatives.

Across the industry, insurers are looking to claim day on payouts, including by pushing more of the cost of treatment on to policyholders.

Patients faced a 6.9 per cent jump in out-of-pocket costs for hospital services last year, paying out on average $301.22.

Worryingly for Medibank and other insurers, there are signs that disenchanted policyholders are starting to vote with their wallets.

Medibank has reported a 2.6 per cent decline in customers, while premium revenue grew by just 5.1 per cent despite a Government-approved increase of 6.59 per cent, showing that many chose to downgrade their cover.

Industry-wide, the number of policies sold increased by just 0.57 per cent, less than half the rate of population growth, and the number insured grew only 0.46 per cent.

The industry's struggles are only likely to intensify in coming months. Government measures to extend the freeze the threshold for the Medicare Levy Surcharge, $180,000 a year for families and $90,000 a year for singles, have come into effect. The thresholds will be frozen at current levels until 2021, when they will be roughly equivalent with average full-time incomes.

The Government is also planning to put a three-year freeze on the thresholds for the Private Health Insurance rebate before Parliament, which would see an increasing proportion of households kicked off the rebate.

Adding to Medibank's woes, the consumer watchdog has taken the insurer to the Federal Court alleging it engaged in misleading and unconscionable conduct by cutting the benefits it would pay without informing policyholders.

Nonetheless, the industry is well placed financially. Total assets increased by almost a billion last financial year to reach $12.8 billion, and are growing at double the rate of liabilities, which were just $5.7 billion in 2015-16.

ADRIAN ROLLINS

Costs force ill to skip care

Almost half of patients with depression, anxiety or other mental health conditions and a third of those suffering asthma, emphysema and other chronic respiratory illnesses are skipping treatment because of out-of-pocket costs.

As the Medicare rebate freeze forces a growing number of general practices to cut back on bulk billing and increase patient charges, researchers have found that out-of-pocket costs for medical services and medications are deterring many with chronic illnesses from seeing their doctor or filling their prescription, potentially making their health problems more difficult and costly to treat.

They found that those with mental illnesses were the most price sensitive – 44 per cent reported deferring an appointment or leaving a script unfilled because of cost, as did 32 per cent with asthma or chronic obstructive pulmonary disorder and 27 per cent of those with diabetes. Even a fifth of cancer patients reported skipping treatment because of the expense.

Out-of-pocket charges were cited as a barrier to care even for some of those without a long-term health problem – 9 per cent said deferred care because of cost.

Lead researcher Dr Emily Callander from James Cook University said that although, as a whole, Australia enjoyed good health outcomes, her study showed that out-of-pocket costs were a substantial barrier to care, particularly for vulnerable and at-risk patients like the chronically ill.

She said the problem was particularly acute for patients with mental health problems.

"Those with mental health conditions were shown to have particularly large out-of-pocket expenditure and be more likely to forgo care, which indicates that the costs of mental health services may be prohibitively high," Dr Callander and her colleagues wrote.

Out-of-pocket costs high

The research, which is part of an international Commonwealth Fund health policy study and draws on data from a NSW Bureau of Health Information survey of 2200 respondents, found that out-of-pocket expenses for Australia patients were high by world standards.

It showed that Australians paid an average of $1185 in out-of-pocket costs, compared with $987 for Germans, $947 for Canadians, $639 for New Zealanders, $488 for British patients and $421 for the French.

Dr Callander's said research showed expenses for patients with chronic illnesses can be particularly high.

Stroke survivors, for example, spent an average of $1110 a year on health costs, including up to $32,411 in the first 12 months following their stroke. Those with arthritis, meanwhile, paid out an average of $1513 a year on treatment, with some spending as much as $20,527.

Those with asthma, emphysema and COPD reported spending an average of $1642 a year on out-of-pocket expenses, while those with a mental illness spent $1350 a year and those with high cholesterol spent $1423 annually.

By comparison, those without a chronic illness spent on average $660 a year on out-of-pocket health costs.

Dr Callender said the point of her research was not that out-of-pocket costs were inherently wrong, but could have a much more significant effect on vulnerable patients, like the chronically ill, than the broader community.

"I don't think that out-of-pocket costs per se are a bad thing," the researcher said. "I am not saying that we should not have them.

"But while maybe a $30 GP out-of-pocket charge might not seem much to most of us, for someone with a chronic disease who is unemployed it might seem a lot. For them it might mean a choice between seeing the doctor or having some extra food.

"It is the disadvantaged – the people with low incomes and ones with chronic health problems – who are the worst affected."

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Chronic catch-22

The chronically ill are caught in a double-bind. They often face much higher health expenses than most, while the effect of their illness can be to make it difficult for them to work.

Dr Callender said it was well documented that people with chronic illnesses were on lower incomes, had less wealth, and were more likely to be in income poverty, "which is likely because of the effect that chronic health conditions have on their ability to participate in the labour force".

And the more they defer or forgo treatment, the worse their health becomes and the more expensive the treatment required.

Dr Callender's research found that the combined effect of high out-of-pocket expenses and low incomes was to force 25 per cent of chronically ill Australians to skip care, exceeded only by the United States, where 42 per cent of patients with a chronic illness said they deferred treatment because of cost. By comparison, just 8 per cent of chronically ill Swedish patients and 5 per cent of British patients admitted to the same thing.

While in the past research had concentrated on a lack of available services as a common barrier to care, Dr Callender said the effect of cost had often been overlooked.

"The [study shows] that the cost of health care does act as a barrier to receiving treatment, particularly for those with mental health conditions," the researcher said. "These findings come at a vital time when there has been much discussion abour the possibility of raising the cost of healthcare to individuals."

She said it was of "vital importance" that there be policies aimed at promoting affordable health care for at-risk and vulnerable patients, "to ensure that out-of-pocket cost is not a barrier to treatment and do not widen the gap in health status between those of high and low socioeconomic status".

ADRIAN ROLLINS

AMA calls for independent scrutiny of asylum seeker health

Disturbing accounts of sexual assault, neglect and harm among asylum seekers being held at the Nauru detention centre reinforce the need for oversight by an independent statutory body of clinical experts, AMA President Dr Michael Gannon has said.

Leaked details of more than 2000 incident reports from staff at the Nauru Regional Processing Centre, published by *Guardian Australia*, reveal a litany of abuse, self-harm, sexual assault, inadequate health care and deplorable living conditions at the centre. The details come less than a week after a joint Amnesty International-Human Rights Watch investigation resulted in a scathing assessment of conditions at the centre.

Dr Gannon said the "disturbing" revelations, particularly regarding the treatment of children, leant fresh urgency to long-standing AMA calls for much greater scrutiny of detention centre operations and the provision of health services to asylum seekers.

"These disturbing reports echo long-held concerns by the AMA about the lack of proper physical and mental health care being provided to people in immigration detention," Dr Gannon said. "The reports detail high levels of trauma and mental illness, especially in children being detained on Nauru."

The AMA regularly received reports from asylum seekers and their advocates – from within and outside the medical profession – detailing failures to provide proper physical and mental health treatment and services for asylum seekers, he said, and called for children to be removed from detention and placed into care in the community.

Prime Minister Malcolm Turnbull said the information published by the Guardian would be "carefully examined to see if there are any complaints there or issues there that were not properly addressed".

But Treasurer Scott Morrison, who was Immigration Minister during much of the period covered by the incident report, said that at this stage they were merely allegations: "They are not findings of fact in relation to an incident".

