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In this issue

Cover pic: AMA President Dr Michael Gannon congratulates Health Minister Greg Hunt for keeping fit at work, then reminds him again to consider the WA mandatory reporting model ahead of the COAG Health Council meeting.

Spotlight on PHI

BY AMA PRESIDENT DR MICHAEL GANNON

I recently had the opportunity to address the Senate Community Affairs Reference Committee Inquiry into Out-of-Pocket Costs in Australian Healthcare.

It was a great opportunity to tell the broader political community and the public the facts about the costs of medical care, and refute some of the mistruths being peddled in the debate about doctors' fees – and have it all recorded in Hansard.

The simple fact of the matter is that private health insurance has to be fixed. We are not the problem. But we are a key part of the solution.

Consumers – our patients – need to be able to afford insurance for themselves and their families.

We need a strong private system to complement our world-class public system in delivering universal health care.

It is human nature that people will not pay significant amounts of money for products if they do not know what that product is going to provide for them. Too many health insurance products do not deliver the basic care promised. They are junk. This is the challenge facing the PHI industry and the Government. Hence the Review.

Now for some facts.

Out-of-pocket medical costs are not the cause of discontent among consumers. Most consumers understand that they may need to contribute to the cost of their care.

The big problem for consumers – and the PHI industry and the Government – is that many believe that they are covered. They have paid good money for their insurance. They must be covered, they think. Surely?! But no.

In many cases, they have paid good money for a product that may simply help them avoid a tax penalty, or cover them for what they would get for free in the public system anyway. These policies are worthless. They are junk. And they should go.

Another fact – out-of-pocket expenses are not growing.

The proportion of health expenditure funded by individuals, not the Government or insurers, has remained relatively static at 17 per cent over the decade to 2015-16.

Importantly, of that 17 per cent, only 10 per cent is spent on medical services.

The spend on other health practitioners is 9 per cent, and other hospital outlays is 11 per cent. The majority of individual expenditure goes on dental services and pharmaceutical products.

The undeniable truth is that out-of-pocket medical expenses are a small proportion of the total amount that patients pay for their health care.

A myth being promoted by some is that medical expenses are the cause of increased premiums. Wrong.

Medical expenses are a small proportion of total benefit outlays for the insurers. Medical expenses, as a proportion of benefits, have remained static at around 16 per cent since 2007.

Compare this to the administration expenditure of the private health insurers, which is around 10 per cent. This means that it is costing the insurers almost as much to run their businesses as it is to pay for the doctors who treat their customers. I stressed this point to the Inquiry, and suggested it may require further investigation.

Another fact, which I highlighted to the Inquiry, is that the AMA does not support exorbitant charges or egregious fee setting. We know that some patients, due to various circumstances, have incurred very large out-of-pocket costs for their care. We need to understand why and how these isolated events occur.

The AMA firmly believes that providing informed financial consent is not only best practice, it is demanded by medical ethics.

The overriding message I provided to the Inquiry is that private health insurance must stick to its core business and reason for being – as a payer for medical services.

The PHI industry must not be allowed to move its business model towards the system in play in the United States – the infamous 'managed care' system where everybody loses out except the insurance companies.

That system allows the insurers to reduce their expenditure by controlling what services are provided to patients. As they put it, they seek to reduce 'low value care'. These decisions are not a matter for insurers. This care may well be 'high value' in the eyes of patients.

There are already signs of this behaviour in Australia. It must be stopped.

We need to head in the other direction. There needs to be greater transparency about PHI products.

Health insurance products must be easy to understand. Payments should be made on clinical need. The 'de facto' risk rating system created through products with incomprehensible exclusions and carve-outs needs to cease.

Universal health care demands a strong private health system, and that system needs the support of the PHI rebate and retention of the community rating system.

Anything less is a threat to the healthcare system Australians rightly cherish.

More accountability needed in aged care system

BY **AMA VICE PRESIDENT DR TONY BARTONE**

There is no question that the Australian aged care sector is in need of a system overhaul. The media stories examining the lack of choice and detailing examples of lack of service and care are all too fresh in our mind.

The AMA has welcomed recent calls for greater quality and more accountability in the aged care system. Indeed, we have led many of those calls.

We therefore strongly support those specific calls in the recommendations of Kate Carnell AO and Professor Ron Paterson ONZM in their report *Review of National Aged Care Quality Regulatory Processes*, which was recently released.

The review was sparked by revelations that aged care quality regulatory processes had failed to adequately detect longstanding neglect and inexcusable flaws in care at the Oakden Older Persons Mental Health Service. The review panel was unsurprisingly overwhelmed by families, advocates, peak bodies, service providers, health and aged care workers, academics and regulatory experts.

Their report reflects many elements of our own submission to the review process.

The appointment of a new dedicated Aged Care Commissioner who would oversee the work of an Aged Care Quality Commissioner, an Aged Care Complaints Commissioner, and an Aged Care Consumer Commissioner, is a recommendation in the report born from our AMA's submission

The report also recommends much-needed improved communications for patient information sharing between State, Territory, and Federal Governments through the new Commission.

The AMA supports new processes to ensure residents are informed and educated on their rights as a consumer, and their right to complain about a service.

And the report suggests accreditation standards to implement restrictions around the use of restraints in residential aged care facilities, which we feel should always be considered a last resort.

Furthermore, there is an urgent need for clearer standards relating to clinical care in residential aged care facilities (RACFs) and the Report recommends more work from the Australian Commission on Safety and Quality in Health Care to make improvements in this area.

We also welcome the recommendation to increase the use of Resident Medication Management Reviews to reduce the risk of polypharmacy, which has led to a large number of medication-related hospital admissions for people aged over 65.

Aged Care Minister Ken Wyatt has also announced that RACFs will no longer be notified when re-accreditation reviews will occur. They will now be completely unannounced.

This is a good move.

While we welcome the Review recommendations, the real issue now is how quickly the Government will consider and adopt them.

Australia's aged care population cannot wait for the other recommendations to be put in place. There is urgency as there have been far too many inexcusable horror stories emerging from some Australian aged care facilities.

Beyond the Review's recommendations, the AMA would like to see further action including, but not limited to, a requirement that doctors be appropriately and adequately compensated by Medicare to increase access to medical care for people living in RACFs. Doctors' clinical software systems need to integrate with My Aged Care and the RACFs' software to improve patient information sharing.

Also, there should be better access to nurses in aged care facilities. Funding to recruit and retain qualified, registered nursing staff and carers who are specifically trained in dealing with issues that older people face should be a priority.

And we need an increased awareness of mental health issues in this vulnerable population to ensure the need for these services is identified through the Aged Care Funding Instrument assessment process.

We can't allow another Oakden to occur. We must, as a nation, ensure our elders are always provided with the care they deserve.

Our strategic vision for the future

BY AMA SECRETARY GENERAL ANNE TRIMMER

The Board of Australian Medical Association Limited spent a day and a half in late October working on the strategic plan for the AMA for the period 2018-2020.

The Board reaffirmed the mission of the association as *Leading Australia's Doctors – Promoting Australia's Health*. This mission reflects the core work of the AMA, as spelt out in its constitution, and underpins all activities carried out by Federal AMA.

The Board identified four key pillars to its strategic objectives:

- Leading on advocacy
- Recognising and valuing our members
- Strengthening our AMA community; and
- Ensuring financial security.

Underpinning these objectives is a statement of commitment: *Our AMA – working for diversity and inclusion.*

Under the pillar *Leading on advocacy*, the strategic objectives provide that the AMA will:

- Reinforce AMA's role as the leader of Australia's doctors;
- Maintain the central role of the AMA in health advocacy for the benefit of patients;
- Maintain the primacy of Federal Council in the medico-political policy debate;
- Promote ethical practice based on the AMA Code of Ethics;
- Develop the next generation of Australia's medical leaders;
- Provide for individual member engagement in the medico-political process; and
- Drive public health policy for a healthier and safer Australia.

Under the pillar *Recognising and valuing our members*, the strategic objectives provide that the AMA will:

- Promote and protect doctors' health and wellbeing;
- Facilitate equitable access to services to improve member experience;
- Support new opportunities that deliver value;
- Collaborate with State and Territory AMAs to identify and deliver targeted member benefits nationally; and
- Develop and promote opportunities to identify as an AMA member.

Under the pillar *Strengthening our AMA community*, the strategic objectives provide that the AMA will:

- Develop shared values, advocacy and ideas with State and Territory AMAs;
- Value and support our staff;
- Foster collaborative engagement with State and Territory AMAs;
- Develop a coordinated communication strategy with State and Territory AMAs; and
- Identify opportunities for sharing of resources to promote cohesive practices and deliver efficiencies.

Under the final pillar *Ensuring financial security*, the strategic objectives provide that the AMA will:

- Grow AMA membership in collaboration with State and Territory AMAs;
- Increase non-membership income streams;
- Undertake investment of capital to provide sustainable income and future growth of capital;
- Require subsidiary businesses to be financially successful and sustainable;
- Require subsidiary companies to align with AMA strategic objectives; and
- Encourage the development of viable innovative business streams through AMPCo.

At an operational level, the strategic objectives are delivered through an annual operational plan. Progress against that plan is reviewed monthly by the Board at its meeting. The revenue expectations and expenses of the annual operational plan are built into the Federal AMA's annual budget.

The Board is interested in your feedback on the AMA strategic objectives 2018-2020. Comments can be sent to me at ama@ama.com.au.

Health COAG progresses approach on mandatory reporting

State and Territory Health Ministers met with their Federal counterpart in Canberra this month for the Council of Australian Governments (COAG) Health Council meeting, where discussion around mandatory reporting was high on the agenda.

Federal Health Minister Greg Hunt reported after the meeting that progress had been made towards providing national legislative protection for doctors seeking treatment for their own mental health and stress-related conditions.

"There will be better protection for doctors and medical professionals who face mental health challenges," Mr Hunt said during a media conference.

"At the moment, many of them feel that there are barriers to seeking mental health treatment because of mandatory reporting.

"We have agreed to work together to rapidly, very rapidly, conclude an approach to a new national health law with regard to mental treatment so as doctors can seek the treatment they need when they need it, in a way that will best protect them, whilst also providing absolute protections for the public."

When pressed for more details, the Minister said the Government would immediately begin the process of working with the Chief Medical and Health Officers of the States, and with the AMA and other health groups.

"We're looking to finalise this before the end of the year, and what that would mean is that there would be a standard, which still has to have final agreement between States and Territories and the Commonwealth," he said.

"But we are looking at ensuring that health workers can seek treatment for mental health in the same way that everybody else can, without fear of being reported for ordinary conditions in relation to mental health.

"We have to move to a safety-based and public safety-based format, because if we don't do that, there's the perverse outcome that the medical professionals, at the very time they may need and want early help, will resist that early help."

Directly before the COAG meeting, AMA President Dr Michael Gannon stressed to the Minister – and to the States and Territories – that the current Western Australian model of mandatory reporting provisions should be adopted across all jurisdictions.

"It is now up to Ministers to deliver on behalf of patients, doctors, and the other regulated professions," Dr Gannon said.

"If they only tinker at the edges – or attempt to reword the existing model – they will only reinforce the existing barriers that are blocking doctors from seeking support.

"We urge Ministers to avoid an alternative proposal, which is based on the current Queensland model. It does not work.

"The principle underpinning the WA model – an exemption from reporting for impairment – has been proven to work.

"The WA model does not pose a risk to patients. There is evidence that it does help doctors.

"Doctors and other health workers are at greater risk of mental illness and stress-related problems, yet the current laws inhibit many from seeking treatment for a mental health condition because they fear for their medical registration.

