AUSTRALIAN
Medicine
The national news publication of the Australian Medical Association

Time for a funding change

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AMA LEADERSHIP TEAM

President
Dr Michael Gannon

Vice President
Dr Tony Bartone

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Vigilance on vaccinations and the vacuous

BY AMA PRESIDENT DR MICHAEL GANNON

Over the past few weeks, we have seen more commentary from ill-informed sources irresponsibly arguing against the need for immunisations. This misinformation comes at a time when it is reported that one in ten children are falling behind in their vaccinations.

The evidence is clear and undeniable – vaccinations work. They are the most effective way of protecting society from the devastating effects of some of the world's most insidious diseases.

As medical practitioners, we must be ever-vigilant to counter the misguided anti-vax message with sound science and evidence-backed education. We should always be on top of keeping our patients informed of the value of vaccinating their children and themselves where appropriate.

Most recently, immunisation talk has turned to the topic of pregnant women.

What is absolutely essential is that pregnant women are advised by whoever is looking after them – a GP, an obstetrician, a midwife – to avail themselves of the free vaccination against influenza and whooping cough.

And, of course, we would then encourage those same mothers to have their children vaccinated according to the National Immunisation Program against things like diphtheria, tetanus and polio, measles, mumps, rubella.

We have now got protection at various stages in life against the top three causes of bacterial meningitis. These are good news stories.

We are trying to beat rheumatic heart disease. The way to do that is to develop a vaccine against the bacteria called group A strep. We are really excited about this. This is what's going on at an international level.

We're trying to eliminate polio in the two countries on the planet where it still exists. And yet, back in Australia, I'm using evidence to debate vaccination-deniers on the internet and on social media about the benefits of vaccination. Sadly, there are lazy people who are heeding the false messages simply because they have not personally witnessed serious vaccine-preventable diseases. They are putting their children and the children of others at risk. We must keep up the good fight and actively promote vaccination.

Misinformation has not been limited to vaccination lately.

One high-profile Federal MP has energetically declared that everyone has the right to use hospital emergency departments as an alternative to paying to see a GP.

This is a silly and dangerous message to send to the community, especially at a time of potential significant health policy reform, which the AMA hopes will put an even greater focus on the central role of GPs in keeping people well.

GPs are specialists in primary care. They are a lot better trained for the kind of presentations the MP was talking about.

The reality is that most people do not pay if they see a GP. The bilk billing rate for GPs is around 85 per cent. The cost to the health system to see a GP is something like an average of $50. The same presentation to a hospital emergency department can cost the system hundreds of dollars.

The MP is pushing irresponsible advice. He's wrong. He doesn't understand the difference between emergency medicine and general practice.

We are very, very fortunate in Australia to have a highly trained, skilful, specialist GP workforce. These GPs represent better value for money than anything else I know in our community.

And let's not forget the after-hours medical services that can go to a patient's home, and that can also be bulk billed. They have an important role as well, and we are going to see some reforms in that area. There might have been a little bit of over-generous billing of so-called urgent item numbers. This is being addressed.

It really saddens me when people don't see the value they get from having their own GP. They're there, working hard Monday to Friday, often extended hours, often Saturday mornings. They are the specialists in preventive health. They are the specialists in primary care. They know more about vaccinations than can be gleaned from an internet chat site or blog. They should be everyone's first port of call for most health problems.

My advice to anyone – anti-vaxxer, blogger, or politician – who wants to enter the all-important Australian health policy debate is to come fully armed with evidence and facts.

New codeine regulations in place

BY AMA VICE PRESIDENT DR TONY BARTONE

New scheduling laws surrounding the sale of codeine have come into effect and now all medications containing codeine are banned from sale without a prescription.

As we know, the decision was made by the Therapeutic Goods Administration, which describes codeine as a commonly used medicine of abuse.

The TGA has said it is clear that alternative regulatory controls were required for the public benefit.

In the face of great pressure from the pharmacy lobby groups, Federal Health Minister Greg Hunt said it would have been unthinkable for the Government to ignore the advice of the TGA.

The AMA, of course, supported the decision from the TGA as the independent regulator acting in the interests of patient safety in the face of strong evidence. A robust public awareness campaign saw the President and me managing an extraordinary number of requests for commentary and interviews. This was another example of the trusted advocacy brand that is the AMA.

The Pharmacy Guild of Australia in particular launched a prolonged and very strong multi-State offensive against this change. As we know now, the Guild was unsuccessful in its lobbying campaign. We will always follow the evidence.

There were a number of over-the-counter preparations that contained codeine in various low dose amounts. Now we have a number of alternative over-the-counter options available for the management of short-term acute pain. We need to educate our patients that nothing has changed in that respect, if they have a toothache or a muscle sprain or some other form of localised pain. They are still able to procure an over-the-counter option that will manage their pain equally, and usually better, than OTC low dose codeine.