Conditions at the Nauru detention centre have been condemned by Amnesty International and Human Rights Watch, who have accused the Federal Government of a deliberate policy of "appalling abuse and deliberate neglect" in its treatment of refugees and asylum seekers being held there.

In their report, based on interviews with 84 refugees and asylum seekers as well as an unspecified number of service providers, the non-government organisations described medical facilities on Nauru as rudimentary and said those with serious conditions frequently faced long delays before receiving specialist care.

> "In one account, a service provider said ambulances sometimes took up to three hours to respond to calls from the centre, and often people were discharged from the local hospital while they were still sick or half-conscious"

In one account, a service provider said ambulances sometimes took up to three hours to respond to calls from the centre, and often people were discharged from the local hospital while they were still sick or half-conscious.

"We are not allowed to ask the hospital why they are being discharged, or what medication they've been prescribed, or for their medical records," the service provider said.

Among the 2116 incident reports from detention centre guards, caseworkers and teachers leaked to *Guardian Australia* are numerous accounts of children threatening to kill themselves, engaging in highly sexualised behaviour, or suffering great emotional distress.

In one account, a group of security guards was heard to laugh moments after one of them was called to a young girl who had sewn her lips together. In another, a teacher reported that a student was "dreaming of blood and death and zombies" because his mother was on hunger strike and refused to hug him. Several reports detailed children sitting on the laps of security guards, including one girl who was "leaning her backside into the crotch of [name redacted]", and a boy who was being bounced on the lap of a guard who was whispering in his ear.

Amnesty International and Human Rights Watch representatives who visited the island for 12 days last month said the circumstances in which people were being detained - a third

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of the 1200 refugees were living in cramped tents in hot and humid conditions, and all were limited to two-minute showers and forced to use filthy toilets – were physically draining and exacerbated mental health problems.

"Prolonged detention in appalling conditions exacerbated the trauma many had suffered from persecution in their home countries," the report said.

Many of those interviewed reported having developed severe anxiety, insomnia, mood swings, prolonged depression and short-term memory loss while on the island, while children were suffering from nightmares and engaging in disruptive and troubling behaviour.

"Adults and children spoke openly of having wanted to end their lives. More than a dozen of the adults interviewed said they had tried to kill themselves...and many more said that they had seriously considered ending their lives," the report said.

It included the account of a nine-year-old boy who told his mother that, "I want to burn myself. Why should I be alive? I want my daddy. I miss my daddy", after his father was transferred to Australia, without his family, for medical treatment.

Amnesty International and Human Rights Watch said support and treatment for those suffering mental health problems was inadequate, and patients whose illness was severe enough to justify their transfer to Australia were returned several months later to the same conditions that had contributed to their trauma in the first place.

Dr Gannon said such treatment was unacceptable.

"The AMA's position is clear - people who are seeking, or who have been granted, asylum within Australia have the right to receive appropriate medical care without discrimination, regardless of citizenship, visa status, or ability to pay," Dr Gannon said. "Asylum seekers and refugees under the protection of the Australian Government should be treated with compassion, respect, and dignity."

The AMA has reiterated its call for the creation of a national statutory body of clinical experts, independent of Government, with the power to investigate and report to the Parliament on the health and welfare of asylum seekers and refugees in Australia and in offshore detention.

"Australia's atrocious treatment of the refugees on Nauru over the past three years has taken an enormous toll on their wellbeing," Human Rights Watch Senior Counsel on Children's Rights Michael Bochenek said. "Driving adult, and even child, refugees to the breaking point with sustained abuse appears to be one of Australia's aims on Nauru."

Amnesty International Senior Director of Research Anna Neistat, who was one of the researchers who visited Nauru, condemned the treatment of asylum seekers as "cruel in the extreme".

The human rights organisations said the Australian Government's failure to address what they described as serious abuses "appears to be a deliberate policy to deter further asylum seekers from arriving in the country by boat".

But the Department of Immigration and Border Protection rejected the findings of the Amnesty report, which it said was conducted without consultation.

"We strongly refute many of the allegations in the report, and would encourage Amnesty International to contact the Department before airing allegations of this kind," it said in a statement.

The Department said Australia did not "exert control" over the Nauruan Government, though it did fund accommodation and support services for "all transferees and refugees, including welfare and health services".

"We welcome independent scrutiny of regional processing matters, noting that access to the [Regional Processing] Centre is a matter for the Government of Nauru."

But the Government's has been accused of trying to hide its treatment of asylum seekers behind a shroud of secrecy.

The Australian Border Force Act, passed last year, threatens up to two years imprisonment for detention centre staff and contractors who publicly disclose information about operations.

But Dr Gannon said doctors should be able to speak out without fear of retribution or prosecution, and the legality of the Act is being challenged in the High Court by the group Doctors for Refugees.

The AMA Federal Council is also looking into claims former medical director of mental health services for detention centre contractor International Health and Medical Services, Dr Peter Yong, was subject to surveillance by the Australian Federal Police.

ADRIAN ROLLINS

Blocking overseas practitioners won't solve rural doctor shortage

The nation needs to do more to encourage medical practitioners to work in under-served rural areas rather than simply seek to choke off the supply of overseas-trained doctors by tightening visa rules, AMA President Dr Michael Gannon has said.

Responding to a report in *The Australian* that the Health Department wants to axe visas for imported doctors to make room for a growing number of domestic medical graduates, Dr Gannon said the real issue was to improve the attractiveness of rural practice for doctors, regardless of where they come from.

A surge in the number of medical graduates in recent years has eased fears of a doctor shortage, leading some to argue the country no longer needs to rely on the recruitment of doctors from overseas to plug gaps in the medical workforce.

But, while acknowledging the big jump in medical graduates had altered the landscape, Dr Gannon said the Health Department's proposal to remove 41 health jobs from the Skilled Occupations List was misdirected.

Dr Gannon said for several decades overseas-trained doctors had been a valued part of the health system, helping ameliorate the effects of a long period of under-investment in medical training.

He said it was important that those with special skills or talent continued to have the opportunity to work in Australia.

Instead of blocking doctors from overseas, the focus should be on addressing the misallocation that sees most doctors, whether locally trained or from overseas, congregating in practices in the major cities rather than moving into rural areas where they were most needed, Dr Gannon told ABC radio.

"We just have to look at a system which is not delivering on its stated intention, which is to get doctors where they're really needed," the AMA President said. "What we've seen now is that we've got a reasonable oversupply of GPs and other specialists in inner-metropolitan Australia, and I think what we need to work harder on is investing in incentives to get doctors to work in rural areas."

Dr Gannon said country practice was a "very, very rewarding professional career", and evidence showed that junior doctors given opportunities to train in rural areas were far more likely to work there.

The AMA has urged increased Commonwealth investment in rural training, and late last year the Government announced the establishment of a $93.8 million Integrated Rural Training Pipeline to improve the retention of postgraduate prevocational doctors in country areas.

Dr Gannon said that while the funding was welcome, it did not come close to replacing the Prevocational General Practice Placements Program (PGPPP) scrapped in the 2014 Budget, and much more effort was needed, particularly to encourage more procedural GPs to set up in the bush.

The AMA has proposed a Community Residency Program which would allow doctors in training to undertake rotations of up to 13 weeks to give them a good experience of life as a rural GP and to enhance their clinical experience.

"The abolition of the PGPPP has left general practice in a position where it is the only major medical specialty unable to offer doctors in training a structured prevocational training experience before they make a career choice," Dr Gannon said.

"The Community Residency Program would provide them with opportunities to undertake important general practice prevocational training in an effort to encourage more young doctors to choose a career in general practice."