"The mandatory reporting laws have a twofold effect – some people will not seek help at all, and those who do may not divulge all the necessary information to receive appropriate care.

"The AMA is extremely concerned that we have a situation now where doctors may be avoiding necessary health care, putting both themselves and their patients at risk."

Dr Gannon said the entire AMA is unequivocal in its support for the WA model, which addresses the issues stopping doctors from seeking treatment they need.

That model should be adopted nationally, he said.

"It has given doctors the confidence to seek the help they need and there is no evidence that it has diminished patient safety in any way," Dr Gannon said.

Other issues discussed at the Health COAG include: a new national approach to protect patients from medical procedures in relation to cosmetic surgery; better protection for nursing staff in rural and remote areas (known as Gayle's Law in response to the 2016 murder of Outback nurse Gayle Woodford when attending a call on the APY lands); and progress towards a quadrivalent vaccine for ACW and Y with meningococcal.

"As well, we are on the cusp of better protections for our seniors and our young children in relation to new influenza vaccines coming forward – vaccines which have not been previously available, which the Commonwealth has expedited," Mr Hunt said.

"And I am confident that both the new meningococcal and the new flu vaccines will be available for the coming seasons.

"Apart from that, the other very significant breakthrough was on the agreement of principles for a new national health reform agreement from 2020 to 2025, and those principles are about prevention, wellbeing and a focus on outcomes, and what that means is that there will be more support and better support for keeping people out of hospital, rather just supporting and paying for people to be admitted to hospital.

"If we can keep Australians out of hospital, it's better for their health, it's better for the health system, and Australians will be the beneficiaries of that."

CHRIS JOHNSON

Treat asylum seekers humanely

Disturbing reports emerging from Manus Island about lack of food, water and medication has led to the AMA calling for assurances from the Federal Government about the health and wellbeing of asylum seekers there.

A week after the scheduled closure of the Manus Island Detention Centre, there remained about 600 men refusing to move – causing local lawyers to seek an injunction from the PNG Supreme Court to compel the Government to reconnect services and provide food and security for the men.

Amid conditions described as "chaotic and dangerous" as detainees are being forced to move from the closing centre to alternative accommodation in the community, the AMA has called on the Australian Government to treat the refugees humanely.

AMA President Dr Michael Gannon said putting the asylum seekers into a dangerous and unhealthy situation was totally unacceptable.

"The Government has a responsibility to ensure the safety, health, and wellbeing of all the detainees on Manus, and we will be seeking assurances to that effect," Dr Gannon said.

"The AMA has been concerned about the health care for asylum seekers in off-shore detention for many years.

"People seeking asylum who are under the care of the Australian Government must be provided with proper health care.

"Many asylum seekers have complex mental and physical health needs.

"The AMA has previously raised their circumstances with the Government as the remote detention facilities are often not able to provide the care needed.

"It is clear that the current situation on Manus is unhealthy and dangerous."

During an interview on ABC Radio, Dr Gannon said he was not hearing a great deal from doctors on the ground at Manus so it was difficult to get a true picture of what is going on.

What the AMA wants, he said, is transparency about the arrangements for the men still at the centre.

"We're concerned about both physical and mental aspects of the health of these wretched souls who are stuck in a bigger political game," Dr Gannon said.

"They have great uncertainty in their lives, they have done for years, and we're hearing unverified reports about reduced access to medication. Some medications, as you know, need to be refrigerated.

"We hear different reports about the quality of what's available in the alternative accommodations being set up elsewhere on the island.

"What we want is independent verification of the living standards of these men. That's the only thing that doctors can possibly call for – is appropriate healthcare standards for a group of people who, although they're not Australian citizens, are entitled to protection under Australian law."

Dr Gannon said the AMA had been advised that IHMS has been contracted to provide primary health care and mental health care at the East Lorengau Transit Centre once the detention centre had been closed.

"We welcome this move as it will ensure continuity of care, but we need to see an urgent and smooth transition to a safe environment for the detainees," he said.

"The AMA acknowledges the efforts of the dedicated medical staff and other health workers who are working in very trying conditions.

"Proper health care must be available to the asylum seekers on Manus who are under the care of the Australian authorities.

"Regardless of how they arrived in Australia, these people have fled places of conflict and unrest and have sought asylum and refugee status. They must be treated as any other person in need of health care."

Prime Minister Malcolm Turnbull urged the men barricaded inside the Manus centre to move to alternative accommodation.

And he criticised anyone who was encouraging them to stay put.

"There are alternative facilities available of a very high quality, with food and all of the facilities," Mr Turnbull said.

CHRIS JOHNSON

Euthanasia debate important, vexed and difficult

As the Victorian Parliament debated its Voluntary Assisted Dying Bill, the rest of Australia watched with interest. And the discussion continues throughout the national community.

Other Australian State parliaments are, or have been, in varying stages of debate on the same topic.

The AMA recognises the diverse views held on this important and emotional issue.

The AMA's policy, revised and updated in 2016, contains several key points and is a positive advocacy piece for better end-of-life care.

The Position Statement calls for better community education on advanced care planning and the "doctrine of double effect" — that is, the notion that a death hastened by a treatment to ease suffering does not constitute euthanasia.

And it calls for much greater investment in palliative care.

The AMA's *Position Statement on Euthanasia and Physician Assisted Suicide* (EPAS) acknowledges the diversity of opinion in the community. And it acknowledges the diversity of opinion within the medical profession.

But at its heart is a clear statement that "doctors should not be involved in interventions that have as their primary intention the ending of a person's life".

AMA President Dr Michael Gannon has recently expressed the importance of conversations about EPAS not failing to take into account the impact new laws would have on the rest of the health system and society as a whole.

"I do not doubt the compassion or motives of most people promoting the Bill in Victoria. I have heard numerous moving stories of the helplessness people feel when they watch a loved one die," he said.

"Compassion is what drives doctors. It is at the heart of our Code of Ethics. I do not lack compassion for those who have watched a loved one die.

"We have all experienced loss. Many of us have suffered the tragedy of watching a parent, child or spouse die. This grief never leaves people. It informs their opinions.

"However, highly emotional stories of the grief felt subsequent to watching a loved one die do not constitute an intellectual argument in favour of EPAS.

"I do not seek to diminish or demean the opinions of those doctors who hold a different view to AMA policy. This debate is vexed. It is difficult.

"But the AMA's Position Statement — which I was elected to prosecute, protect and promote — is the result of thousands of hours of work supported by generations of wisdom and ethics.

"It is appropriate that parliaments, not doctors, make laws on behalf of their citizens."

Dr Gannon recently attended the World Medical Association (WMA) meeting in Chicago, where only the fourth editorial revision of the 1947 *Declaration of Geneva* was endorsed. At the heart of this document about medical ethics is the sanctity of human life.

"It is not surprising that 107 of 109 national medical associations affiliated with the WMA have statements opposing EPAS," Dr Gannon said.

"This includes the US and Germany – nations with one form or another of EPAS law.

"Euthanasia and physician-assisted suicide are at odds with modern and ancient codes of medical ethics. Every life is precious."

But the AMA has moved to clarify differences between the WMA's recent *Declaration on Euthanasia* and the Federal AMA's *Position Statement on Euthanasia and Physician Assisted Suicide.*

He said the AMA's Position Statement was largely in line with the WMA's position, but there was a clear difference. The WMA has labelled doctors who participate in euthanasia as unethical. The AMA disagrees.

The AMA's Position Statement "recognises that there are divergent views within the medical profession and the broader community in relation to Euthanasia and Physician Assisted Suicide".

Further, "the AMA acknowledges that laws in relation to Euthanasia and Physician Assisted Suicide are ultimately a matter for society and government".

"We have not and will not describe doctors who support or participate in euthanasia or physician assisted suicide as unethical," Dr Gannon said.

"Learning from the Dutch and Canadian experience, the AMA believes that doctors who participate in Euthanasia or Physician Assisted Suicide are more likely to require the industrial, professional, medico-legal, and pastoral support of organisations like the AMA."

CHRIS JOHNSON

The AMA's Position Statement can be viewed here: https://ama.com.au/position-statement/euthanasia-and-physician-assisted-suicide-2016

INFORMATION FOR MEMBERS

Important information about the renewal of the National Cervical Screening Program

As we prepare for the commencement of the renewal of the National Cervical Screening Program (NCSP) on 1 December 2017 and the implementation of the National Cancer Screening Register (NCSR), we are keen to keep you updated.

From 1 December, the Cervical Screening Test will replace the Pap test for participants aged 25 to 74 years, who have ever been sexually active, to undergo a Cervical Screening Test every five years. Participants are managed according to their risk of developing significant cervical abnormalities within the next five years, which is determined by their human papillomavirus (HPV) test result and reflex Liquid Based Cytology (LBC) result, if indicated. Those vaccinated against HPV still need to have regular cervical screening as the vaccine does not protect against all oncogenic HPV types. New MBS items and numbers will come into effect from 1 December and the existing Pap test and LBC MBS items will be withdrawn.

In preparation for the upcoming changes to the NCSP, you are encouraged to undertake training on the renewed cervical screening program. This is now available at NPS MedicineWise at https://learn.nps.org.au/

Visit www.cancerscreening.gov.au/cervical and join us in raising awareness about these important changes to the program which will commence on 1 December 2017.

Applications invited for the 2018 AMA Indigenous Medical Scholarship

Applications are now open for the 2018 AMA Indigenous Medical Scholarship, a program that has supported Aboriginal and Torres Strait Islander students to study medicine since 1994.

The successful applicant will receive $10,000 each year for the duration of their course.

There are fewer than 300 doctors working in Australia who identify as Aboriginal and/or Torres Strait Islander – representing 0.3 per cent of the workforce – and only 286 Indigenous medical students enrolled across the nation.

AMA President Dr Michael Gannon said the significant gap in life expectancy between Indigenous and non-Indigenous Australians was a national disgrace that must be tackled by all levels of Government, the private and corporate sectors, and all segments of our community.

"It's evident that Indigenous people have a greater chance of improved health outcomes when they are treated by Indigenous doctors and health professionals," Dr Gannon said.

"Indigenous people are more likely to make and keep medical appointments when they are confident that they will be treated by someone who understands their culture, their language, and their unique circumstances.

"Previous Scholarship recipients have gone on to become prominent leaders in health and medicine, including Associate Professor Kelvin Kong, Australia's first Aboriginal surgeon.

"The AMA strongly encourages Indigenous students to apply for the Scholarship, which, along with the AMA's annual *Report Card on Indigenous Health* and the work of the AMA Taskforce on Indigenous Health, is part of the AMA's commitment to improving the health of Aboriginal and Torres Strait Islander Australians."

Applications close January 31, 2018. Applicants must be currently enrolled at an Australian medical school, be in at least their first year of medicine, and be of Aboriginal and/or Torres Strait Islander background.

Further information, including the application form, can be found at https://www.ama.com.au/indigenous-medical-scholarship-2018.

Major and Doctor Susan Felsche, military medic

Dr Susan Felsche, a Major in the Australian Army, was the first Australian woman to die on an overseas military operation since the Second World War.

On September 14, the Australian Peackeepers Memorial was opened and Major Susan Felsche was honoured at the Australian War Memorial Last Post Ceremony. Dr Steve Robson, President of AMA ACT was in attendance.

Dr Felsche, nèe Stones, studied medicine at the University of Queensland. In 1983 she joined the army as an undergraduate medical officer. Her medical training included a series of postings in Richmond and Townsville, and at the Princess Alexandra hospital in Brisbane when, in 1987, she began her duties as a Captain Medical Officer at 5 Camp Hospital, Duntroon.