We all are aware of the studies showing that there are significant thousands of Australians who are using codeine inappropriately and putting themselves at risk, be it of organ damage or long-term tolerance dependency and addiction.

We have also heard a lot about the idea that people tried to stockpile codeine before the new rules came into effect and that many will keep trying to get around the regulations that have been brought in.

A crucial point in the changeover period has been to emphasise the relationships our regular patients have with their family GPs or other medical specialists. This relationship will underpin the education and wider health literacy around the transition and it is improved health literacy which is fundamental to a number of our public health aims.

Of course, the pharmacy lobby also attempted to hijack the issue by saying the new regulations would do nothing to stop doctor-shopping, and that the limited Pharmacy Guild MedAssist system was the answer. The AMA has long called for a genuine Real Time Prescription Monitoring system that tracks all prescribing and dispensing, is nationally consistent, and interoperable with prescribing doctor software programs. This continues to be a very important area of our advocacy.

These new regulations are about reducing the level of codeine in the community. They are not about switching the source of the supply of codeine in the community.

We know that outside of cancer pain, there is really no significant justification for long-term codeine use. A key message during our campaign was that non-pharmacological options, or other more effective opioid alternatives, can work better for managing a person's pain. Of course, the focus is the importance or need to have an individualised clear management plan for pain for each of our patients. As doctors we can and will facilitate that.

In addition there has been enormous information, education, and professional development options to assist all health professionals in the switch-over period. Everybody in this chain of supply should know exactly what's happening, what's required, and what needs to be done.

So in the final wash-up, the independence of the TGA and the associated scientific evidence was upheld but perhaps more importantly, a serious discussion robustly continues on the amount and type of opioid medication in our community and the world wide emerging crisis that is evolving in this space.

Policy debate important for all

BY AMA SECRETARY GENERAL ANNE TRIMMER

In preparing for a speech to a summit on women's health hosted by RANZCOG on March 2, I was contemplating the breadth of health policy that the AMA tackles in its advocacy. The AMA covers the bread and butter issues that impact the professional practices of doctors such as Medicare funding, private health insurance and the future of the private health system, the distribution and support for the medical workforce, and training of the next generation.

The AMA also covers issues relevant to the society in which doctors practice through its advocacy on behalf of patients, and the public health concerns of those patients.

Federal AMA is often called upon to outline the work that has been undertaken for specific subgroups of members in order to substantiate the value proposition of membership. I have written previously in my column that the AMA's advocacy supports all doctors, the difference being that not all doctors choose to pay a membership subscription.

While this does not mean that the AMA restricts its advocacy, it does sometimes affect the range of advocacy that can be undertaken and, for the State and Territory AMAs, it can limit the services available to members.

The AMA's advocacy, as outlined in its Constitution, has two primary objectives:

- To preserve, maintain, promote and advance the intellectual, philosophical, social, political, economic and legal interests of members; and
- To promote the wellbeing of patients and take an active part in the promotion of health care programs for the benefit of the community and to participate in the resolution of major social and community health issues.

Members will have received the Christmas message from Federal President Dr Michael Gannon in late December. The message highlights the range of work that was undertaken for members during 2017. The Annual Report to be released in April similarly highlights the breadth of AMA advocacy.

I am looking forward to the National Conference in May which, for the first time, will include a day of debate on topical policy issues that reflect these objectives of the AMA.

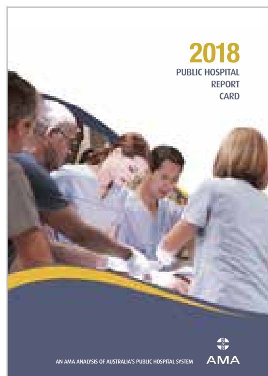
The topics for debate are sourced from the State and Territory AMAs, and the Councils of Federal AMA. Federal Council will consider the draft motions at its meeting in March before the final selection is sent to delegates attending National Conference.

Federal Council and the Federal AMA Board are keen to encourage increased member participation in the formulation of policy. I have written previously about my experience at the annual delegates meeting of the American Medical Association and its 'democracy in action'. Debate is robust with differing views often strongly, but respectfully, argued. The British Medical Association at its annual meeting takes a similar approach.

National Conference in 2018 will provide an opportunity for a greater number of members to participate in the formulation of AMA policy, not just the appointed delegates.

While voting for the next President and Vice President, which also occurs at National Conference this year, is restricted to appointed delegates, all delegates who are members of the AMA are encouraged to participate in policy debate at the meeting.

Business as usual not good enough for public hospital funding



Public hospitals continue to face a funding crisis that is rapidly eroding their capacity to provide essential services to the public.