The AMA President said it would complement the Government's plan to establish a National Rural Generalist Pathway as a way to address rural workforce issues.

ADRIAN ROLLINS

Late-life IVF 'selfish and wrong': Gannon

> "As a community, we need to consider the rights of the child, the rights of society, the responsibilities of proper parenting, the health of the parents, the health risks to the child at birth and beyond, and the costs to the health system and the taxpayers that fund it" - *Dr Gannon*

AMA President Dr Michael Gannon has called for the "mother of all debates" over the funding and regulation of assisted reproduction following revelations that a 63-year-old Tasmanian woman has become a first-time mother using IVF technology.

Dr Gannon criticised the mother's decision to use IVF to conceive a child at such an advanced age as "selfish and wrong", and said the community needed to consider carefully who should have access to assisted reproduction technology, and the consequences it can have for children, parents and broader society.

"As a community, we need to consider the rights of the child, the rights of society, the responsibilities of proper parenting, the health of the parents, the health risks to the child at birth and beyond, and the costs to the health system and the taxpayers that fund it," the AMA President said. "This must not be narrowly viewed as a women's rights issue. Nor is it about ageism."

Dr Gannon, who is a Perth-based obstetrician, sparked a firestorm of comment after he responded to news of the birth by commenting on Twitter that the use of IVF to have a child so late in life was "madness". He said that not only were women "not designed" to give birth in their 60s, but the decision disregarded the rights of the child and the burden on taxpayers.

Critics accused Dr Gannon of making a moral judgment about the mother and downplaying the role of the father, who is 78 years old.

But the AMA President said there were compelling medical, social, financial and ethical reasons for ensuring that such cases did not become commonplace.

Most IVF clinics in Australia do not offer treatment to women beyond the age of 53 years, and the Tasmanian mother went overseas to be impregnated with a donor embryo before returning to Australia and giving birth at 34 weeks at Melbourne's Frances Perry House private hospital.

Dr Gannon said there was good reason why Australian IVF services would not treat a woman so late in life.

He said that from around the age of 30 years onward problems associated with pregnancy and birth gradually increased, including miscarriage, chromosomal abnormalities, pre-eclampsia and the risk of stillbirth: "None of this is avoidable, and no amount of anti-oxidant supplements or kale smoothies can arrest the inevitability of ageing".

By the time women were in their 50s and 60s, the effect of ageing on their blood vessels meant they were more susceptible to blood clots, heart attacks and strokes – "a potentially high price to pay to have a baby".

Dr Gannon said the baby, because it was born premature, also faced an elevated risk of health problems such as breathing difficulties and jaundice, and would be more vulnerable to chest infections, asthma, diabetes and hypertension later in life. Because it potentially missed out on crucial in utero brain development, the child could also experience learning problems and developmental delay.

Costs to society and taxpayers also needed to be considered, he said. It cost about $2500 a day to care for a baby in the Neonatal Intensive Care Unit, much of it subsidised by the taxpayer, and such demands diverted resources from other parts of an already-stretched health system.

He said the decision of couples denied IVF in Australia to seek treatment overseas was "not simply an expression of choice, or a case of 'user pays'. The health system picks up the bill".

Dr Gannon said the birth of a child to a 63-year-old mother was not what the pioneers of IVF had in mind when the developed the technology in the late 1970s.

"This amazing technology has brought much joy to many across the world. But just because medical science can do something does not mean we have to do it, or should do it," he said. "Stories like this cannot become the norm. Let's talk to Australian women and men about starting their families in their 20s, not normalise the dubious use of medical science and powerful hormones to wake the womb from its normal, physiological, post-menopausal sleep."

ADRIAN ROLLINS

Nurturing the AMA's future leaders

AMA Future Leader Program participants visit Parliament House, Canberra

In adopting its strategic plan for 2015-2017, the Board of the AMA recognised that one of the key responsibilities of the AMA is to develop its future leaders.

To address this need a program to develop potential leaders in the AMA was launched in 2016, aimed at members within the first five years of joining a State or Federal AMA committee, council or board.

Following a call for applications, 11 doctors in training, including the winner of the 2016 DiT of the Year Award, Dr Ruth Mitchell, participated in an immersion program on AMA advocacy, federal politics and health policy, the life of an MP, understanding how the Parliamentary system works, and using the media and social media.

The group had presentations from Member for Canberra, Gai Brodtmann, the Director General of Health in the ACT, Nicole Feely, the Clerk of the House of Representatives, David Elder, and senior members of the Senate staff.

The policy and media teams from Federal AMA worked through case studies outlining the effectiveness and influence of AMA advocacy, including the use of media and social media to publicise and advance the AMA policy agenda.

The weekend was well received by participants and will become a regular feature of the annual calendar.

ANNE TRIMMER

Chiro caught up in crackdown

A chiropractor has been charged with false advertising in the latest action by regulators to crack down on practitioners making inflated health claims or practising outside their area of expertise.

The Australian Health Practitioner Regulation Agency (AHPRA) has taken a New South Wales chiropractor to court over allegations that his website advertised services "in a way that was likely to be false, misleading or deceptive".

The case follows recent action in which chiropractor Dr Ian Rossborough was banned from manipulating the spines of children younger than six years after a video in which he cracked the back of a four-day-old baby was made public.

In June, AHPRA imposed a number of conditions on Dr Rossborough including banning him from any chiropractic treatment of children younger than two years and excluding any spinal manipulation for two to six-year-olds. In addition, he will be subject to monitoring and assessment by the Chiropractic Board of Australia.

The cases underline long-standing AMA concerns about health professionals promoting and practising unproven therapies.

While evidence-based aspects of complementary medicine can be part of patient care, unproven therapies could put patient health at risk, either directly through misuse, or indirectly where patients defer seeking medical advice or fail to inform a treating doctor about a complementary medicine they may be taking.

The AMA said children were a particularly vulnerable group because of the complexities of diagnosing and treating their ailments, and a medical practitioner should always be informed of any diagnosis and ongoing treatment plan.

There have been several reports of chiropractors "sneaking" into maternity wards to treat newborn babies without the knowledge and consent of either hospitals or treating doctors, and the Chiropractic Board told Fairfax Media it was investigating a number of such complaints.

Chiropractic Australia President Rodney Bonello told the *Sydney Morning Herald* many in the profession were horrified and embarrassed by such actions.

"If there's no [hospital] approval, then that's a travesty and should never be acceptable," Professor Bonello said.

The Chiropractic Board said that chiropractors must provide evidence-based care, and "are expected to practise safely and within the limits of their competency, training and expertise".

ADRIAN ROLLINS

AMA in action

The AMA, under the leadership of President Dr Michael Gannon, has been operating in high gear. After the AMA's success in helping push health to the top of the agenda during the Federal election campaign, Dr Gannon and his leadership team have been working hard to keep it there.

In the past month Dr Gannon has met with Prime Minister Malcolm Turnbull (his second meeting with the PM since the election) and Health Minister Sussan Ley, as well as with Shadow Health Minister Catherine King.

He used the AMA President's annual address to the National Press Club to urge the Government to re-think its approach to health policy and make it a focus of investment, not cuts. He warned that the Medicare rebate freeze was not only hurting patients and doctors, but was standing in the way of reforms such as the Health Care Home model of chronic disease care.

Dr Gannon continued his work of meeting with other peak health organisations and advocates, including a discussion of shared interests and concerns with the Consumer's Health Forum.