She married a fellow army officer, Klaus Felsche, in August 1988 and settled in Canberra where she worked after hours at the Woden Valley and Calvary Hospitals. In 1991 she was promoted to major and given a posting to the Directorate General of Army Health Services. The following year she was posted to the 1st Military Hospital at Yeronga in Queensland as the Medical Officer in Charge of Clinical Services; not long afterwards she was admitted as a Fellow of the Royal Australian College of General Practitioners.

In 1993, Dr Felsche accepted a six-month posting as the Australian Medical Officer with the 4th Australian Staff Contingent to the Mission des Nations Unies pour le Rèfèrendum au Sahara Occidental (United Nations Mission for the Referendum in Western Sahara, Minurso).

Her work there began with an attachment to a Swiss medical unit working out of tents in Layounne, she then moved on to deployments at United Nations observation posts under the control of Minurso. These deployments had their own dangers and discomforts: strong desert winds blew relentlessly and land mines in the surrounding countryside were known to move with the shifting sands.

On 21 June 1993 Felsche joined a small team of staff that were travelling to provide medical support from a United Nations tent base at Awsard, in the middle of the Sahara Desert. The small Pilatus Porter aircraft in which she was travelling developed problems on take-off and crashed, killing three of the four crew and most of the passengers, including Dr Felsche.

BY ASSOCIATE PROFESSOR SUSAN NEUHAUS

Refs: Australian War Memorial https://www.awm.gov.au/collection/P10676763

Other People's Wars pp 189-198 in Not For Glory: A century of service by medical women to the Australian Army and its Allies. Susan J Neuhaus and Sharon Mascall-Dare, Boolarong Press 2014

Invitation from AMA President to participate in aged care survey

The Australian Medical Association invites you to participate in a brief online survey to help inform AMA policy and lobbying in the area of medical services for older Australians.

Australia is experiencing an ageing population with more complex medical conditions than before. In 2016, there were 3.7 million people aged over 65 in Australia, and this is expected to rise to 8.7 million by 2056. The prevalence of Dementia, a leading cause of death in Australia, is predicted to increase to 900,000 by 2050 (298,000 in 2011).

Currently, Australia's aged care system is failing this older population. This has become increasingly evident over the past year, with multiple stories of negligence highlighted in the media. In particular, the serious neglect in patient care at the Oakden Older Person's Mental Health Service has sparked both an independent review and a Senate inquiry into the quality of the whole aged care system.

If nothing changes, Australia's ageing population will see a system diving further into inadequacy, putting the lives of our patients, and families, at risk.

This is why the AMA will continue, and increase, our advocacy in aged care. Part of this advocacy will also involve updating our position statements to reflect the current climate.

This is where we need your help. As members, this aged care survey gives you an opportunity to comment on your experiences with aged care, and better inform our advocacy strategy, our position statements and our submissions. In developing our future advocacy resources, we want to focus our efforts on ensuring that medical practitioners who provide medical care to older Australians are supported, and their needs are highlighted to government.

Similar surveys were undertaken by the AMA in 2008, 2012, and 2015.

In 2015, the AMA Aged Care Survey revealed the major reasons affecting the provision of medical care in the aged care sector were the lack of availability of suitably trained and experienced nurses, and MBS rebates not properly compensating for the time spent away from surgery.

The results from this 2017 survey will be compared to these earlier surveys to identify trends and measure some of the changes over the past nine years.

The survey takes approximately 15 minutes to complete. Your individual response will not be identifiable, however overall survey results will be published. I urge you to please take the time to complete this very important survey.

Click the following link to begin. Please complete the survey only once.

https://www.surveymonkey.com/r/amaagedcaresurvey2017

The survey closes on Monday 27 November 2017.

DR MICHAEL GANNON
AMA PRESIDENT

November is Asbestos Awareness Month

Australia has one of the highest rates of asbestos related illness in the world. Every year, thousands of Australians die from asbestos-related illnesses such as mesothelioma, asbestosis and lung cancer. It should come as no surprise. Hailed for its durability and affordability, asbestos enjoyed a heyday in Australian construction sites up until the mid-1980s. Such was our love affair with the product, it is estimated that one in three Australian homes contain some form of asbestos.

We now know that for all of asbestos's hardiness and cost effectiveness, the characteristic it should be most defined by is its carcinogenic properties. Generations of Australians were exposed to asbestos through their occupation, through home renovations or simply through living in a house built with asbestos-containing materials. While the risk of developing asbestos-related diseases increases with the extent of exposure, no safe level of exposure exists.

With the benefit of hindsight, it is easy to see the abhorrence in the wilful cover-up that allowed thousands of Australians to continue to be exposed to a known carcinogen. The use of asbestos was largely discontinued in the 80s, however, it was not until 2003 that asbestos and all asbestos-containing products were banned.

Symptoms of asbestos-related diseases may take up to 30 years after initial exposure to develop, and the average latency period of mesothelioma is 45 years. Consequently, the end of the asbestos-related illnesses is generations away.

The month of November is Asbestos Awareness Month in Australia and it provides an important opportunity to reflect on our own risk of exposure, and that of our patients. The risk is not confined to the fibro weatherboard archetype that has become synonymous with asbestos; it can appear in roofing, gutters, vinyl flooring and in brick cladding. There is a risk of asbestos in any house built or renovated before 1987, yet many people are unaware that they are living with such a threat.

It is never safe to assume that your house does not contain asbestos. Asbestos Awareness has developed a number of materials to allow everyone from professional tradies, to DIY renovators to better understand the risks of asbestos. These tools are an essential starting place for anybody looking to undertake any home renovations, and what you discover may save your life.

For more information visit: asbestosawareness.com.au

GEORGIA BATH
AMA POLICY ADVISER

Progress and barriers to a digital health upgrade

In collaboration with Harvard Business Review Analytic Services, Microsoft has published a briefing paper that highlights the progress being made in digital-enabled health care, the barriers to progress, and how a digitally augmented system can improve the lives of all Australians.

Microsoft sought input from Australian experts on the current and future state of our health care system and has released *Embracing the Change Mandate: The 2020 Digital Transformation Agenda for Australia's Health Care Sector.*

Establishing a new digital health care system is complex.

"We need to deliver care; reduce errors, waste, and duplication of services; and create a sustainable system amid growing expectations and financial constraints," says Professor Johanna Westbrook, Director of the Centre for Health Systems and Safety Research (CHSSR) at Macquarie University in Sydney.

The report states there are key steps for leveraging digital technologies: working towards full digital transformation; localising international technology options; collaborating with technology providers and IT staff; sharing lessons learned within the sector; promoting digital success; and developing digital health skills.

With Australian healthcare organisations clearly moving down the track to digital health initiatives, many have seen positive results.

Richard Royle at PricewaterhouseCoopers Australia believes the evidence supports electronic records leading to improved length of stay and clinical outcomes.

"The ability to document, in an electronic record, the clinical pathways to follow for diagnoses produces greater consistencies of clinical outcomes and reduces readmissions," he says.

However, there are still digital challenges needed to be overcome.

Dr Andrew Hugman of South East Sydney Local Health District, part of NSW Health, also contributed to the report and believes there needs to be greater engagement across all stakeholders.

"Many clinicians believe health IT projects create barriers to patient care as opposed to being the crucial tools for delivering the potential for massive gains," he says.

"Once there is a better awareness from both the public and clinicians of how we can use the huge amount of health data we are collecting, there will be more drive for greater transparency to interrogate and analyse the data."

The AMA provided a submission earlier this year to the Joint Standing Committee's inquiry into the rollout of the National Broadband Network (NBN). The submission focused on broadband access for regional, rural and remote health services, while centred around the principle that all Australians, regardless of where they live or work, should have equitable access to high-speed and reliable internet services.

The submission highlights that the NBN is a necessary and worthy investment that is needed to enhance the important contribution made by regional areas to Australia's economy. It notes that the economic and social benefits of advances in information and communications technology can only be fully realised through access to fast, reliable and affordable broadband services.

However, the submission notes there are many regional rural and remote areas that have very poor broadband connection. Internet services delivered via satellite only make available relatively small download allowances and these come at a much higher cost and slower speed than those services available via fibre or fixed wireless in metropolitan areas. The submission stresses that this 'data drought' must be addressed as a matter of priority.

Among other things, the AMA has urged the Government to find ways to extend the boundaries of the NBN's fibre and fixed wireless footprints into the satellite footprint wherever possible to lessen the reliance on satellite for those living in rural and remote Australia and to address the increase in internet usage over time.

A copy of Microsoft's report can be found here: file:///C:/Users/mhorne/Downloads/20624_HBR_Briefing%20Paper_Microsoft_Health.pdf

The AMA's response to the Joint Standing Committee's inquiry into the rollout of the National Broadband Network (NBN) can be found here: https://ama.com.au/system/tdf/documents/AMA%20submission%20to%20Joint%20Standing%20Committee%20on%20the%20NBN.pdf?file=1&type=node&id=46166

MEREDITH HORNE

GPs - more accessible than ever

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

> "All that is required is a little communication. Our patients should know that if they need to see us they only have to call to see if we can help them."

As a GP who is there for his patients, providing urgent appointments, aged care visits, home visits and palliative care, I am fed up with the claims being perpetuated by those pursuing their own agendas under the guise of improving access to health care. Time and time again, we hear that GPs are over-burdened and inaccessible. This is used to argue the case for expanded scopes of practice and healthcare models that fly in the face of medical evidence.

A quick search of online GP appointment booking systems quickly demonstrates the significant number of appointments available on any given today. While patients may not always be able to see the GP of their choice, the vast majority of practices provide patients with an option to see a GP.

The most recent Australian Bureau of Statistics *Patient Experience Survey* highlights that the proportion of patients who waited longer than they felt acceptable for a GP appointment has decreased, and has been decreasing in recent years, both in metropolitan and rural areas.

In my experience of general practice, practices always keep aside a number of appointments each day for acute cases. In addition, newer doctors to the practice will often have more appointments available as they build their patient lists. Cancelled appointments can be utilised by others who need them and we often squeeze in a patient between appointments.

All that is required is a little communication. Our patients should know that if they need to see us they only have to call to see if we can help them.

The story that it is too hard to see a GP is being perpetuated by other groups with their own agenda. Some use it to justify overhauling the health workforce while others use it to promote or improve their own business models. Most recently this argument has been propagated in an attempt aimed at circumventing the TGA's recommended up-scheduling of codeine.

When it comes to pain management, the evidence is in. Low dose codeine is ineffective for the majority of people and it comes with significant health risks. Acute pain can be better treated with other combination analgesics which remain available over-the-counter (OTC).

Persistent pain should be a signal for patients to see their doctor, not a reason to escalate self-medication with a highly addictive drug. How many OTC purchasers of codeine products truly understand that, once metabolised, they are effectively using morphine. These ineffective medications not only carry the risk of addiction but the risk of harm by over use of their companion analgesics.

Frankly, I find the suggestion that GPs would be burdened by discussing with patients their pain and the best ways to treat or manage it, highly offensive. Reducing access to potentially harmful medications is good for patient care. A GP consultation for patients experiencing strong and persistent pain is the best pathway to a good health outcome.

GPs are busy, but we have seen a significant increase in GP numbers across the county. Access is much improved and our patients need to know that we are there for them, including on those occasions when they need more urgent care. Our politicians need to know this too.

As part of the AMA's effort to spread this word, the Council of General Practice, at its recent meeting, agreed that the theme for next year's Family Doctor Week will be 'Your family doctor: here for you'. It is up to each of us to disseminate this message and to deliver on it.

Physician – care for thine own health

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

The suicides of several young doctors recently have activated concerned discussion about how to do better in preserving and protecting the health of caring professionals. If there were a simple solution it would have been applied decades ago.