That is the take home message from the AMA's *2018 Public Hospital Report Card.*

AMA President Dr Michael Gannon launched the Report Card in Brisbane on March 9 and called on Governments to get it together when it comes to hospital funding.

"Health is the best investment that Governments can make," he said.

"Funding for public hospitals is an essential investment in the health of the Australian population, and therefore in the capacity of Australians to participate in the workforce and as members of society.

"In the past, Governments have justified extreme health savings measures, including cuts to public hospital funding, on the basis that Australia's health spending is unsustainable.

"This falsehood needs to be dismissed, once and for all. There is no evidence to support the contention that Australia has a health spending crisis."

The Report Card reveals that substandard funding levels are reflected in the performance of Australia's public hospitals against key measures. Their performance remains frozen at the unsatisfactory levels of previous years.

Bed number ratios for the general population are static. For patients aged over 65, bed ratios continue to fall and are now at their lowest level since 1992-93.

Pressure on emergency departments continues to increase, with waiting times worsening to remain well below the 80 per cent target set in 2012-13 and which has since been abandoned by Governments.

"After three years of no improvement in the percentage of ED patients who leave emergency within four hours, this year's report highlights a worsening to 72 per cent," Dr Gannon said.

"It is of concern that the patients least likely to leave an ED within four hours are the sickest."

Elective surgery performance in 2016-17 is mixed. Nationally the proportion of elective surgery patients treated within clinically indicated treatment timeframes of 90 days improved by five per cent, but performance by jurisdiction varied.

Dr Gannon used the Report Card to call for a change in approach to public hospital funding, saying Governments must promote performance rather than punishment.

It was disappointing, he said, that the 2020 hospital funding agreement tabled at COAG in February this year was business as usual.

"No one wins by playing politics with public hospital funding," he said.

"The Commonwealth Government had an important opportunity in 2018 to offer an increased level of hospital funding in the 2020 funding agreement.

"While some State Governments share the blame for under-funding their public hospitals, the Commonwealth's offer to contribute up to 6.5 growth in hospital episodes year on year will not be realised unless State and Territory Governments can find the additional funding to pay the remaining 55 per cent of every additional public hospital episode.

"Jurisdictional jostling to gain the upper hand in funding negotiations is only going to let down those who need essential public hospital services.

"If the Commonwealth fails to fund primary care properly, it will pay, along with the States and Territories, in increased costs.

"If the States and Territories fail to put their fair share of funding in public hospitals, then we will experience worse patient outcomes and deteriorating performance which, under current and future funding arrangements, will reduce the year on year growth in Commonwealth funding."

The Report Card states that the AMA will fiercely resist any approach to use the same methods of the past, which are to simply reduce funding when activity in hospitals doesn't meet the desires of Governments.

"Public hospitals need adequate, long-term funding to improve their performance," Dr Gannon said.

"Integrating linkages across sectors to improve patient outcomes, and reduce admissions offers potential.

"But this potential will be difficult to realise unless these new responsibilities are adequately funded and co-designed with those who keep our hospitals working, day in and day out."

The full *2018 Public Hospital Report Card* can be found on the AMA website.

CHRIS JOHNSON

AMA secures investigation into Bupa blooper

The AMA has forced an investigation into Bupa, after the private health insurer reworked its medical gap scheme and told its Australian customers their cover for a range of procedures will change from a minimal benefit to total exclusion.

AMA President Dr Michael Gannon described the announcement as a big leap towards US-style managed care and he demanded a 'please explain'.

Dr Gannon called on the Government to launch an investigation into the move.

Federal Health Minster Greg Hunt subsequently ordered the Private Health Insurance Ombudsman to do exactly that.

The affected procedures, which will apply to one third of Bupa's Australian customers, include hip and knee replacements, IVF services, cataract and lens procedures, and renal dialysis.

Bupa made the announcement initially via letter to medical practices, suggesting to them that: "Prior to the commencement of any treatment, patients should be encouraged to contact Bupa directly to confirm their cover entitlements, and any possible out-of-pocket expenses that may be applicable."

Bupa's Head of Medical Benefits Andrew Ashcroft also wrote: "Customers affected by these changes will be given an opportunity to upgrade their cover should they wish to receive full coverage for services that were previously only restricted cover."

The punitive changes were announced just weeks after Mr Hunt approved a 3.95 per cent increase to private health insurance premiums.

Dr Gannon told the Minister that the Government should urgently seek advice from the Health Department and the Private Health Insurance Ombudsman as to the legality of Bupa's actions.

"The fact that the change has occurred straight after a premium increase, straight after agreement was made to retain second tier rates for non-contracted facilities, and straight after an announcement by Government to work collaboratively with the sector on the issue of out-of-pocket costs, is unconscionable," Dr Gannon said.