Reflecting the AMA's strong commitment to quality medical training and fostering the medical leaders of the future, Dr Gannon addressed the Australian Medical Students' Association conference in Hobart, and the AMA Secretariat hosted a two-day Future Leaders program in which 11 doctors in training heard presentations from Federal MPs, senior bureaucrats, high ranking Parliamentary officials and senior AMA staff on federal politics, health policy, AMA advocacy and nation media.

The August meeting of the AMA Federal Council included a speech from Dr Graeme Killer, former principal medical adviser to the Department of Veterans' Affairs and personal physician to several Prime Ministers and Governors-General, who was presented with his AMA President's Award by Dr Gannon.

ADRIAN ROLLINS

AMA President Dr Michael Gannon presents former personal physician to Prime Ministers and Governers-General Dr Graham Killer with the AMA President's Award

AMA President Dr Michael Gannon (r) with AMA Vice President Dr Tony Bartone, AMA Federal Council Chair Dr Bev Rowbotham (second from l) and Medical Board of Australia Chair Dr Joanna Flynn at the August AMA Federal Council meeting

AMA President Dr Michael Gannon meets with Shadow Health Minister Catherine King at St John of God Subiaco Hospital

AMA President Dr Michael Gannon meets with Consumer's Health Forum CEO Leanne Wells and Chair Tony Lawson

Health on the hill

POLITICAL NEWS FROM THE NATION'S CAPITAL

Assisted dying advocates won't lie down

The major parties are being challenged to declare their position on assisted dying after the Australian Greens announced plans to introduce national assisted dying legislation during the current term of Parliament.

As a review of the AMA's policy on euthanasia and physician-assisted suicide reaches its final stages, Greens leader Senator Richard Di Natale has flagged his intention to put proposed Dying with Dignity laws up for debate.

"It's never easy to talk about death, but our political leaders need to have the courage to take on challenging issues, especially when it concerns the rights of every Australian," Senator Di Natale said. "The Greens believe that patients with intolerable suffering should have the right to have a say in the timing of their death. As a doctor, I know many patients would be comforted just by knowledge that the right existed, even if they never exercised it."

While history suggests the Greens will fall well short of the support they need to make their Bill law, there is a growing push to make assisted dying legal.

In Victoria, a cross-party parliamentary committee has recommended that assisted dying be legalised for patients with serious and incurable illnesses, and high-profile television producer Andrew Denton has founded Go Gentle Australia to campaign for the right for patient to choose what happens at the end of their life.

In a nationally televised speech, Mr Denton accused conservative politicians from both the major parties of conspiring to thwart efforts to legalise euthanasia, and called on those with religious or moral objections to assisted dying to accept the right of others to have such a choice.

The presenter has urged the adoption of laws that, subject to strict criteria, would provide legal protection for doctors who assisted patients with terminal illness to die.

He said it would not be "a licence to bump off granny", and would in practice make legal what was "already happening in Australia without regulation, without support, without transparency or accountability and, from the evidence received, sometimes without consent".

The Greens Bill follows similar legislation in Canada and California.

In Canada, the Trudeau Government has proposed laws to allow adults with serious and irreversible medical conditions to seek a doctor-assisted death. To do so they must apply

in writing, with two witnesses, and the request must be evaluated by two doctors or nurses. Once a request is granted there is a mandatory 15-day waiting period.

California has passed laws that allow people with less than six months to live to seek physician-assisted death, subject to assessment that they are of sound mind.

But in the United Kingdom, the House of Commons last year overwhelmingly rejected a similar proposal.

The issue of assisted dying was debated at length at the recent AMA National Conference, where a panel of medical practitioners and a medico-legal expert argued the merits of the idea.

Though there were sharply divergent views on whether or not doctors should be involved in helping patients to die, there was broad agreement that the medical profession could do better in supporting patients, families and friends at the end of life.

At the time of going to press, the results of an AMA member survey on the issue were to be discussed at the AMA Federal Council, along with issues raised at the National Conference forum and a separate consultation on current AMA policy conducted through the pages of Australian Medicine.

Doctors, nurses and other health professionals working in acute care settings can learn more about caring for patients approaching death and their families through Flinders University's End-of-Life Essentials package. The free online resource includes three learning modules looking at managing end-of-life issues in hospitals, recognising dying, and communication and decision-making.

The modules can be accessed at: www.caresearch.com.au/EndofLifeEssentials

ADRIAN ROLLINS

Health on the hill

POLITICAL NEWS FROM THE NATION'S CAPITAL

When to pull the plug

Is there really such a thing as a fate worse than death?

Seriously ill patients at a Philadelphia hospital certainly think so.

In a novel study, researchers asked 180 patients with advanced cancer, severe heart failure or restrictive lung disease, to rate various states of functional debility relative to death, including incontinence, mechanically-assisted breathing, being bedridden, relying on a feed tube, chronic moderate pain, and being confined to home or a wheelchair.

Two-thirds thought suffering bowel and bladder incontinence or relying on a breathing machine to live would be equal to or worse than death, as was being bedridden.

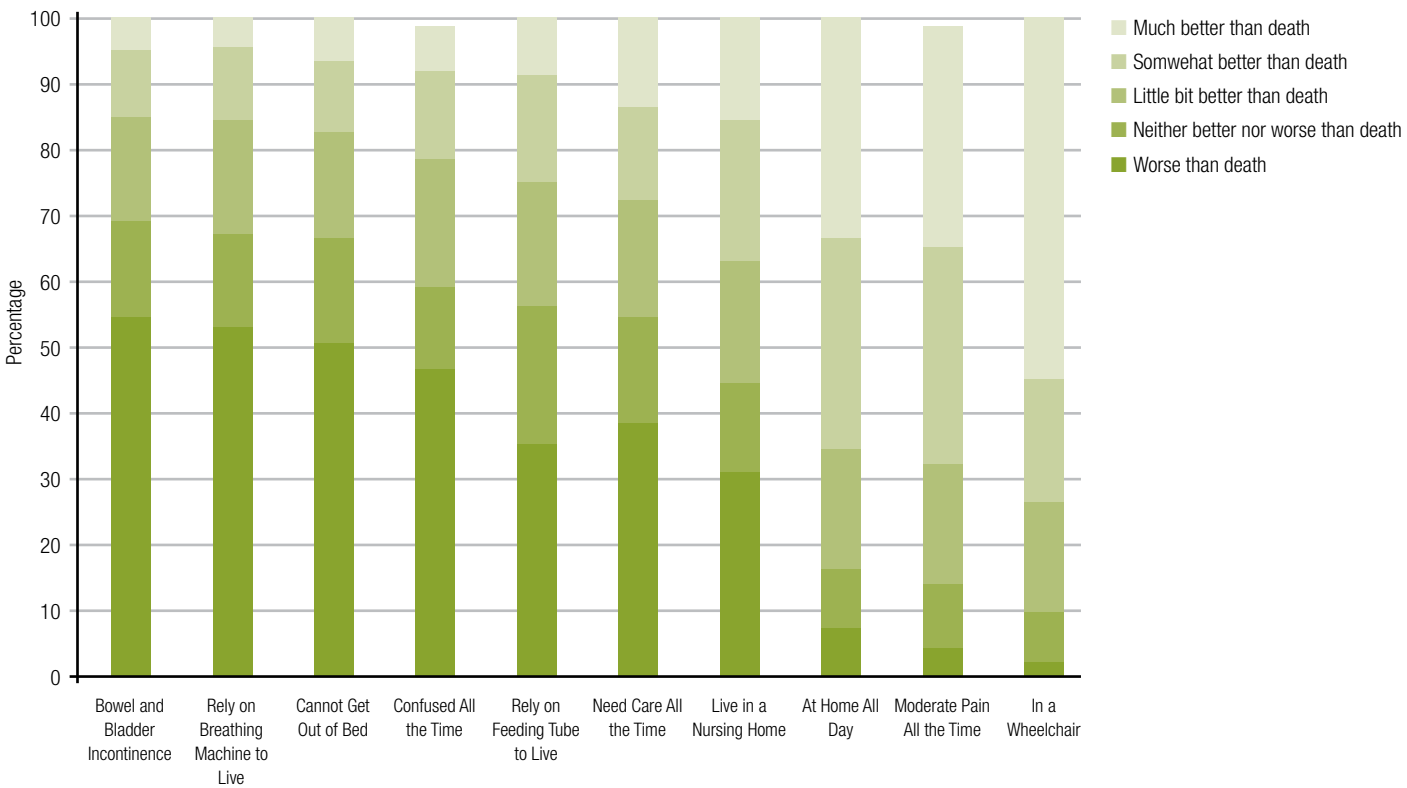
Just over half thought being perennially confused would be equal to or worse than death, as was being in constant need of care.