It is not only mental health that is a concern, complicated by illicit drug use or not, identity crisis or relationship upheavals. Doctors' health more generally is a worry. That such is the case is clear testimony to the insufficiency of knowledge about health and illness alone to empower the individual to choose wisely.

Recently I spent 10 days in a Sydney teaching hospital receiving intravenous antibiotics for a nasty episode – my first – of diverticulitis. The literary genre of 'I am a doctor and I got sick and I will tell you all about it' contains the occasional interesting account but much dross, so I won't bang on about my experience. But reflecting on my illness confirms insights. I doubt that I took action soon enough and instead used symptom-denial and fantasy to justify delay. It was lucky I did not have an enteric rupture.

I discussed this experience with my friend Peter Arnold, a retired general practitioner who has served on boards and committees concerned with doctors' health and impairment. Writing in *Australian Medicine* in 1997, Dr Arnold put the proposition that every doctor should have their own general practitioner.

"Despite regular advice to this effect to the profession at large, from bodies concerned with doctors' health, it is patently difficult for doctors to accept another doctor as their GP. It is, of course, more difficult for doctors in small towns, but, in an age of modern telecommunications [to which may now be added Skype] and air travel, it is possible to have a one-to-one relationship with a GP, distance notwithstanding."

Why does this not happen? Arnold advanced several reasons derived from his experience with doctors who were impaired or ill. A fear of ridicule if the ailing doctor's own diagnosis is wrong, a denial of the import of symptoms (I can identify with that one), a loss of 'doctor authority' as one becomes a patient, the question as to whether one doctor can trust another who may not be as expert, making an appointment and sitting in the waiting room, and concerns about the confidentiality of my record in a group practice.

"Each of the reasons has some validity," Arnold wrote. "Added together, they constitute a formidable obstacle to having your own GP. But against this, the downside must be considered carefully.

"By not having a GP, you leave yourself open to a lack of preventive care, missing the onset of insidious illness and the opportunity of early intervention, objective assessment and appropriate management of your problems, psychological support when under stress and all the other 'good things' about having that continuing, monitoring relationship with a GP which makes you recommend them to all your patients.

"If there is one universal piece of advice which we give to doctors presenting with problems at the NSW Medical Board, it is: 'Get yourself a GP'."

I was embarrassed, when I fronted up to my GP with my discharge papers in hand, to realise how irregularly I had attended. Was my most recent colonoscopy five years ago? "Actually seven!" I was told politely. The list of meds in my record was wildly out of date.

A further barrier to seeking medical assistance for our own ills has been the requirement for mandatory reporting of impairment. This is a two-edged sword, the self-destructive edge being that it may prevent doctors from seeking necessary care because of fear. Recent changes to the law have diminished this problem and Minister Greg Hunt is taking positive action,

Another trick I used when ill was an imaginative reinterpretation of my symptoms that I think owed more to my interest in poetry than in rational prose! In retrospect I was surprised that I could have spun such a confected set of interpretations around apparently minor bodily dysfunctions. In reality they weren't! I swear that I will not fall into this trap again – but then...

The message is clear. Don't treat your family and don't treat yourself. When it comes to your own health seek external interpretation and treatment, preferably from a practitioner who knows you well. Try your GP.

The wind against, Out Back

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

Professor Paul Worley, as you all are now aware, is our inaugural Rural Health Commissioner.

Just pick up any medical newsletter and you will get his background, credentials, experience and why he was appropriately chosen for this difficult role.

So rather than attempt another biography, I'd like to share a story he shared with some of us in a workshop we attended at the Rural Medicine Australia Conference in Melbourne. The subject was "When paying your bills is not enough" and was addressed to the RDAA Female Doctors group, mainly to an all-woman audience.

This story allows you to get to know a bit of his personal perspective*, and it may give you a glimpse of the man.

Paul rides his bike with his two sons in the countryside around Adelaide. You know, where the Tour Down Under is held. Gorgeous countryside, the rolling hills were for them to attack and conquer. And one morning they did. The three of them were in their glory, on top of the world, three athletic cyclists. This was so easy! What a super sport, didn't they have such great stamina, quadriceps, speed?

Time to go home, they turned around and quickly realised they had been cycling with the wind on their backs. The road back home was another journey altogether, against the wind. Their lungs burned, lactic acid in those super quadriceps, stamina waning. This was really tough! They required frequent rest breaks, more hydration, and some internal resilience to get the job done. Same road, same equipment, they now had a new force to deal with, fighting this hidden powerful adversary. The way home was humbling.

Paul then summarised: pedalling with the wind on your back is like being a man in this medical workforce.

The journey, the achievement necessary to succeed appears to be the same for both men, women, IMGs, visible minorities, those with English as a second language.

But there are those of us who are pedalling against the wind. My extrapolation, I think those of us in Rural Australia are also pedalling against the wind.

Our "winds" are:

- The Tyranny of distance;
- Lack of both medical and personal resources;
- Insufficiency in the workforce;
- Impossible rosters;
- The need to be a GP and a specialist at the same time;
- Third World chronic diseases;
- Decrementing infrastructure with hospital closures;
- Environmental hardships such as 50 degrees and dogs;
- Lack of broadband internet;
- Disrespect from our Urban critical colleagues;
- Loneliness, depression, distance from family; and
- Lateral violence.

If you haven't thought of your journey from this light, just take a look from Paul's perspective.

Dr Worley will affect you profoundly as the orchestrator of new Rural Pathways. I want you to know, I think he gets it, this new Rural Health Commissioner. I hope you meet him soon, he is familiar with Rural Medicine. But you will also find he knows humility, fighting against the wind. He knows us.

* *With acknowledgement to his wife Liz for the idea.*

INFORMATION FOR MEMBERS

Essential GP tools at the click of a button

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

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

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

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

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

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

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

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

Fearmongering with doctors in training

BY DR KATHERINE KEARNEY, CO-CHAIR AMA COUNCIL OF DOCTORS IN TRAINING

> "DITs are afraid, of not passing exams, not getting onto a training program, not getting a job at the end of many years training. Fear about the state of the Australian medical workforce is drilled into us from the first year of medical school."

Over the past decade, there's been a remarkable development of companies and offerings for doctors in training (DITs) to help them pass their exams, get selected onto a program or generally get ahead in an increasingly competitive environment. The range of companies putting forward these type of services has developed from opportunistic small businesses to, now, prestigious universities looking for their piece of the DIT panic money pie. These courses have a significant logistical impact on service provision within hospitals as well as financial and stress impacts on trainees.

What is the appeal of pursuing these type of extracurricular activities? DITs are afraid, of not passing exams, not getting onto a training program, not getting a job at the end of many years training. Fear about the state of the Australian medical workforce is drilled into us from the first year of medical school.

As students, we hear about it from stressed interns and residents. As interns and residents, we hear about it from panicked registrars and fellows. Ceding control over how, where and in what capacity we'll be able to practise medicine - and live and raise our families – to the whims of medical system that isn't investing meaningfully in medical workforce planning would raise the heckles of most in the community. Getting a little self-direction back is pitched as, as easy as signing up to our course, which will definitely get you through your exam, or improve your chances of selection.

Exams are challenging and in an uber-competitive job market, failure appears untenable. It seems insurmountable, career-defining, and not enough of those on the other side talk about their own challenges and how they faced them on the journey of their medical careers. If everyone else is doing it, and it purports to be necessary to pass - you don't want to be the only one left behind.

Aside from the monetary cost, which is reaching new heights especially for exam years beyond even the expense of college annual and exam fees, the message that DITs allow in their mind is that this is legitimately necessary. My education provided by my hospital, my supervisors and my College aren't enough. I have to spend significant chunks of my own hard-earned income to be able to do this. This feeds impostor syndrome - that little voice that says I'm not good enough to do this, I'm not meant to be here. Separately, it drives the CV arms race where a Masters Degree is rapidly becoming a necessity, not a standout.

So, what can be done? We can take notice. Colleges and hospitals and supervisors can take notice. We can look at our curricula and educational strategies. Are they really effective if this is happening? Are we testing the right knowledge and the right skills if it has to be delivered at such cost and outside of the workplace? The RACP advocates for both fellows and trainees to follow the 70:20:10 model of learning - where 70 per cent is experiential, 20 per cent social and 10 per cent formal learning. This is the type of sensible approach that DITs need to reinforce in their own thinking and see demonstrated in the workplace. Supervisors and mentors are an important part of modelling realistic behaviour.

There's a place for some of these courses, as complementary educational strategies, but which are truly beneficial and which are exploiting trainee fear, under a guise of empowerment? I would ask DITs to consider how any course aligns with their educational aims and assess as objectively as possible the cost-benefit in terms of time, money and stress.

Democracy Inaction

BY ROB THOMAS, PRESIDENT AUSTRALIAN MEDICAL STUDENTS' ASSOCIATION

> "The tyranny of a prince in an oligarchy is not so dangerous to the public welfare as the apathy of a citizen in a democracy."
> - Montesquieu

The position of AMSA President has been rewarding in many ways for me. I've had the opportunity to learn and be inspired by those around me, and come to high-level meetings, often several decades younger than the next person in the room. I get to hear the many views of my peers and on my best days, hope to represent 17,000 young people.

It's fair to say that this year has been an incredible learning curve, beyond that of an average medical school year. I've learnt more about health and the education systems and have advocated for improvements in both. But perhaps most interestingly, I've learnt much more about leadership and the democratic process.

I find young people in general get a bad rap when it comes to political engagement. It's true, there is less identification with traditional party politics among young people, but engagement through petition-signing or demonstrations is much higher. I find this very interesting in an age where political leaders are torn down just as quickly as they emerge. Perhaps we demand too much from our leaders, particularly if we're not engaging them in traditional ways.

With the information revolution also comes the need to be discerning, and to protect oneself. I've seen this myself in the marriage equality debate, one that I have a stake in and at times need to actively block from my mind. On issues such as climate change and health inequity overseas and at home, young people can be discouraged by inaction from our leaders and in so doing disconnect.

One very interesting thing I've found about the advocacy sphere is how lonely it can be. Organisations such as the AMA and AMSA, and of course the Government, rely on facts and opinions from their constituents. We do this through survey or election, but often we only get half the picture. Worse still, some representatives receive feedback only when it's negative, and I feel for those who don't get the thanks they deserve.

On the other hand, representing any large group of people will involve strong differences of opinion, especially when it may involve life and death. The success of the National Rifle Association in America depends on the simplicity of their message – "no" to any information or regulation on gun ownership. The larger the organisation and more diverse its mandate, the more power it may hold; but it may start to represent more differences of opinion than similarities. On leadership, it's important to be aware of these differences, as I believe it only legitimises your stance to show respect to the other side. As health professionals, we need to be able to flex and adapt to new information, and that only comes when we refuse to switch off. By our very nature we should challenge our assumptions and our preconceived notions to achieve the best for the public.

At the top I left a quote about the danger of apathy. Yes, democracy has its flaws, as we seem to witness time and time again. However, the only answer I can come up with is to engage in it - for those in power to make themselves available to opinion, and for those not in power to realise that there is power in that too. There is no good in burying one's head in the sand. Democracy inaction is democracy in disaster.

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What will the next health reform agreement bring?

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

The Health Financing and Economics Committee (HFE) has a very keen interest in the likely direction and detail of the next public hospital funding agreement that will take effect from 2020.

Negotiations between the Commonwealth and State Health Ministers will begin in earnest in 2018 but early signs of the likely reform agenda are emerging, with some consistent themes coming to the fore. Unsurprisingly, most of these themes are a continuation of the changes to public hospital financing agreed by all Australian Governments in June 2017 as documented in the National Health Reform Addendum. Whether States and Territories agree is hard to predict and will likely depend how much new funding, and over what period, the Commonwealth Government is prepared to offer it.