"The AMA will not stand by and let Bupa, or any insurer, take this big leap towards US-style managed care.

"The care that Australian patients receive will not be dictated by a big multinational with a plan for vertical integration."

Dr Gannon said customers were right to be concerned with the new list of exclusions, but that there was even more bad news hidden in the fine print of Bupa's new business plan.

"From 1 August 2018, no-gap and known gap rates will now only be paid to the practitioner if the facility in which the procedure takes place also has an agreement with Bupa," he said.

"Medical benefit rates outside those facilities will now only be paid at the minimum rate that the insurers are required to pay – that is, 25 per cent of the MBS."

Mr Hunt's office said: "The Minister has written to the Private Health Insurance Ombudsman and asked him to review and investigate this action."

Dr Gannon has written to all AMA members to explain the changes and why they are bad for patients and the medical profession (the full letter can be viewed at https://ama.com.au/ausmed/bupa-decision-bad-news-patients-and-profession).

"They are bad for the reputation of private health insurance. They are bad news for the contribution that the private system makes to the Australian health care system," he said.

HBF, which is planning to merge with HCF, has also announced it will remove services such as cochlear implants, weight-loss surgery, and dialysis from entry and mid-range hospital policies.

Dr Gannon said private health insurance policy holders should start asking questions about whether or not their policies are fit for purpose.

"If it does nothing more than give you treatment in a public hospital, how is that better than relying on the public system?" he said

"If it does nothing more than give you a whole list of exclusions where you can't access care when you're sick, when you're scared, that's not worth it.

"So, what we're saying is there needs to be more focus on the value in the policies. We're worried about the changes in the industry, we're worried about the junk policies throughout there.

"We do have a Private Health Insurance Ombudsman, and when you look at the complaints there, you get a real feel for the problem. We see a lot of talk in the media about out-of-pocket expenses being the real problem with the value proposition. If you look at the Ombudsman's report, that's not the problem.

"Nearly 90 per cent of operations are provided by doctors at no-gap; another five or six per cent at known gap of less than $500.

"We don't think we're the problem, but when we see unilateral action like we've seen from big insurers like Bupa to say what they won't be covering, we encourage individual policyholders to ring up, ask, and make sure they're covered if and when they get sick."

CHRIS JOHNSON

Trainee doctors resit RACP exam after first attempt fails them

The AMA successfully intervened on behalf of trainee doctors around the country, following the distressing mid-test crash of the computer-based Royal Australasian College of Physicians examination.

Following strong interventions from AMA President Michael Gannon and Chair of the AMA Council of Doctors in Training John Zorbas, the RACP agreed to fully refund the exam fee, to release the questions from the computer-based exam to ensure that no participants were disadvantaged, and to offer a paper-based exam.

The AMA reports that discussions with the RACP were positive.

Dr Gannon wrote to all State and Territory health departments asking them to accommodate the more than one thousand trainees who had to sit the test again.

“This is a high-stakes examination that trainees spend months preparing for and involves sacrifices in their personal and family lives,” he said.

Dr Gannon asked the health departments to allow the trainees extra time for study and revision, and to the sit the rescheduled exam. The dramatic episode had a huge impact on hospital rosters and leave entitlements.

Dr Gannon asked the trainees’ bosses to be understanding of their predicament.

About 1200 trainee physicians in Australia and New Zealand had to re-sit the RACP Basic Exam on March 2, after a massive IT failure caused the computer-based written test to be cancelled while they were sitting it last month.

IT company Pearson Vue was employed to conduct the exam on February 19.

A technical fault left a significant number of candidates locked out of the computer based system and unable to complete the second part of the examination after their scheduled break.

Even though some trainees had completed the test, the RACP insisted that all candidates resit the exam and that the cancelled test will not count as an examination attempt.

The Adult Medicine and Paediatric Written Examinations are one exam in two papers. The final score relies on completion of the whole exam, and the complex calculation of pass marks is dependent on this, the College said.

RACP President, Dr Catherine Yelland, apologised to the trainees for the “stress and disruption” caused by the cancellation of the exam and vowed to release findings of an investigation into it.

“We understand that this has been unexpected, stressful and distressing. We have and continue to apologise for this. We encourage all trainees to talk with their supervisors, colleagues, family and friends,” she said.

An RACP panel was established to review the issue, including the technical failure of the exam, the College’s response, and the impact on trainees – including incurred travel costs, cancelled holidays, and other expenses.

The AMA is making a comprehensive submission to the review, using extensive feedback given by its members.

Dr Zorbas said the system failure had caused enormous stress throughout the medical profession.

“This is an exam that some people have been studying for years for, and for it to come apart at the last minute because of a technical glitch without a backup system in place is incredibly distressing for these trainees,” he said on the day.

The exam cost each trainee about $1800.