By contrast, few thought being confined to a wheelchair, being in constant moderate pain or being stuck at home all day was such a grim fate. And though a third thought relying on a feeding tube to live was worse than death, more thought it was preferable to dying.

The study was published in *JAMA Internal Medicine.*

ADRIAN ROLLINS

Ratings of States of Functional Debility Relative to Death by Hospitalised Patients with Serious Illness



Distribution of patient ratings of each queried health state on a 5-point Likert scale

A 30-year view of general practice in Australia reveals huge changes

BY PROFESSOR STEPHEN LEEDER

That general practice has survived upheavals in payment methods, changing health policy, substantial shifts in disease profile towards the chronic end of the spectrum, IT and computerisation and corporatisation surely speaks of a level of admirable resilience and ability to shift gears when required.

This has occurred in tandem with major changes to the general practice workforce, which has increasingly become part-time. But all these changes are not free of side-effects.

> "I am not aware of any formally-acquired evidence that the move from Medicare Locals to PHNs has had a health impact, but as I speak to those operating PHNs several positive messages are common"

The notion of a practice providing 24/7 cover from within its own staff has decreased in power. Major, unanswered questions arise in the context of continuing care for the increasing number of patients with complex and chronic conditions where connectivity to a person who knows them and has their case notes in front of them when they call out-of-hours for help seems a distant memory.

MLs v PHNs

A recent change, of which I was originally very sceptical, has been the replacement of Medicare Locals with Primary Health Networks or PHNs. These are larger entities than Medicare Locals, and half their number, and it is intended that they only provide clinical services in exceptional circumstances. Instead, they are principally in the business of identifying primary care needs and then commissioning practitioners to provide responsive services.

Two advisory councils, one of clinicians and the other of consumers, provide local insights about needs, guidance and direction.

I am not aware of any formally-acquired evidence that the move from Medicare Locals to PHNs has had a health impact, but as I speak to those operating PHNs several positive messages are common.

In western Sydney I have frequent and positive contact with the PHN that shares the same catchment as the local health district in which I work, so please note that my comments are biased. With that proviso I offer four observations.

How are we doing?

First, not all PHNs are operating optimally, but most are doing well. Leadership is as critical to the success of a PHN as it is elsewhere in health care. Without it performance is mediocre.

Second, many PHNs are handling well the tension between taking risks by doing new things and following safe, traditional practice. There is always a risk that over-weaning governmental instructions will prevent the innovation that general practice and other forms of primary care surely need.

Third, there is a struggle to impress all decision-makers in the management of PHNs that they are more than funding agencies, a kind of ATM for governmental funding for general practice. Unless the PHNs contribute to the capacity needed for new programs to work, they are being underused. Commissioning services is not like buying groceries: when well done there is a constructive relationship between the PHN and the general practices they are funding for special programs.

So, fourth, if PHNs are to help commission services in mental health and drug and alcohol, they need to be able to do more than provide brown envelopes to the dozens of variable quality agencies currently operating. It makes no sense if no intellectual value and rationality is added to the mess that currently exists.

One of the moves afoot in relation to general practice at present, especially through the review of the Medicare Benefits Schedule, is to ensure that in future we progressively pay for performance.

This means attending to the outcomes of what we do – and this has been a much neglected activity in all health care, whether preventive or therapeutic, community- or hospital-based. PHNs, when commissioning service provision, (just as those introducing the new concept of the Health Care Home do), need to show that these interventions are not bureaucratic impediments, but actually improve patients' health and satisfaction. That's the only way forward that will guarantee progress.

It is all about the patient

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

Being the Chair of the AMA Council of General Practice, I thought I would take the opportunity to talk about what drives my passion for general practice and why I have devoted countless hours over many years to encourage an environment where we can deliver the best possible care for our patients.

Inspired by reading about Dr Albert Schweitzer, I wanted to be a doctor from the age of seven. When training as a specialist physician I soon realised that I had to be a general practitioner. A specialty that allows me to care for people from the cradle to the grave provides a unique opportunity to have an ongoing relationship with my patients. It crosses generations, and I am now looking after the babies of patients whose parents I cared for before they were born.

Since the age of two I have been a self-confessed bully basher. I hate bullying and strongly stand against it in all its forms. My school motto was "Be true to yourself", and it underpins my philosophy today, which sees me standing up against the injustices that surround us.

As a young volunteer and the only doctor for some 225,000 people in the West Sepik Province of Papua New Guinea, I had to confront criminals to protect and retain my nurses so they could look after our patients in a 130-bed hospital.

As co-founder of the recently formed group, Doctors for Refugees (D4R), I am adamant that out of sight should not be out of mind. It is also intolerable that doctors who care for the most vulnerable are denied their voice because of offensive provisions in the Border Force Act. I hope these provisions will be struck down in a challenge D4R is taking to the High Court.

Besides my interest in refugee health, I have strong interests in mental health, aged care, palliative care, medical education and translational research. I enjoy teaching and value the chance to learn from my patients, my students, registrars and colleagues. I am a huge advocate for continuous quality improvement and the benefits it delivers my patients, the health system and me as a professional.

Providing quality care is not always easy, and requires conviction about what is right for your patients.

Having been subjected to the Medicare audit process and accused of spending too much time with my patients, as though it was a crime, was a very difficult experience. It has helped me to see the need to help colleagues feel safe and free to practise and teach medicine to the highest standards, for the benefit of our patients.

I have always strived for equitable access to the excellent services GPs provide, recognising that we need to improve health outcomes for vulnerable and marginalised patient groups. I do this in my own general practice, and have worked closely with my local Primary Health Network, local hospital service as well as other state and federally funded services. I believe that the foundation of good care is when doctors and other clinicians feel supported, safe and able to work to their full scope of practice, often in high functioning teams.

I believe doctors, especially general practitioners, need a sense of their true value in the health system, and need to be fairly remunerated for the comprehensive care they provide.

My own practice is a mixed billing practice, charging a modest gap to patients that can afford to make some contribution to the costs of their health care while at the same time sheltering the less well-off from out-of-pocket costs.

'Penny wise and pound foolish' probably best summarises the current Government's approach to general practice funding.

Its efforts at budget repair in health will lead to much bigger costs in the longer term. My job will be to highlight just how unwise this approach is and that making a substantial investment in general practice will deliver real rewards – both in terms of health outcomes and costs to government.

There is abundant evidence that a properly resourced and motivated primary health care service will deliver even more effective, high quality and cost efficient care, resulting in better patient outcomes and providing substantial savings by reducing pressure on expensive hospital-based services.