The themes in the Addendum we would expect to see considered as part of a 2020 agreement are:

i. improve patient outcomes;

ii. decrease avoidable demand for public hospital services;

iii. improve the coordination of care for patients with chronic and complex conditions to reduce avoidable demand for hospital admissions for this group;

iv. incentives to reduce preventable, poor quality patient care; and

v. incorporate quality and safety into hospital pricing and funding to reduce poor quality patient care: sentinel events, hospital acquired complications and avoidable readmissions.

Recent media speculation suggests Minister Hunt will seek COAG agreement to reward jurisdictions that can demonstrate improved patient outcomes, with the goal of readmissions over the short term being avoided.

Such a move may also represent the first step towards 'outcome based' hospital funding. Media speculation also suggests the Government will frame the push as a reduction in 'low value care'. It is likely not coincidental that the Productivity Commission released a report on 24 October 2017 that recommends low value care in public hospitals should not be funded. Of course, what is finally argued by the Commonwealth in the lead-up to the negotiations with State Ministers is yet to be seen – but it is clear they are laying the groundwork.

On the topic of coordinated care, it is worth noting that jurisdictions already have the ability to enter bilateral agreements to trial coordinated care initiatives, for the 2017-2020 period. These are intended to inform the development of an evidence-based national approach in the 2020 funding agreement – but clearly we are also in early days of this work.

The National Health Reform Addendum reforms might be worthy in the abstract – it is hard to argue against improved patient outcomes, a reduction in preventable poor quality patient care, better care coordination across the boundary of admitted/non-admitted care – especially for patients with one or more chronic conditions.

But whether they are they worthy in practice depends entirely on how they are implemented. For example, shifting public hospital funding away from payments based on cost and quantity to a formula based on patient outcomes represents a massive organisational change for the public hospitals delivering the care. They will require substantial additional funding to build the necessary organisational capacity. And this will take time.

Outcome-based funding will also require substantial new government investment in data infrastructure to collect and measure robust clinical patient outcome data - not just patient reported outcomes, which may or may not be clinically relevant. It must include patient outcomes in the non-admitted setting. This capacity does not yet exist. We first need robust, consistent primary healthcare data definitions used and recorded by all primary healthcare providers. The primary and tertiary outcomes data must be linked. And if the Government is serious about linking outcomes to funding and 'quality' then it would need to develop an entire framework of quality-adjusted life year (QaLYs) per episode of care. Overcoming the constraints and barriers inherent in health system that is structured within a Federated system of a government is no small feat, nor will it be cheap.

So far, the AMA has been bitterly disappointed in the government's opportunistic use of the 'improved safety and quality' agenda to do little more than reduce the Commonwealth's share of public hospital funding. My *Australian Medicine* article published on September 18, 2017 summarises this. The AMA will be carefully examining the detail of the 2020 health care agreement to ensure it is a genuine effort to empower public hospitals, including in providing them with the resources they will need to successfully transition to outcomes based funding with improved care-coordination. These are massive reforms that will require time, a clearly articulated evidence-based pathway and substantial new Commonwealth investment, not less.

Close the clean drinking water gap

BY AMA PRESIDENT DR MICHAEL GANNON

Safe drinking water is an indispensable human right. The leading national and international health bodies, such as the World Health Organization and the United Nations, all agree that safe drinking water is essential to sustain life, and a prerequisite for the realisation of other human rights. The UN General Assembly explicitly recognises the human right to clean drinking water.

Having access to sufficient, safe, accessible and affordable drinking water is an important public health issue.

In developed nations such as Australia, it is often assumed that safe drinking water is accessible to all. However, this is not the case, particularly in many remote or very remote communities where artesian (bore) water is often the primary source of drinking and household water.

According to the Bureau of Statistics (2007), for discrete Indigenous communities the majority accessed bore water (58 per cent), while other sources of water included: town supply (19 per cent), river or reservoir (5 per cent), rain water tank (3 per cent), well or spring water (3 per cent), and other sources of water (2 per cent).

While the supply of potable water (defined as water that is safe to drink or to use for food preparation, without risk of health problems) impacts on all people living in remote areas of Australia, Aboriginal and Torres Strait Islander people are disproportionately affected.

Many Aboriginal and Torres Strait Islander people living remotely find it challenging to obtain water that is of sufficient quantity (and quality) to meet their needs.

In 2012, the Australian Bureau of Statistics estimated that there were more than 400 discrete Aboriginal communities across Australia, with the largest number in Western Australia. Data collected on over 270 remote WA communities indicated that the quality of drinking water did not meet the Australian standards, as outlined in the Australian Drinking Water Guidelines (ADWG), approximately 30 per cent of the time.

While the National Health and Medical Research Council (NHMRC) has responsibility for the ADWG, this is not a mandatory standard, with State and Territory Governments and local councils responsible for the implementation and monitoring of water quality and safety. Yet during the two year period 2012-2014, 80 per cent of remote Aboriginal communities in Western Australia failed to meet quality standard testing at least once.

There are obvious health consequences from drinking poor quality water. Some Aboriginal communities are known to have unsafe levels of chemical contaminants such as nitrates and uranium in the water. Nitrates and uranium occur naturally, and are common in the Goldfields and Pilbara regions.

'Blue Baby Syndrome' – where an infant's skin shows a bluish colour and they can have trouble breathing – can be caused by excessive nitrates in the diet, which reduce the blood's ability to carry oxygen. It can occur where prepared baby formula is made with well water. Water tested in over 270 remote communities in WA showed nitrate levels 10 times the recommended levels.

It is concerning that Aboriginal and Torres Strait Islander people living remotely often have no choice but to pay for safe drinking water. While the majority of us enjoy free, safe drinking water from the tap, those who can least afford it often have to pay just to ensure they are not drinking water sourced from rivers, streams, rivers, cisterns, poorly constructed wells, or water from an unsafe catchment.

The AMA is a member of the Close the Gap steering committee and the Public Health team has raised potable water as a Close the Gap target.

The solution may not just be in more bottled water. In communities without adequate recycling and waste disposal services, thousands of extra plastic water bottles create additional environmental problems.

Governments must invest in infrastructure, such as proper treatment facilities, water storage facilities and distribution systems to meet the changing demands of communities.

All Australians must have permanent and free access to safe water. It is a basic human right and it is difficult to understand how this hasn't already been implemented and addressed.

Encouraging times for rural health

BY **AMA VICE PRESIDENT DR TONY BARTONE**

> "The challenge remains – we need to get doctors to rural communities, and give them the opportunity to experience rural and remote medicine and make it an attractive and valuable career option."

Readers of this column will know that improving access to health care for rural Australians is one of my chief motivating passions.

We know there are many indicators that show people living in the bush generally suffer worse health outcomes than those in major cities.

Regrettably, many of the initiatives put in place to increase training places in rural Australia and expand the local medical workforce have not improved these discrepancies, kept pace with the demand for rural medical services, nor resulted in a better distribution of suitably qualified doctors.

The challenge remains – we need to get doctors to rural communities, and give them the opportunity to experience rural and remote medicine and make it an attractive and valuable career option.

Some may feel achieving real change is a truly Sisyphean task.

But with the recent appointment of Professor Paul Worley as the nation's new Rural Health Commissioner, there is perhaps some cause for optimism. Professor Worley has made a substantial contribution to rural health over many years; all of his experience will be needed for this welcome opportunity to build a strong health care workforce in regional, rural and remote Australia.

One of Professor Worley's important tasks is to help the Government design and roll out a national rural generalist pathway. The pathway will try to address the lack of access to training for rural generalists with the ultimate aim of improving the supply of doctors to rural and regional communities.

Many people have been waiting for the announcement on the Rural Health Commissioner for a long time; we are not alone in believing that Australia's medical workforce needs more generalists to meet the healthcare needs of rural (and metropolitan) communities as the demographics of the population shift and the numbers of patients with long-term chronic conditions and co-morbidities rises.

The AMA has been championing for a long time an improved and expanded advanced training pathway for rural generalists, with the proper resources to attract and train the appropriate number of doctors with the right skills mix necessary for rural practice.

The Queensland Rural Generalist Pathway is often put forward as the model for vocational training that could increase the numbers of doctors training and staying in rural locations, and able to deliver a broad range of hospital and community-based medical services, as well as the much-needed specialised services.

The Queensland model is a good starting point, and there is the potential to apply its principles to a national pathway that can be adapted to suit the geography and demographics of different regions.

Nonetheless, there are some contentious and vexing issues that will need to be addressed as the national rural generalist pathway is conceived and put into effect. For example, should there be quarantined procedural training places for rural generalist trainees? Should some thought be given to extending the training pathway beyond general practice as a strategy for ensuring a balanced rural workforce with the right skills mix?

Concerns around accreditation, training and recognition will need serious collaboration between the Colleges and health services.

Several AMA committees are considering the design principles for the national rural generalist pathway.

We look forward with great purpose to meeting with Professor Worley soon to discuss our ideas. Overall, the signs are positive for rural health.

Health on the Hill

POLITICAL NEWS FROM THE NATION'S CAPITAL

Senate Committee hears AMA on private health insurance

AMA President Dr Michael Gannon appeared before the Standing Committee for Community Affairs Senate Inquiry into the Value of Private Health Insurance on 31 October, supplementing the AMA submission lodged with the Committee in July.

Dr Gannon told the Committee that the private system is an essential part of the health system and working with the public system to deliver the care Australians expect and deserve.

But he also began dispelling a few myths about the causes of consumer discontent with private health insurance.

Out-of-pocket medical costs are not the cause of discontent among consumers with their health insurance, he said.

"Most consumers understand that they may need to contribute to the cost of their care," Dr Gannon said.

"The problem facing consumers is that they believe they are covered, but have inadvertently purchased a product that is, unfortunately, useless. If a policy does nothing more than avoid the tax penalty, it is a junk policy."

Out-of-pockets costs are not growing. The proportion of health expenditure funded by individuals, not Government or insurers, has remained relatively static at 17 per cent over the decade to 2015-16.

Importantly, of that 17 per cent of health expenditure funded by individuals, only 10 per cent is spent on medical services. The majority of individual expenditure is on dental services and pharmaceutical products. Out-of-pocket medical expenses are a small proportion of what patients pay for their healthcare.

"The second myth is that medical expenses are the cause of increased premiums," Dr Gannon told the Committee.

"Medical expenses are a small proportion of total benefit outlays for private health insurers. Medical expenses, as a proportion of benefits, have remained static at around 16 per cent since 2007.

"In fact, administration expenditure by private health insurers is around 10 per cent. So it is costing insurers almost as much to run their business as it is to pay for the practitioners who treat their customers."

With regard to individual out-of-pocket costs, the AMA has a clear position that it does not support exorbitant charges or egregious fee setting, i.e. fees that the majority of a practitioner's peers would consider to be unacceptable.

Further AMA position statements maintain that providing informed financial consent is not only best practice, it is demanded by medical ethics.

The clear majority of practitioners charge a reasonable amount. The vast majority of health care provided in Australia is provided at no direct cost to the patient. 88.1 per cent of services are provided at no-gap and a further 6.9 per cent have a known-gap charge of less than $500.

A major source of gaps is the extended freeze on Medicare Benefits Schedule rebates, which has led to insurers also freezing payments to doctors or indexing well below inflation.

The MBS continues to fall behind. Health inflation has sat between 3.6 per cent and 6.6 per cent per annum over the past seven years. Over the same period of time, PHI premium increases have been between 4.8 per cent and 6.2 per cent. Even when it was not frozen, MBS rebates have increased at best by 2 per cent, meaning that the MBS rebate is far removed from the cost of providing a quality specialist service.