The RACP advised that if a trainee did not pass the resit or alternative resit exam, it would not be counted as one of three attempts at the examination that trainees are allowed. Similarly, the cancelled exam will not count as one of the three attempts.

CHRIS JOHNSON

MJA Editor-in-Chief surprised by AC

Professor Nick Talley

When Professor Nick Talley received a letter from the Governor-General, his wife asked what he had done wrong. But when the letter was opened and he read the words Companion in the General Division of the Order of Australia, he was somewhat "shell-shocked" to say the least.

Then the citation: "For eminent service to medical research, and to education in the field of gastroenterology and epidemiology, as an academic, author and administrator at the national and international level, and to health and scientific associations."

The Editor-in-Chief of the *Medical Journal of Australia* – the scientific journal of the AMA – was among only a handful of AMA members to be named in this year's Australia Day awards with the highest honour, the AC.

"It was a mixture of emotions when I read it," Professor Talley told *Australian Medicine*.

"I immediately thought of all the people who have supported me; I felt very honoured; I thought of my family; I thought of my father who had received an OAM some years ago.

"It was a funny mixture of feelings. A series of emotional senses."

Professor Talley is Pro Vice-Chancellor (Global Research) at the University of Newcastle, and a senior staff specialist in gastroenterology at John Hunter Hospital in Newcastle. He is a board member of the Sax Institute, a Fellow of the Royal College of Physicians of London and Edinburgh, the American College of Physicians, the American College of Gastroenterology, and the American Gastroenterology Association.

He was a founding Fellow of the Academy of Health and Medical Sciences in Australia; President of the Royal Australasian College of Physicians between 2014 and 2016, and was elected Chair of the Council Presidents of Medical Colleges in 2015.

He is a mentor and an author of medical text books.

In short, Professor Talley is a very busy person.

"I have always been interested in many things and they have always been an eclectic set of interests," he said.

"But I'm strategic in what I decide to accept. I think I'm very efficient and pretty effective. I always worry about things crashing down of course, as you do. But it helps enormously to have great people to work with."

It is his role at the *MJA* that *Australian Medicine* wants to hear more about. His vision for the publication and what he sees as its strengths.

"With the *MJA* I am the strategic head of the journal. I have been the Editor-in-Chief for a couple of years," he said.

"Australia deserves a great medical journal and that comes down to the quality of people who are part of it.

"The *MJA* is a great journal and it can be even greater. My drive is for it be one of the world's very best journals.

"We have rigorous standards at the *MJA*. We have an 89 per cent rejection rate, but we help authors as well, to get over that hurdle.

"The red section is the science and research and the blue section is more the medical politics. We are totally apolitical and just present the pros and cons of issues. We also have reviews of things that are relevant. But our standard is very, very high.

"Great medical research can transform medical practice. It can save lives and it can save money. If you push the translation of the research and facilitate it, there are better outcomes.

"I don't think of myself as a journalist but I guess I've turned into one a bit in this role. I never meant to be a journalist. But I take no particular view in the journal and if things change, we present new evidence."

Does he think Australia is served well by its politics?

"I really like this idea of a vision for the country. It's a great mission," he said.

"I think our political system is good and healthy, but ideology is a bit of a concern for me.

"For health, we cannot be ideologically driven. Sometimes as a country we tend to ignore evidence. But evidence is evidence; it's not political.

"Pressure groups concern me. We need pressure groups, but only ones with the interests of the country at heart and not the interests of the pressure group.

"I'm convinced that we could in all parameters be the healthiest country in the world. I want to keep pursuing how we can help in that regard.

"And I think doctors all deserve to be honoured."

And can he name any highlights from his illustrious career to date?

"Highlights? I think this one probably gets there."

CHRIS JOHNSON

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Snippets

Your local GP, a Nationals MP, the ACCC, and the PIP

AMA President Dr Michael Gannon has stressed the important role GPs play in delivering primary health care in Australia. His comments come on the back of Nationals MP George Christensen saying that Australians have a right to use hospital emergency departments instead of paying to visit a GP.

Appearing on *6PR Perth Live* Dr Gannon outlined the unique role both GPs and emergency department doctors play. He said Mr Christensen had got it wrong.

"The reality is that you're not talking the same thing when you compare what my colleagues who work in emergency departments do to what my colleagues who are general practitioners do," Dr Gannon said.

"GPs are specialists in primary care, so for a start they're a lot better trained for the kind of presentations he's talking about, and the reality is that if you go and see a GP, we're still at 85 per cent bulk billing around Australia."

Dr Gannon said that Australia was lucky to have high level quality of primary care.

"We're very, very fortunate in Australia to have a highly trained, skilful, specialist GP workforce, and they represent better value for money than anything else I know in our community."