For me it is always all about the patient, and about doctors being properly valued and supported to deliver the care and outcomes our patients should have.

Putting assessment under examination

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

We all know the story. First day of medical school. Turn to your left. Turn to your right. Only one of the three of you will be here in a year's time. It made the lead character from Saw look like Dr Phil.

Luckily for us, and for our patients, medicine has come a long way from those days.

Examinations and assessments aren't what they used to be, and medical school certainly isn't as barbaric as it used to be. As for what follows, residency is a relatively comfortable time of your career when it comes to assessment, where you can journey the garden of medicine as you get pulled one way or another towards your specialty.

Registrars? Well... it's complicated.

Colleges occupy a unique position in the Australian social fabric. They have a monopoly on how specialist doctors are created from our pluripotent medical graduates, because society expects the highest of standards when it comes to the training of doctors in Australia.

This social contract is not taken lightly by the colleges, and curriculum renewal is a constant standing item on most education committee agendas.

Changes are underway in assessment. Colleges are moving decidedly away from single pole vault-style barriers to a race of multiple hurdles. They should be applauded for doing so.

However, examination and assessment is still a tricky area. On the scale of difficult professions, medicine is right up there.

The starting point for the colleges is a set of over-achievers who often haven't failed a single assessment in their lives. How do you create an assessment that can discriminate between these trainees appropriately? How do we best identify the underperforming trainee?

Because that's what this is ultimately about, isn't it? The trainee that lacks insight, or lacks skill, or maybe is just having a rotten time with life and all that comes with it. How do you manage that trainee without the stigma of failure? How do you protect those that need help while sifting out those who just aren't making the cut?

With record numbers of graduates making their way through the training system, the problem of the underperforming trainee will only become bigger.

It's a numbers game alright. The number of dollars spent on lawsuits by trainees and colleges on failing to progress. The number of doctors who expect to move into consultant positions at the end of their training without having to deal with free market forces in the process. The number of people who leave medicine entirely through dissatisfaction with an assessment, when maybe things would have gone differently in another specialty and another area.

Examination and assessment was a key area of discussion at our last Council of Doctors in Training meeting.

We currently have a working group discussing the principles that should guide open and transparent assessment in medical training.

Now, I don't want to foreshadow what this group of trainees might come up with, but I will share an analogy with you.

It feels like the models that fail are like traffic lights without a yellow light. You're either a trainee in the green, or you hit a red light. There's no in-between and usually it's at the end of the training when the red lights come along, which can be a massive shock for the trainee involved. Tens of thousands of their dollars, tens of thousands of hours of their lives... all gone. Just to sit at a red light.

Good assessment utilises the yellow light. Think of your first failure as a yellow light. Your supervisors send a message to you saying, "Look, things aren't fantastic at the moment. The light ahead of you is red, unless you can lift your game".

Most importantly, and here's the significant part, you get feedback on how to get those green lights coming back your way. Good feedback is a core element of good assessment.

In all my discussions with trainees, I've never met a doctor who wanted to take the easiest path to their end point. They understand that training is not a green light corridor. Early openness, transparency in assessment and honest feedback are essential to becoming the doctor most trainees want to be. Trainees shouldn't be afraid of failure, and neither should the colleges. If we are, there's something wrong with our system.

Annual migration a doctor's bane

BY DR HIROWATARI, CHAIR, AMA COUNCIL OF RURAL DOCTORS

Every winter the Top End of Australia sees the annual migratory activity of the species Latro cinericii*.

They have been seen in the deepest Outback locations such as Windjana Gorge and the Gibb river Road, on isolated seasides from the Gold Coast all the way around to Exmouth on the West. All forms of terrain can be their temporary home, tropical Daintree forests, cliffs and caverns of the great King's Canyon in the Northern Territories, steep pillars of the Bungle Bungles, or the vast dry expanses of the Central desert. They are however a bit timid in the dense populated areas since their migration is stymied by city traffic and small parking spaces.

> "Latro cinericii are the bane of us rural doctors. Generally not in the best of health, chubby, puffed out, of poor physical condition and a bit slow in thought, they fall from ledges, slip on loose rocks, quite often breaking a major joint"

Social in their nature they congregate together near sources of water, often staying for days in one resting spot before making their circuitous journey around The Top End. Their social habits mean they migrate together in clumps. They seem to mate for life. Strangely the mated pair tend to look like each other. Offspring are nowhere to be seen. They are quite mature and for this reason the heads of both male and females are a bit bald. A dab forgetful, there is documented evidence of an incorrect migration where they appear to be making repetitive circles around a destination before finally alighting at the intended spot.

Their greatest enemy is the Wet. Cyclones, floods and downpours are their greatest fear. In fact when little clouds start to spot blue skies, their panic is a sight to behold. One day the bitumen is full of these creatures, slowing road trains down, causing near accidents while vehicles try to circumvent them. The next day, with a squawk and flurry of smoke they are gone. I am not sure if National Geographic has found their summer resting spot, which I suspect is located in scattered big cities in the cooler Southern parts of Australia.

In general quite tidy, they do not leave their droppings or spoors behind, choosing instead to bin or dump them in waste depots. Their tidiness is countered by the racket they make. They make noises similar to a lawn mower, they entertain themselves with boxes that squeal and screech. And they chatter. Loudly. Part of the noise created is because most of this species are quite deaf.

To the local residents they are both loved and hated. The local acceptance of the Latro cinericii stems from the fact their influx makes a great profit for stores, markets, tour operators, and caravan parks. But they are hard to like when they take up every available seat in the best diners, take away nearly all the stock of bread, milk and eggs from supermarkets. The servos are drained of diesel, they are often found lined up waiting for the next delivery of petroleum. For this reason locals tend to stock up on basic necessities and make sure they fuel up their vehicles before the influx descends.

Latro cinericii are the bane of us rural doctors. Generally not in the best of health, chubby, puffed out, of poor physical condition and a bit slow in thought, they fall from ledges, slip on loose rocks, quite often breaking a major joint. They strain parts of their bodies they should not use. They tend to bleed a lot as they are on at least one anticoagulant, if not two. Even worse, they have a tendency to infarct something, either their heart, their brains or their mates. Recently one got eaten by a crocodile near Port Douglas.

I'd just like to say something kind on their behalf, since they are far from their home, a bit lost. Be patient with them. They are doing the best they can. They are working on a bucket list. One day we may be one of them.

**Grey nomad*

Are Medicare's principles still relevant?

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

The AMA's Health Financing and Economics Committee (HFE) met on 6 August, its first meeting with new members on board following National Conference.

HFE discussed the post-election context and its broad implications for health financing, including public hospital funding. Part of this context is the general view of most political commentators that it will likely be difficult for Government to develop, legislate and implement significant reforms in health. (Of course, many might consider this is not new.)

Notwithstanding the general post-election view, HFE considered that the current political climate could provide an important opportunity for a strategic pause in health policy - a pause that allows us to reconsider what the health system was designed for and assess to what extent it is still achieving its original purposes.

A good place to start this rethink could be to review and reassess the Medicare principles.

These principles have typically accompanied, or been incorporated into, health funding agreements between the Commonwealth and the states and territories. They were reaffirmed at the Council of Australian Governments (COAG) meeting in April when all jurisdictions committed to ensuring:

a. eligible persons be given the choice to receive, free of charge as public patients, health and emergency services of a kind or kinds that are currently, or were historically provided by hospitals;

b. access to such services by public patients free of charge is to be on the basis of clinical need and within a clinically appropriate period; and

c. arrangements are to be in place to ensure equitable access to such services for all eligible persons, regardless of their geographic location.