Dr Gannon then turned to the next challenge for this inquiry. It is an issue of social policy – what is the role of the private health insurer?

From the AMA's perspective, he said, it is a payer for medical services, not a manager of clinical care.

"Private health insurers are moving private health care in Australia towards a system similar to that of the United States – a 'managed care' system," Dr Gannon said.

"Health insurers in Australia are focused on minimising their expenditure and are creating barriers for patients accessing care. These are the same patients that have paid substantial premiums for top cover.

"Who is running the health system? The shift to a for-profit industry has created the need to ensure that there are sufficient profits to allow a return to shareholders. APRA data show an industry surplus (before tax) of $1.56 billion for the 2015-16 financial year, up from $1.45 billion for the previous year."

Health on the Hill

POLITICAL NEWS FROM THE NATION'S CAPITAL

This inquiry has come at a crucial time. Insurers are understandably concerned about the viability of the sector.

Insurers need to improve their offerings. Insurance products should be easy to understand, payments should be made on clinical need, and the 'de facto' risk rating system created through products with incomprehensible exclusions and 'carve-outs' needs to cease.

The AMA supports a system of Bronze, Silver and Gold product standards. All policies should cover maternity services and mental health services.

The policies must be based upon an agreed set of standard understandable clinical definitions, Dr Gannon stressed, saying the categories must be more than labels. "The review into private health and the Government needs to deliver on removing the policy confusion from the 20,000-plus policies," he said.

CHRIS JOHNSON

Government's Brain Cancer Mission

The Federal Government has announced a $100 million funding plan to rapidly increase brain cancer survival by bolstering patients' access to clinical trials and accelerating the discovery of new therapies.

This will be done by expanding research platforms and technologies, and equipping researchers with the best tools and infrastructure.

The Australian Brain Cancer Mission is a partnership between the Federal Government, philanthropists, medical experts, patients and their families.

As a first step, the Government is providing $50 million through the Medical Research Future Fund (MRFF), combined with $10 million from the Minderoo Foundation's Eliminate Cancer Initiative and a commitment of $20 million from Cure Brain Cancer Foundation.

The Government is expected to announce the remaining $20 million in the coming months.

Health Minister Greg Hunt said the commitment was made with the aim of halving deaths from brain cancer over the next decade and to "imagine the potential in our lives to eliminate brain cancer as a fatal disease".

The Mission is underpinned by a research roadmap developed by Australian and international experts in brain cancer treatment and research, and those affected by brain cancer, their advocates and philanthropic interests.

Cure Brain Cancer Foundation chief executive officer Michelle Stewart said the announcement: "Makes a massive difference in the new activities that can be started up, but also in terms of providing a spotlight for brain cancer.

"We've never had an overall strategic framework or a plan for tackling brain cancer and now we have a national plan."

Ms Stewart said brain cancer killed more than 30 children in Australia each year, more than any other disease. It also kills more people aged over 40 than any other type of cancer.

A key objective of the Australian Brain Cancer Mission is to ensure every patient, adult and child in Australia has the opportunity to participate in clinical trials.

"We want to get every Australian who has brain cancer the opportunity to be part of a clinical trial to address their particular type of brain cancer, there are more than 100 subtypes, and at the end of the day our goal is to halve mortality rates over the course of the next decade, but ultimately to defeat it as part of a global initiative," Minister Hunt said.

Prioritised first investments include the establishment of an Australian arm of the GBM AGILE, an international adaptive trial platform for adults with glioblastoma, which will be co-funded by the Turnbull Government, the Minderoo Foundation's Eliminate Cancer Initiative and Cure Brain Cancer Foundation.

Other priorities are new funding for Australian and New Zealand Children's Haematology Oncology Group (ANZCHOG) clinical trial centres, and support for the consolidation of the national ZERO Children's Cancer initiative.

There will be opportunities for new research grant projects, scholarships, fellowships and biopharmaceutical industry partnerships to collaborate on drug discovery.

Cancer Australia will administer the Mission, supported by a Strategic Advisory Group.

MEREDITH HORNE

Research

Cancer patients have increased risk of heart failure

Cancer patients have a high chance of heart failure within 12 months of diagnosis and subsequent chemotherapy treatment, a recent South Australian study has found.

The study of 15,987 patients identified 8,339 who received chemotherapy (817 children and 7,522 adults) subsequently received hospital treatment for heart failure, with 70 per cent of children and 46 per cent of adults having an index admission within 12 months of their cancer diagnosis.

The study, funded by the Heart Foundation, was led by Professor Robyn Clark, who is a senior fellow as well as Flinders University's Professor of Acute Cardiovascular Care and Research in the College of Nursing and Health Sciences.

The research examined cardiac toxicity both quantitatively and qualitatively to gain greater understanding through a meta-review of 18 systematic reviews, linked data analysis, risk assessment, process mapping, patient interviews and a Consumer Consensus Statement.

Cardiotoxicity is a condition where there is damage to the heart muscle. It can be a complication from some cancer therapies, and as a result the heart may not be able to pump blood throughout the body as well.

"Despite being aware of this risk for over 30 years, currently there is no high-level evidence in Australia to guide clinician decision-making in the prevention, detection or management of cancer treatment associated cardiotoxicity," Professor Clark said.

The findings from the study included the revelation that more men than women developed heart failure (48.6 per cent versus 29.5 per cent). Also, heart failure (HF) patients had increased mortality risk compared with non-HF patients, with 47 per cent occurring within one year and 70 per cent within three years from cancer diagnosis.

The study recommends an increase for patient awareness of the risks and updating clinical guidelines aims to save lives and includes close heart monitoring. When patients receive a cancer diagnosis they should get a Heart Health Check with their GP and to work with their doctors to reduce their risk factors of heart disease.

Imelda Lynch, CEO Heart Foundation SA, believes it is vital to help clinicians identify cancer patients at greater risk of developing cardiac complications and, through early intervention, to improve patient outcomes.

"The impact of this research will be far-reaching and would not be possible without the generous donations the Heart Foundation receives from our wonderful community," Ms Lynch said.

Professor Clark's research was published on 17 October in the *Cardio-Oncology* journal.

MEREDITH HORNE

Diabetes data linked to double death rates

The Australian Institute of Health and Welfare (AIHW) has examined data from National Diabetes Services Scheme and the National Death Index to provide a more complete understanding of deaths among people with diagnosed diabetes.

With 280 Australians developing diabetes every day, the bearing of the disease and its complications have a major personal cost to the individual and their family as well the health system.

The AIHW believes their comprehensive picture of diabetes-related deaths is important for population-based prevention strategies and could help to improve care for all people with diabetes.

The report found that overall death rates among people with diabetes were almost twice as high as the general population. And, with around 1.7 million Australians having diabetes, the numbers are significant.

"Overall in Australia, there is a trend toward lower death rates, but for people with type 2 diabetes, these improvements have not been seen," AIHW spokeswoman Dr Lynelle Moon said.

"In fact, death rates among people with type 2 diabetes increased by 10 per cent between 2009 and 2014, mainly driven by the increase among the very old (85 and over)."

The disparity in death rates between people with diabetes and the general population was highest at younger ages – death rates were 4.5 times as high for people aged under 45 with type 1 diabetes and almost 6 times as high for those with type 2 diabetes, compared with the Australian population of the same age.

"Overall, diabetes, coronary heart disease and stroke were the most common underlying causes of death among people with type 1 or type 2 diabetes," Dr Moon said.

"Kidney failure was also a leading cause of death for people with type 1 diabetes, while dementia was a common cause of death

Research

in those with type 2 diabetes."

The report also shows that death rates among people with diabetes increased with socioeconomic disadvantage and remoteness.

People with diabetes living in the lowest socioeconomic areas experienced higher death rates than those in the highest socioeconomic areas. Among people with type 2 diabetes, the highest death rates were in remote and very remote areas.

Diabetes is the fastest growing chronic condition in Australia; increasing at a faster rate than other chronic diseases such as heart disease and cancer, according to figures from Diabetes Australia.

The total annual cost impact of diabetes in Australia is estimated to be at $14.6 billion. This includes a cost to the Australian health system of around $875 million per year in amputations. Diabetes Australia estimates that 4,400 amputations are performed in Australian hospitals every year, with up to 85 per cent of these preventable.

Diabetes Australia believes that awareness and early detection is incredibly important to address this growing concern and has called on the Australian Government to implement a Diabetes Amputation Prevention Initiative to ensure systematic early detection of foot problems, and early treatment to prevent amputations.

"Most people in the community have no idea that diabetes causes so many amputations. We need to raise awareness within the community and with key political leaders about the scale of the problem, its impact and what we need to do to fix it," Diabetes Australia CEO Professor Greg Johnson said.

"Every year thousands of Australians are not so lucky and have to undergo traumatic and debilitating amputations. The sad truth is that health outcomes for people undergoing major amputations are poor. Many people will die in the first five years after a major amputation."

MEREDITH HORNE

Research leads to innovative new lens

New research into eye health and the effect of prolonged exposure to digital devices has led to the introduction of innovative lenses designed to filter artificial blue light emitted from computer screens.

Crowd-funded Australian start-up EXYRA has developed a

ground-breaking lens that blocks natural and artificial blue light from entering retinas and causing muscular and visual damage to the eyes.

The eye's natural lens is not designed to filter artificial blue light from computer screens, tablets and other hi-tech devices.

Yet, as a society, Australians have become massively technology-dependent, with the average household using up to six different digital devices daily for two hours or more.

This includes for work, school and pleasure.

Prolonged exposure to such devices, more specifically the blue light emitted from LED screens, can be detrimental to overall eye health.

This can lead to a range of symptoms, including but not limited to, eyestrain, headaches, fatigue, neck and back pain, and blurred vision.

The newly developed lenses, offered in a range of optical frames, are currently being used in non-prescription and prescription applications, but not yet as bi-focals or multi-focals.

The option exists, however, of upgrading lenses to include greater magnification, allowing the wearer to accommodate varying degrees of contrast without the need for excessive focussing effort.

The glasses are specially designed to optimise vision when viewing digital screens by reflecting high energy blue light and enabling healthier blue-turquoise wavelengths to enter the retina in order to enhance full colour perception and protect the eye from muscle strain.

The lens's multi-layered construction also protects from UV damage, including glare.

CHRIS JOHNSON

WHO discusses health strategies for our region

Low breastfeeding rates and "aggressive" baby formula marketing have been raised as an urgent issue by delegates at the World Health Organisation's Western Pacific Regional Committee in Brisbane last month.

The annual meeting brings together ministers of health and senior officials from 37 countries and areas to decide on issues that affect the health and well-being of the Region's nearly 1.9 billion people.

A new WHO regional action plan has been developed to strengthen protections for children from the harmful impact of food marketing.

WHO remains concerned that the baby food industry manipulates policies and practices by creating a positive public image as well as denying wrong-doing. WHO also believes evidence suggests that infant formula industry advertisements, gifts and sponsorships promote misconceptions and myths and ultimately have a negative impact on feeding practices.

Marketing of breast-milk substitutes, including infant formula, follow-up formula and growing-up milk, to caregivers continues to undermine breastfeeding in the first six months and continued breastfeeding beyond that age.

"The baby formula business is booming," WHO's regional director Dr Shin Young-soo said.

"And that is undermining breastfeeding."

WHO believes that globally, 13 per cent of child deaths can be prevented with exclusive and continued breastfeeding.

Protecting children from the harmful impact of food marketing is critical in a region where more than 6.3 million children are overweight or obese. Countries were at the forum to develop a regional action plan to provide greater protection for children and support better health and nutrition, from birth onwards.