"They're there, working hard Monday to Friday, often extended hours, often Saturday mornings, Sunday mornings. They are the specialists in preventative health. They are the specialists in primary care. That should be your first port of call for most health problems."

Dr Gannon also discussed the importance of vaccination, especially for children.

"There is not a single credible voice anywhere on the planet that argues against national immunisation programs like we enjoy in Australia and in other developed nations."

The ACCC has released its final decision to renew for another 10 years the AMA's existing authorisation that protects AMA member and non-member GPs from action under the Competition and Consumer Act (2010).

The ACCC has accepted that the authorisation continues to be in the public interest.

The specific conduct that has been authorised by the decision includes:

- Intra-practice price setting - this allows GPs in a practice to discuss the fees charged to patients, which provides patients with certainty about the costs, if any, they face when they visit their GP or general practice.
- Collective bargaining as a single practice for Visiting Medical Officer (VMO) services to public hospitals – this is particularly relevant in rural areas where GPs in a practice can negotiate collectively with their local hospital about the services they provide to the local hospital.
- Collective bargaining as a single practice with Primary Health Networks (PHNs).

The authorisation provides GPs with legal protection and avoids the administrative and legal costs that GPs would otherwise incur in having to seek legal and other advice that would be needed in the absence of this authorisation.

Following strong lobbying by the AMA, the Federal Government has made the decision to delay the introduction of the Practice Incentive Program Quality Improvement Incentive (PIPQI) until 1 May next year.

This is the second time the introduction of the PIPQI has been put back, reflecting the strong concerns in the profession about its implementation.

The AMA has previously written to the Health Minister objecting to the inadequate level of funding for the Practice Incentives Program (PIP), and the impact this would have on the implementation of the PIPQI. Under planned changes, many practices would have been left worse off.

Significant concerns over the governance and use of data also need to be addressed.

The changed time frame will mean that the following five incentives which were to cease on 1 May 2018, will now continue through to 30 April 2019. The five incentives are:

- Asthma Incentive
- Quality Prescribing Incentive
- Cervical Screening Incentive
- Diabetes Incentive, and
- General Practitioner Aged Care Access Incentive.

While the 12 month delay is welcome, it still does not overcome the fundamental implementation problem facing the PIPQI – a lack of adequate funding.

The AMA will continue to press the Government on this issue, including in relation to the loss of valuable incentives like the Aged Care Access Incentive.

Cancer and comedy at Melbourne festival

This year's Melbourne International Comedy Festival will see one highly awarded comedian take a fresh look at cancer.

Adam McKenzie, winner of the festival's Best Comedy Award in 2014, its Moosehead Award last year, and numerous other prestigious nominations, will present *Laser Light* to share his own account of fighting the disease.

"This year I will be telling the hilarious story of how I totally almost died," he said.

"At the age of 37, in April 2016, three weeks into a sold out run at Comedy Festival, I was diagnosed with bowel cancer and rushed into emergency surgery."

Laser Light is a hilarious look at what it takes to laugh in the face of death.

It's about the things that make Adam happy.

"Lasers and *Star Trek*," he said.

"It's definitely not about cancer! … It's mostly about cancer.

"Will there be lasers in the show? Absolutely!

"Budgetary constraints, OH&S issues, literally no experiences with lasers whatsoever – none of that is stopping me from promising you the most amazing laser light show you've ever seen….. Lasers may be metaphorical."

Turning serious for a moment (kind of), Adam says Australia needs to talk more about health.

"Men's health, women's health, everyone's health. Why not laugh about it as well?" he said.

"*Laser Light* uses comedy to talk about cancer, health and having to poo into a bag.

"Focusing on my personal story of recovery, this show highlights how important it is to take care of yourself, no matter how old you are.

"They say comedy is the best form of medicine. Well, I'm putting that to the test.

"Just to be clear though, I'm also taking actual medicine. I'm not crazy."

CHRIS JOHNSON

Adam McKenzie's *Laser Light* runs April 10 to 22 at 8.30pm (7.30pm on Sundays) at ACMI – Games Room – Federation Square, Melbourne.

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

The PM has prizes for science innovators

The Federal Government has opened nominations for the 2018 Prime Minister's Prizes for Science, and this year there are some changes.

Every year the Government honours Australia's best scientists, innovators and science teachers through the awards.

Prize winners are applauded as positive role models to all Australians. Nominations are sought from inspiring women and men across all categories.