The Medicare principles are a creation of their time, focusing on what in the early 1980s was seen as the key responsibility for health provision by Government: public hospital services.

While they encapsulate some elements of what is popularly understood by the term 'Medicare', the principles are actually very narrowly focused on the provision of public hospital services to public patients.

More recently, the principles have been complemented by a general statement on the Commonwealth's lead responsibility for general practice (GP) and primary health care (added in the National Health Reform Agreement 2011, and reaffirmed in the COAG Heads of Agreement earlier this year).

While the principles form only part of what is now broadly understood as Medicare, starting with them is a useful first step for review.

Are the Medicare principles still relevant, applicable and useful in the way they were when they were developed more than 30 years ago? For example:

- are the hospital services that were in mind at the time the principles were developed still applicable? Should they include 'new' services not in scope in 1984 (as distinct from changing clinical practice and technology) that may have developed since?
- Are there aspects of treatment or services associated with, or provided in conjunction with, a public patient service that should be funded differently?
- Do the Medicare principles provide or support an optimum basis for public hospital funding arrangements, including for transparency and minimising cost shifting?
- Should they include principles to cover other parts of health care?
- Should the principles include a future focus and the long term sustainability of health care, beyond short term political cycles?

HFE plans to get a perspective from one of the original architects of Medicare on what the intentions of the system were at the time it was designed.

HFE recognises that changes to Medicare that affect the public's understanding, assumptions and expectations will ultimately need broad support, including from all sides of politics.

While some groundwork and rethinking could be done now, such as reviewing the Medicare principles, a public discussion and debate is some way off.

In the meantime, HFE will be considering these issues to inform the AMA's position and its contribution to future public debate.

Your input and views will be valuable as part of this work.

Small investments can make a big difference

BY AMA PRESIDENT DR MICHAEL GANNON

For the AMA, Aboriginal and Torres Strait Islander health has been, and will remain, a priority. It is our responsibility to advocate for and support efforts to improve health and life outcomes for Australia's First Peoples.

The AMA works closely with Aboriginal and Torres Strait Islander people in a number of ways to contribute to our mutual goal of closing the health and life expectancy gap between Indigenous and non-Indigenous Australians.

We have close relationships with NACCHO, the Australian Indigenous Doctors' Association and the Close the Gap Steering Committee, through which we collectively contribute to the national debate on Indigenous health issues. The Taskforce on Indigenous Health, which I Chair, is another way that the AMA works in partnership with Indigenous people.

Each year, through the Taskforce, the AMA produces an annual *Report Card on Indigenous Health* – a landmark publication that makes practical recommendations to governments on how key Aboriginal and Torres Strait Islander health issues should be addressed.

This year the Report Card will have as its focus the eradication of rheumatic heart disease (RHD). RHD is an entirely preventable, third world condition that is wreaking havoc on the lives of Indigenous people in remote communities, primarily those in central and northern Australia. The 2016 *Report Card on Indigenous Health* will be a vital contribution to addressing RHD – a disease that should not be seen in Australia in the 21st century.

The AMA also supports policies and initiatives that aim to reduce other chronic and preventable diseases - many of which have an unacceptably high prevalence in remote Indigenous communities. An example of this is the little-known blood-borne virus HTLV-1, which in Australia occurs exclusively in remote Aboriginal communities in central Australia.

The AMA recognises that Aboriginal people living in Central Australia face many unique and complex health issues, and that these require specific research, training and clinical practice to properly manage and treat.

The AMA, as part of our broader 2016 election statement, called on the next government to support the establishment of a Central Australian Academic Health Science Centre. This is a collaboration driven by a consortium of leading health professionals and institutions, including: AMSANT, Baker IDI Heart & Diabetes Institute, Central Australian Aboriginal Congress, Central Australia Health Service, Centre for Remote Health, Charles Darwin University, Flinders University, Menzies School of Health Research, Ngaanyatjarra Health Service and Nganampa Health Service.

The AMA sees the proposed Health Science Centre as a very significant endeavour to improve the health outcomes of Aboriginal people living in remote communities. There are already tangible benefits from this type of collaborative and multi-disciplinary approach to health services and research.

The aim of the AHSC is to prioritise their joint efforts, principally around workforce and capacity building and to increase the participation of Aboriginal people in health services and medical research.

Some examples of achievements include: the Central Australia Renal Study, which informs effective allocation of scarce health resources in the region; the Alice Springs Hospital Readmissions Prevention Project, which aims to reduce frequent readmissions to hospital; and the Health Determinants and Risk Factors program, which better informs health and social policy by understanding the relationship between health and other factors such as housing, trauma and food security.

Having a designated Health Science Centre would be a massive boost for research, clinical services, and lead to greater medical research and investment. The Centre would likely see more expertise and opportunities to develop Aboriginal researchers and health care workers.

Establishing and operating this Centre would cost $4 million a year - a modest ask considering the potential benefits it could deliver.

The AMA recognises that Aboriginal and Torres Strait Islander people have a lead role in identifying and developing solutions to respond to their health needs - the proposed Central Australian Academic Health Science Centre is a clear example of this. The AMA will continue to support the efforts of Indigenous people to improve health outcomes and urges governments to do the same.

Understanding societal ills part of being a good doctor

BY **ELISE BUISSON**

The most valuable lessons I have learnt in medicine weren't taught in my medical degree. In classrooms and clinics I have learnt the pathology of disease, how to cannulate and intubate and where to find additional pages for a patient file in the split second before a ward round. The most valuable things I have learnt about being a doctor, however, have been about how our society works, and who gets sick as a result.

> "Society has moved from an exclusive focus on the 'three Rs' of reading, writing and arithmetic to a broader view of what schooling should entail"

In primary and secondary schools around the country, there has been an ongoing conversation for many years about the aims of education. Society has moved from an exclusive focus on the 'three Rs' of reading, writing and arithmetic to a broader view of what schooling should entail. Increasingly there is consideration of the need to teach the life skills young adults need firmly cemented upon graduation: how to apply critical thinking; what a respectful relationship looks like; how to make career decisions in a world where career progression increasingly resembles a jungle gym rather than a ladder.

Fast-forward a few years along the educational continuum, and the conversation around medical education has miles of well-travelled ground. Are the students learning enough anatomy, now that we're giving it less teaching hours? Are there too many students to a team to learn effectively? Are they getting enough clinical experience to stand on their own two feet when they graduate? Each of these are essential in creating safe and effective doctors, not least because few lessons can be learned when students are five-deep in an operating theatre. So, in the already overcrowded environment of medical education, why should we make room to teach broader societal lessons?

We can all agree that it is essential to understand the mechanism by which alcoholic hepatitis develops. But what of the entrenched social disadvantage that first caused the patient's early exit from school in order to escape an unstable home, then resulted in that person's underemployment due to a lack of education, which left a person from a traumatic background with far too much time to dwell on their past and no resources to seek help, which led to high consumption of alcohol, which was more freely available because they lived in a low socioeconomic area, which resulted in the illness their doctor is now managing. By the time a doctor begins their first day of internship, have we learnt enough about the 'why', rather than just the 'how'?

I take the view that doctors are indebted to the Australian public for its continuous and voluntary role in training them. As a student, I have well and truly lost count of the number of patients who have graciously allowed me to take their medical history or examine their sore knee, and I will never forget that the sickest of those patients often mention how proud they are to be helping a young doctor learn. In exchange for patients participating in our training, for which they receive no individual benefit, we owe it to the community to become a certain standard of professional as a result.