"When children are exposed to food marketing, their diets change," Dr Shin said.

WHO and the Australian Government have also launched their first ever country cooperation strategy, on the sidelines of the 68th session of the WHO Regional Committee for the Western Pacific.

Issues discussed at the forum included: eliminating major communicable diseases, including measles and rubella, as well as mother-to-child transmission of HIV, hepatitis B and syphilis; financing of priority public health services; strengthening regulation of medicines and the health workforce; improving food safety; and health promotion for sustainable development.

Dr Shin said the forum was important to the region because: "Our strength in solidarity is our best defence against whatever the future holds."

It also provided a vision for WHO's joint work with Australia over the next five years to improve the health of Australians and contribute to better health outcomes in the broader region.

Dr Shin Young-soo said the strategy with Australia is the first of its kind, but it builds on a history of strong cooperation while also looking towards the future. Traditionally, country cooperation strategies are established between WHO and developing countries, where the Organisation has offices and provides direct support.

"I sincerely thank Minister Hunt and the Department of Health for their commitment to this strategy – and for paving the way for other high-income countries in this Region, with a new form of engagement that goes beyond the traditional donor country relationship," he said.

Health Minister Greg Hunt, who attended the meeting, said the strategy: "Strengthens our systems to guard against emerging diseases at home and abroad, boosts our public health capacities and improves our already robust regulations to ensure we have safe and effective medicines and treatments."

Australia's breastfeeding guidelines are in line with WHO recommendations that infants up to six months should be exclusively breastfed. However, the Department of Health Australian National Breastfeeding Strategy expired in 2015.

The AMA believes that breastfeeding should be promoted as the optimal infant feeding method. AMA has also called for doctors and other health professionals to be appropriately trained on the benefits of breastfeeding, including how to support mothers who experience difficulties with breastfeeding.

AMA's position statement can be read here: https://ama.com.au/position-statement/infant-feeding-and-parental-health-2017 .

MEREDITH HORNE

Rec leave rewards for non-smokers in Japan

Japan currently comes in last on the World Health Organisation's ranking of nations' anti-smoking regulations, rated according to the type of public places entirely smoke-free.

So, it is quite remarkable that Japanese marketing company Piala Inc has announced it is granting its non-smoking staff an additional six days of holiday a year to make up for the time off smokers take for cigarette breaks.

"I hope to encourage employees to quit smoking through incentives rather than penalties or coercion," Chief Executive Officer Takao Asuka said in regards to his company's decision.

Hirotaka Matsushima, a spokesman for the company, said the idea came about following a message in the company suggestion box earlier in the year saying that smoking breaks were causing problems.

Other companies are also pushing for change. Convenience store chain Lawson Inc has introduced an all-day ban on smoking at its head office and all regional offices in June with an eye toward lowering the ratio of smokers in its entire workforce by around 10 percentage points in fiscal 2018.

"The company is willing to take an even tougher anti-smoking measure in the future," a public relations officer for Lawson Inc said.

A recent government survey in Japan showed that the number of smokers nationwide has fallen below 20 percent of the population for the first time on record, estimating about 18 per cent of Japanese are believed to smoke. Both genders recorded a decrease. The rate of male smokers fell 2.6 points to 31.1 per cent, while smoking among women declined 1.2 points to 9.5 per cent.

The Japanese health ministry is seeking new restrictions on smoking in public places before the 2020 Tokyo Summer Olympics. But the proposal is likely to encounter strong opposition from Japan Tobacco, which is one-third government owned.

MEREDITH HORNE

Declaration of Geneva now includes doctors' own health

The World Medical Association (WMA) has updated the oath sworn by doctors in order to reflect the importance of them taking care of their own health.

The Declaration of Geneva, which is the modern successor to the 2500 year-old Hippocratic Oath, was revised on October 14 this year at the WMA General Assembly in Chicago.

The Declaration was first adopted by the WMA at its second General Assembly in 1948 and clearly outlines the ethical principles and professional duties of physicians.

It has only been slightly amended since its adoption almost 70 years ago.

So it was no small thing for the most recent General Assembly of the WMA to make such a significant change to the Declaration of Geneva.

The revised oath, now referred to as a pledge, offers a refocus to ensure that doctors are attentive to their personal health.

"*I WILL ATTEND to my own health, well-being, and abilities in order to provide care of the highest standard*," the amendment states.

AMA President Dr Michael Gannon was in attendance at the General Assembly and witnessed the historic change.

More than 50 national medical associations were present at the international gathering.

Additional changes were also approved, including a refocusing to reflect changes over time in the nature of the relationships between treating doctors and their patients.

The new pledge refers to the autonomy of the patient. Previously, the oath referred to respect only for teachers, not from teachers to their colleagues and students and the updated pledge amends this.

It is currently in the two-year revision process, which includes a period for public consultation.

Dr Yoshitake Yokokura, President of the Japan Medical Association, was installed as President for 2017/18, and Dr Leonid Eidelman, President of the Israel Medical Association, was named President-elect.

The World Medical Association Declaration of Geneva, known now as the Physician's Pledge, states:

> AS A MEMBER OF THE MEDICAL PROFESSION:
>
> I SOLEMNLY PLEDGE to dedicate my life to the service of humanity;
>
> THE HEALTH AND WELL-BEING OF MY PATIENT will be my first consideration;
>
> I WILL RESPECT the autonomy and dignity of my patient;
>
> I WILL MAINTAIN the utmost respect for human life;
>
> I WILL NOT PERMIT considerations of age, disease or disability, creed, ethnic origin, gender, nationality, political affiliation, race, sexual orientation, social standing, or any other factor to intervene between my duty and my patient;
>
> I WILL RESPECT the secrets that are confided in me, even after the patient has died;
>
> I WILL PRACTISE my profession with conscience and dignity and in accordance with good medical practice;
>
> I WILL FOSTER the honour and noble traditions of the medical profession;
>
> I WILL GIVE to my teachers, colleagues, and students the respect and gratitude that is their due;
>
> I WILL SHARE my medical knowledge for the benefit of the patient and the advancement of healthcare;
>
> I WILL ATTEND to my own health, well-being, and abilities in order to provide care of the highest standard;
>
> I WILL NOT USE my medical knowledge to violate human rights and civil liberties, even under threat;
>
> I MAKE THESE PROMISES solemnly, freely, and upon my honour.

CHRIS JOHNSON

Lonely Planet's Atlas of Adventure

by Lonely Planet

REVIEWED BY **CHRIS JOHNSON**

If outdoor adventure is what keeps your mind, body and soul healthy, then there is no shortage of places to go and activities to attempt across this huge planet of ours.

But discovering just what is on offer and where might be easier said than done.

So much to see. So many things to try. So little time.

A new release from travel publishers Lonely Planet provides a perfect snapshot of outdoor experiences to be had in more than 150 countries around the globe. How helpful is that?

Lonely Planet's Atlas of Adventure is a beautifully produced coffee table book full of stunning photographs and inviting, succinct descriptions of outdoor romps to tackle from Afghanistan to Zimbabwe.

With maps, expert advice and interviews from those who have dared before, the atlas offers an inspiring and informative globetrotting tease of more places and adventures than can hardly be imagined.

Diving in Thailand, sea kayaking in Antarctica, cycling the Canary Islands, white water rafting in Canada, skiing in Switzerland, or climbing in Mexico are just a few examples of what's on offer.

And that's just for the faint at heart.

Why not also try parachuting in Pokhara or trekking around Everest (both in Nepal), kitesurfing off Mozambique, riding with eagle hunters in Mongolia, or surfing the deserted swells of Kiribati.

And everyone wants to know about dune boarding in Namibia!

This atlas is a fascinating read – all 336 pages of it – entertaining and engaging.

With a thorough 17 pages on Australia alone (one of the larger sections of the book), it also showcases some of the best outdoor adventures to be had in our own backyard.

Below are a few extracts from the book, just to whet the adventure appetite.

FRANCE

Bouldering

An hour south of Paris is the best, most famous and historic bouldering area in the world: Fontainebleau. Imagine all the things that would make for a perfect bouldering area – flat, sandy landings, endless boulders, soft-on-the-skin sandstone,

unique shapes, densely concentrated problems – and you find it here. Originally considered a training ground for the Alps, bleausards (local climbers) have been bouldering here for more than 100 years, and it's considered a rite of passage to get burnt off by geriatric (but well-muscled) bleausard, who generally have all the classics wired. Best of all, you are never too far from a café au lait and croissant, while rest days can be sent touring the art galleries and museums of Paris.

NAMIBIA

Dune Boarding

The Namib is the world's oldest desert, but there's a new way to experience its dunes: on a board. Not far from Namibia's coastal town of Swakopmund, one of Southern Africa's top adventure-activity capitals, there are mountains of sand that provide perfect slopes to carve down. When you first set eyes on the dunes towering hundreds of feet into the blue African sky, you'll begin to buzz with anticipation, though it's wise to conserve a little energy – your journey of joy starts with some hard work: a hike up to your launching point. With board, gloves and goggles in hand, you're eventually staring down over some serious off-piste action. Now strap in, lean further back than you're used to (if you're familiar with snowboarding) and let loose! Once you've had your fill, try the lie-down 'schuss' option, which will see you hit speeds of 80km/h. Alter Action runs daily dune boarding trips from Swakopmund.

Country blues guitarist in the Deep South … of NSW

BY CHRIS JOHNSON

Ragtime – it's that feel-good sound of yesteryear that is currently enjoying a healthy revival among music lovers everywhere.

Fast, earthy and complicated, it is designed to get people's toes tapping and their feet stomping.

Long gone ragtime piano players such as Scott Joplin and Jelly Roll Morton popularised the music with their compositions and sheer ability in the dying years of the 1800s and into the first half of the 20th century.

Brilliant guitar players from the same era like Blind Blake, Reverend Gary Davis, Blind Boy Fuller and Blind Willie McTell (yes, they were all blind) revolutionised the sound.

Only in their old age did some find wider popularity than the juke joints and black audiences their "race music" was, until then, exclusively played for.

In the latter half of the 20th century, when blues in general revived thanks mostly to young British white boys who sought out their almost anonymous black musical heroes and attempted to mimic them, was the style dragged out of the southern and Midwestern states of America.

Young American (white) guitarists who learned the fingerpicking country blues, of which ragtime forms a part, from the "rediscovered" (black) bluesmen of the south, are keeping the music alive today as they continue to record and perform around the world.

Notable exponents of the country blues fingerpicking guitar style include Americans Stefan Grossman, Roy Book Binder, Woody Mann, Rory Block and Paul Geremia.

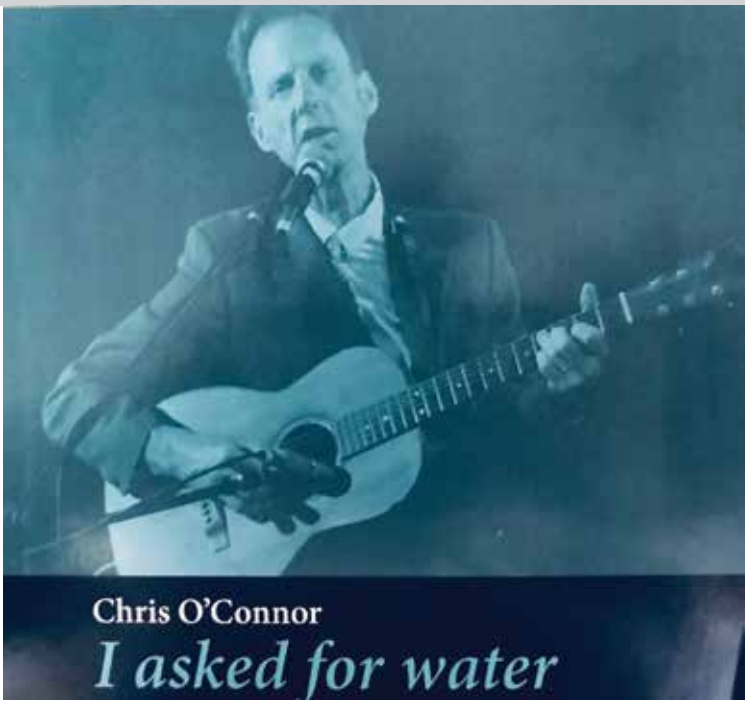
But even here in far away Australia, there are some brilliant acoustic blues guitarists who keep ragtime and country blues music alive and well.