What the judges will be looking for this year are:

- Leading Australian scientists who have made a significant contribution to the advancement of knowledge through science—for the $250,000 Prime Minister's Prize for Science;
- Exceptional innovators from both industry and research who have translated scientific knowledge into substantial commercial impact—for the $250,000 Prime Minister's Prize for Innovation;
- Early to mid-career scientists whose research is already making, and will continue to have, an impact on our lives—for the $50,000 Frank Fenner Prize for Life Scientist of the Year and $50,000 Malcolm McIntosh Prize for Physical Scientist of the Year;
- Promising early to mid-career innovators from industry and research whose work has the potential to enhance our economy through the translation of scientific knowledge into a substantial commercial impact—for the $50,000 Prize for New Innovators; and
- Inspiring science, mathematics and technology teachers who are dedicated to innovative teaching and inspiring the next generation—for the $50,000 Prime Minister's Prize for Excellence in Science Teaching (Primary and Secondary).

The guidelines for the prizes have been updated for 2018 and can be reviewed, along with the latest information and nomination forms, at: business.gov.au/scienceprizes or phone 13 28 46.

Read about past winners at science.gov.au/pmscienceprizes.

Nominations are open until 5pm (AEDT) 26 March 2018.

CHRIS JOHNSON

Indigenous Medical Scholarship saved me

India Latimore is presented the 2015 AMA Indigenous Medical Scholarship from then AMA President Professor Brian Owler.

Dr India Latimore doesn't think she would have graduated from university if it wasn't for the AMA Indigenous Medical Scholarship.

Now part of the first team at Mater Mental Health Facility in Newcastle, NSW, Dr Latimore was the 2015 winner of the scholarship, receiving $30,000 towards her studies.

She completed her medical degree in 2017 at the University of Newcastle.

"The AMA scholarship came at a critical time for me," she said recently.

"I was actually thinking of deferring my fourth year just to get a job and pay some bills.

"But it paid my way. It let me relax and concentrate on my studies.

"It absolutely changed my life. It was fabulous.

"I don't think I would have graduated without the scholarship."

A proud descendant of the Worimi people, she realised her passion for medicine after travelling around Australia with her family.

During that time she witnessed the difficulties experienced by Aboriginal patients in remote Indigenous communities.

"Why I got into medicine was to help people," she said.

"I'm actually really enjoying it. I think it was my calling.

"And yes, I do like being a bit of an inspiration to others. I do think some people look up to me because I received this scholarship. It was a big deal.

"I try and help others learn about the scholarship. People definitely want to know about it, what it is and how can they apply for it.

"I've always been interested in Aboriginal health, and this scholarship allowed me to do electives around it and the local community.

"Eventually I want to go on to dermatology. I'm on the right track for that."

When approached by *Australian Medicine,* Dr Latimore was more than keen to talk about the AMA Indigenous Medical Scholarship.

It has done so much for her, she said, that she wants others to benefit too.

Those benefits flow not only to recipients of the scholarship, but to the Aboriginal and wider communities they serve as medical professionals.

Dr Latimore likes the idea of there being more than one scholarship granted each year.

"If there were a few more scholarships added it would really help," she said.

CHRIS JOHNSON

Information about donations to the AMA Indigenous Medical Scholarship can be found at:

https://ama.com.au/donate-indigenous-medical-scholarship

Australian Medical Association Limited ABN 37 008 426 793

AMA Public Health Awards 2018 Call for Nominations

The AMA is seeking nominations of people or groups who have made an extraordinary contribution to health care and public health.

Recipients will be invited to attend the 2018 AMA National Conference in Canberra in May 2018, where the awards will be presented. The AMA may contribute to travel costs for recipients to attend the presentation.

In the year following the presentation of the awards, recipients will have the opportunity to participate in interviews with interested media, and engage in AMA supported activities promoting their work in their field of expertise.

All awards are presented, pending a sufficient quantity and/or quality of nominations being received in each category.

Nominations are sought in the following categories:

AMA EXCELLENCE IN HEALTHCARE AWARD

The AMA Excellence in Healthcare Award is for an individual, not necessarily a doctor or AMA member, who has made a significant contribution to improving health or health care in Australia. The person may be involved in health awareness, health policy or health delivery.

The recipient of this award will be an individual who has made a major contribution to health care in Australia in one or more of the following criteria:

- Showing ongoing commitment to quality health & medical care; and/or
- Contributing to medical research within Australia; and/or
- Initiation and involvement in public health projects or health awareness campaigns; and/or
- Improving the availability & accessibility of medical education and medical training; and/or
- Advancing health & medical issues in the political arena; and/or
- Promoting awareness of the impact of social and economic issues on health; and/or
- Contributing to community needs as a health care provider; and/or
- Improving health care services in any field.

Nominations for this award can be submitted by any member of the community.

Previous recipients of this award include Dr Denis Lennox, Associate Professor John Boffa, Ms Donna Ah Chee, Associate Professor Smita Shah, and Dr Mehdi Sanati Pour.