Even newly graduated doctors should know how to be respectful and relevant teachers to their juniors; should understand the impact of disadvantage on health across a lifetime and generations; and should have the interpersonal skills and political know-how to be able to advocate, both for the individual patient and for the health of the wider community. We owe it to those patients to become doctors who are not only clinically competent but who are culturally, emotionally and politically competent as well.

In the lecture theatre, during ward rounds and in the GP's office, every day there are opportunities for doctors and students alike to teach those junior to them the most important lessons of all, about respect, compassion, and being a voice for those without one. Each of us should play our part. To quote Royal Australasian College of Surgeons Trainees' Association Chair, neurosurgery registrar and AMA Doctor in Training award winner Ruth Mitchell, *"We need to get this profession right, because our patients need it."*

Shaw's paradox

BY DR MICHAEL RYAN

1

I always admire those people who dream the dream and chase it relentlessly.

Philip Shaw's thoughts of making his own place in the wine world began humbly as a 14-year-old washing bottles at Penfolds. His family has always been involved in agriculture, but the lure of the romantic world of wine was his siren. The result was Philip Shaw Wines of Orange.

Philip's knowledge base was forged at Roseworthy College. His first legitimate wine role was with Lindeman's in Cowra, and he later became head wine maker at Rosemount. Over time, with ever expanding knowledge and experience, in the late 1990s he became chief wine maker for Southcorp. But by that time he had already started his own plantings in the Orange district.

2

His son, Damian, recalls that every family holiday for about five years they were dragged around the country looking at potential vineyard sites. The Shaw family visited places like Geelong, northern Tasmania and Tumbarumba: obscure regions when they went there in the in the 1980s but bonafide winegrowing areas now.

A confluence of factors, including soil, elevation, heat ripening units and more led them to choose a site in Orange. This would become the Koomooloo Vineyard - 47 hectares of rolling hills at an elevation of 600 to 1100 metres near Mt Canobolas. Philip was attracted by the area's similarities to Burgundy; in addition, his fondness for producing Chardonnay and Pinot Noir. Orange's versatility as a geographe of wine is shown by the many varietals in the region.

3

The Koomooloo Vineyard produces Chardonnay, Pinot Noir, Shiraz, Cabernet Sauvignon, Merlot, Cabernet Franc, Pinot Gris, Sauvignon Blanc and Viognier. It is planted at high altitude vineyard in soil comprising red loam over limestone. The temperature can vary as much as three degrees Celsius between the lowest vineyard at 600 metres and the highest at 1100 metres, which gives the vineyard great versatility. The numbered Block series of wines produced are high-end products, while the Character series are Philip's alter egos.

4

Philip has always been true to his philosophy of making wine for the people. They are also wines that he would consume himself. Even at Southcorp, he tried to steer major brands to produce styles of wine for the consumer, and not just for technical experts.

Forward fruit in white wine with balanced acidity, varietal characteristics and subtle but appropriate structure in the reds is paramount in the Phillip Shaw wine philosophy. The end product exemplifies this. Philip believes the wine making process is simple: "Ferment grapes in a bucket and stop them turning to vinegar."

His role as a wine maker is to guide this process to an end product that captures the terroir and results in our senses taking flight.

WINES TASTED

1. 2015 The Dreamer Viognier Orange

Light pale green color. A delightful nose of white peaches, apples, hints of apricot and, as it warms up, some spicy notes. The palate reflects the nose, with juicy upfront varietal expression and clean minimal acidity. Have with Jindi Brie and fresh apple.

2. 2015 Architect Chardonnay Orange

Light yellow with green hues. Lively white peach nose with complex notes reflecting lees contact. Contrasting grassy notes with nutty complexities add to its attraction. Mid-palate wine structure with balanced restrained fruit layers and mouth feel. Sashimi scallops would go well.

3. 2013 No. 17 Merlot Cabernet Franc Orange

Dense garnet to purple tinges. Dark plums, earthy notes, hints of brambly aromas with glimpses of vanillin oak. A generous wine, with the Shaw trademark of elegant silky tannins. The structure supports the fruit. Have with cured Kangaroo and bush chutney.

4. 2015 No.8 Pinot Noir Orange

Light garnet color. A bouquet of dark cherries to plums, toasty oak notes, opening up to reveal savory herbaceous elements. Flowing front palate merging seamlessly with restrained complex tannins and acidity. Duck and more duck.

"Girls Just Want To Have Fun" - women in sport

BY **DR CLIVE FRASER**

Once every four years a host city puts on the biggest show on Earth.

This year the world has seen the 2016 Rio Olympics come and go.

As usual, these games were not free of controversy, with doubts about security, venue preparedness, mosquito-borne diseases, systemic doping scandals and even a stoush about the reporting of female athletes. All too often, women in sport find that journalists on what they wear and how they look rather than on their performance as athletes.

All of this in a town which hosts an annual Carnival where many female participants are baring more flesh than an Olympic swimmer.

Closer to home, I've just been to a much smaller show in Brisbane called "The Ekka", hosted for the 139th time by the Royal National Agricultural and Industrial Association.

I love going to "The Ekka". There are no metal detectors and no security on the gate, and where else in a big city do you get to see wood chopping, so many animals, so much embroidery and so many elaborately iced cakes.

I remember as a child seeing a man shot out of a cannon in the arena, and every year there was the Holden Precision Driving Team.

Monaros, and then Commodores, would race around the track barely touching.

In later years one extra vehicle would do circuit on two wheels - but please, don't try to do this at home.

The Ekka was also a place where innovations would be showcased.

This year they had a Tesla Model S.

Apparently there are 115 other Model S's on the road in Queensland, but I haven't seen one, and I certainly haven't heard one yet.

While $111,196 will get you a basic Tesla Model S 60, the variant on display at The Ekka was the P90D for $245,387, fully optioned.

For that money you get the $15,000 Ludicrous Speed Upgrade, which is exactly what it says.

This vehicle will take the occupants from 0 to 100km/h in 3.3 seconds.

That's less time that it takes to say our Prime Minister's name.

So a trip to The Ekka is always memorable.

Bathurst 1000 driver Renee Gracie

But for me the best memory from the 2016 Brisbane Exhibition was seeing 21-year-old Renee Gracie in the Hot Wheels V8 Commodore ute drifting around the speedway track.

Readers will remember that in 2015 Ms Gracie and fellow driver Simona de Silvestro were an all-girl team at the Bathurst 1000.

Twenty-nine women have previously competed in the race but, at only 20 years of age, Ms Gracie was pushing the boundaries of both age and gender.

Less memorable was the sexist comment by fellow Bathurst driver David Reynold, which earned him a $25,000 fine and for which he quickly and unreservedly apologized.

Ms Gracie did have the misfortune of running into a concrete barrier during the 2015 race, but the all-girl team never gave up and they did finish the race.

Sure, they qualified second slowest (3.5 seconds off the pace) and finished last, but none of that matters because they beat the sceptics, including Dick Johnson, who said they were only a "million to one" chance of actually finishing the race.

Ms Gracie retorted that, "Dick Johnson hasn't finished heaps of races so he can't talk".

Well done Renee! Simona and you were both winners in my mind.

Thank you also so much for staying back at The Ekka to sign autographs for your legion of female (and male fans), including yours truly.

An enduring memory for me will be how much inspiration you gave to so many young girls who were at The Ekka that night.

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**

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

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 Advisory Hub: Is your one-stop shop for expert advice, support and guidance to help navigate your medical career. Get professional tips on interview practice, CV reviews, and application guidance to get competitive edge to reach your career goals.

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

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

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

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

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