One such musician is Chris O'Connor from the NSW south coast who is about as true to the music as you can find in this country – or anywhere else, for that matter.

O'Connor is the genuine article. Listening to him play and sing the blues is like being transported back in time.

And as is the case with most good music these days, he is an independent artist doing it all his way.

Beyond ragtime, O'Connor plays other earthy blues like the haunting slide guitar blues from the Mississippi Delta region.



His latest album, just released, is a wonderful showcase of all these country blues styles.

The CD *I asked for water* is available through his Facebook page https://www.facebook.com/Chris-OConnor-151291655024114/ and at www.chrisoconnor.com.au and has 14 tracks, all of which are his cover tributes to some of his favourite blues artists.

Traditional rags like *East St Louis* and Blind Blake's *Too Tight* sit comfortably next to Willie Brown's *Mississippi Blues* and Tampa Red's *Things About Coming My Way* and more.

As well as his exceptional guitar playing (hearing is believing), O'Connor has the perfect blues voice – deep and dark but also able to get up to those falsetto highs like early blues singers often did.

And for this latest offering, he made the clever decision to have ragtime/blues piano player Don Hopkins accompany him on numerous tracks.

Add some sweet harmonica and mandolin on other tracks, from Jim Conway and Marcus Holden respectively, and Chris O'Connor's *I asked for water* is pretty much the perfect country blues album.

Everything old is new again

BY DR CLIVE FRASER

1959 Dodge Coronet

Anyone in the market for a new car these days would expect air conditioning, power windows and cruise control.

Electric seats and an auto-dimming rear vision mirror might also be welcome additions to any new car's specifications.

But anyone thinking that these are new automotive technologies might be surprised to know that they were all available as options on the 1959 Dodge Coronet.

And back then the automatic transmission even had three speeds.

But the transmission's push-button feature was a safety problem and a parking lock was added in 1960.

All of this technology was shown to me when a colleague proudly demonstrated the features of his recently purchased 1959 Dodge Coronet.

His vehicle sold for $5,300 USD when new and some of the options were expensive.

For example air conditioning added $2,200 to the original price, but working compressors for the Coronet now sell for upwards of $10,000.

The optional radio was an extra $600, but it did have an automatic station-seeking feature.

All of this technology was at the cutting edge in its day as it was only in 1956 that the Nobel Prize in Physics was awarded for the development of the transistor.

With so many features available the Dodge Coronet would need to be roomy and at 5.52 metres long it still won't fit into most garages.

My colleague's car is powered by a 326 cubic inch Red Ram V8.

He assures me that it returns 25 mpg on the open road, but 14.9 mpg might be more realistic in daily driving.

This engine produced 190 kW of power and 475 Nm of torque propelling the car to 100 km/h in 10.1 seconds.

Dodge also offered a slightly more economical 230 cubic inch straight six with 101 kW and a leisurely 17.8 seconds to 100 km/h via a two speed automatic gearbox.

For serious acceleration there was a 383 cubic inch V8 that could catapult the Coronet to 100 km/h in 8.2 seconds.

Economy in this variant was down to 11.2 mpg.

Interior space in the Coronet is cavernous, particularly as my colleague's car has no seats as they are being re-upholstered.

His car was originally a Texas Highway Patrol car and still has a Texas registration sticker.

Back in 1959 prospective officers were obliged to provide their own vehicles and Dodges were popular because they were robust.

There was a saying back then that said: "If you can't afford a Dodge, dodge a Ford."

After nearly 60 years everything on the old Coronet still works, including the air conditioning.

As I am approximately the same age as this car it did appear to me that the Coronet was in better condition than I am.

With the tender loving care that this Coronet receives I was sure that in another 60 years it will still be on the road.

Safe motoring,

Doctor Clive Fraser
doctorclivefraser@hotmail.com

Nocton wines

BY DR MICHAEL RYAN

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2

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You can just about grow anything in Tasmania. It is a blessing that someone realised the Tasmanian potential to grow grapes and hence make wine. We are in debt to vinous pioneers like the Alcorso family for their heritage and vision.

We are also in debt to people having the romance and sense of place to acquire land for viticulture. The Coal Valley was first planted in 1973 at Stoney Vineyards near Richmond. In 1996, an Oriental purchase of next door Nocton Park resulted in 34 hectares of vine cuttings taken from the original Stoney Vineyard being planted in 1999.

The wines are made under contract by Alain Rousseau from Frogmore Creek Wines. He has a philosophy of fruit and terroir expression. This shows in the wines with the wine makers hand guiding the wine on its journey.

This cool dry maritime influenced climate is favourable to growing Pinot Noir, Chardonnay, Sauvignon Blanc and Merlot. The soils are dolerite free draining over Triassic sandstone. The soil structure is embossed on the stylish wine label, symbolising the textural nature of the wines it adorns. The vines are close planted to encourage competition to thrive.

Anthony Woollams is the new general manager. Arriving from Europe via South Africa in 1994 he has worked in Burgundy on his journey to Tasmania. He has been employed by Pipers Brook, Devils Corner and Tamar Ridge. So his Tasmanian wine knowledge is expansive.

His vision is to grow the brand and improve the quality of the wines. There is the well-credentialed Estate range and the Willow Series reserve range. The latter being specific areas in the vineyard selected for their various characteristics that enhance the sum of the parts.

There will always be artistic differences between the grower and the wine maker with Anthony and Alain passionately discussing areas such as malolactic fermentation and oak influence for example. The outcome is worth the friction as the wines are stellar. The cellar door is open Wednesday- Saturday 10am-4pm so you can enjoy the wines and Anthony's wine tales.

WINES TASTED

1. Nocton NV Sparkling

A light bright yellow with a medium bead. The nose is an aromatic seduction of mandarin and marmalade, with subtle but complex yeasty notes. Generous palate with a nice dry balanced finish. This would cellar and be an amazing sparkling in about 3 years. Enjoy with a plate of Tassie oysters.

2. Nocton Estate Chardonnay 2015

Light yellow in colour. The wine exhibits creamy lemon notes, rock melon and pecan nut nuances. A hint of lees exposure exists. The palate is full with evidence of a softness from malolactic fermentation. The acidity is still evident with a crisp finish. Some Tasmanian white bait would be a treat.

3. Nocton Estate Pinot Noir 2015

A dusky Cherry red colour. A complex bouquet of red berries with hints of strawberry jam, a layer of intricate spice, white pepper and herbal notes exists. Subtle oak nuances with faint mandarin peel add to the olfactory pleasure of this wine. The wine glides over the anterior palate slightly dipping then surges with a balanced supportive tannic structure. Will cellar for 3-7 years. Have with Sashimi Petuna Tasmanian Ocean trout.

4. Norton Estate Merlot 2015

A deep garnet colour. The nose is full of cool climate spicy bright red fruits. There is a seductive austerity to its fruit that combines with its tannic features that propel this wine into an elegant gustatory companion. The flavours leap frog each other and are punctuated by a balanced decrescendo of tannin. After three hours, the wines complex layers morphed into a seamless seductive wine that had the right bank of Bordeaux calling. Cellar 7-10 years. Enjoy with a Tasmanian venison pie.

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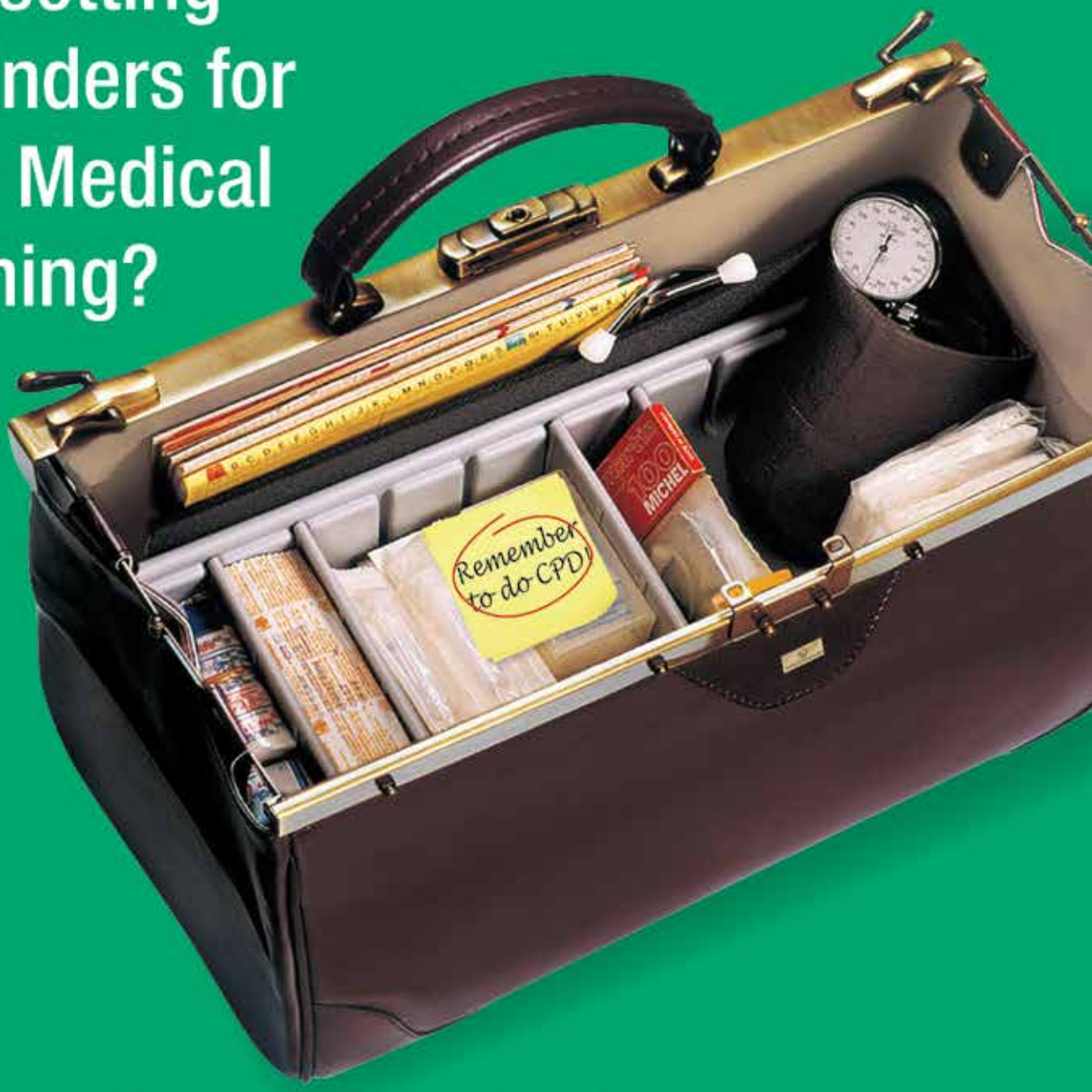

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