AMA WOMAN IN MEDICINE AWARD

The AMA Woman in Medicine Award is for a female member of the AMA who has made a major contribution to the medical profession by:

- Showing ongoing commitment to quality care; and/or
- Contributing to medical research within Australia; and/or
- Initiation and involvement in public health projects; and/or
- Improving the availability and accessibility of medical education and medical training for women; and/or
- Contributing to medical politics.

This award is presented to a female member of the AMA. Nominations for this award may only be made by a member of the AMA.

Previous recipients of this award include Dr Genevieve Goulding, Associate Professor Diana Egerton-Warburton, Dr Joanna Flynn AM, and Professor Kate Leslie.

NOMINATION INFORMATION

How are nominations assessed?

Nominations will be reviewed by a judging panel consisting of the Federal AMA President and two members of AMA Federal Council, after a shortlisting process undertaken within the secretariat. Award recipients will be informed as soon as possible after the panel has made its decision.

How do I make a nomination?

Nominations must be made by completing the Nomination Form, which must include a personal statement by the nominator describing the merit of the nominee in relation to the criteria for the relevant award. A Curriculum Vitae for the nominee/s, and any additional supporting documentation relevant to the nomination can also be included with the nomination form. The nomination form is available at https://ama.com.au/article/ama-public-health-awards

Nominations should be submitted electronically to awards@ama.com.au. Nominations are open from 19 February 2018, and the closing date for receipt of nominations for each award is **COB Monday 23 April 2018**.

When will I find out if my nomination has been successful?

Awards are presented at the AMA National Conference, which is held in Canberra on 26 -28 May 2018. Award recipients will be notified 2-3 weeks prior to arrange attendance at the ceremony, where possible. The person who made the successful nomination will be notified prior to the ceremony. If your nomination is unsuccessful, you will be notified by email in due course.

President updates on advocacy over Medicare

The AMA advocated tirelessly to end the Medicare rebate freeze, resulting in the announcement by the Government in the last Federal Budget that the freeze on patient rebates was to be progressively lifted.

The freeze was lifted on bulk billing incentives for GP consultations on 1 July 2017. Reindexation will commence for GP consultations and other specialist consultations on 1 July 2018, for procedures from 1 July 2019, and targeted diagnostic imaging services from 1 July 2020. The lifting of the freeze on Medicare rebates will cost the Government around $1 billion.

Of course we would have liked to have seen it lifted all at once. The freeze, introduced by the previous Labor Government and continuing through the Abbott and Turnbull Governments, was a harmful policy.

But the gradual thaw is good news for our patients, GPs and other specialists alike. It will be lifted earlier than planned, and one of the major contributors to out of pocket costs to patients will finally, albeit modestly, be indexed going forward.

The lifting of the freeze was prominent in the national media, but it is in reality but one component of our ongoing advocacy on appropriate funding for medical practitioners. We've also been successful in:

- reversing proposed cuts to bulk billing incentives for diagnostic imaging and pathology services;
- scrapping proposed changes to the Medicare Safety Net that would have penalised vulnerable patients;
- delaying the introduction of the Health Care Homes trial to allow fine-tuning of the details;
- moving to an opt-out approach for participation in the My Health Record; and
- recognising the importance of diagnostic imaging to clinical decision-making.

The second component of the rebate issue relates to the ongoing MBS Review – a body of work that seems to have been around forever, but is really only in its infancy in terms of implementation of changes to items.

The AMA committed to support in principle the ongoing operation of the MBS Review Taskforce, including a transparent, consultative clinician-led approach to high-value care and 'future-proofing' the system. We have also been responsible for regularly bringing together the Colleges, Associations and Societies (CAS) to be updated by the MBS Review Chair on the progress of the work of the Clinical Committees.

The AMA is continuing to work with members to identify areas to improve the review process and recommendations. We continue to press the Government to ensure that reviews remain more than just a cost-cutting exercise, or a mechanism to meddle with the scope of clinical decision making.

This work is supported through engaging with our wider membership via an AMA Working Group, as well as our Medical Practice Committee. I am reassured by the calibre of the feedback and advice we receive from our wider membership on medical policy – the feedback is constructive, insightful and always aims to improve patient care. Be assured the feedback makes its way directly into our day to day advocacy efforts.

Indeed, as a result of member feedback, the AMA has responded to every MBS Review consultation round in 2017, supplemented by my direct representations to the Health Minister, the Department of Health, and to Professor Bruce Robinson, the Chair of MBS Review Taskforce.

It is fair to say the AMA feels the MBS Review process still needs improvement in a number of areas. Our direct intervention in the Anaesthetic committee has seen Minister Hunt order a re-boot.

That is why we have also called for early engagement of the relevant CAS on each of the Clinical Committees to ensure future recommendations are practical and consistent.

We have called for complete transparency, starting with how Clinical Committee members are selected and details of the Committees' scope of work. Finally, the AMA has strongly recommended the Clinical Committees engage early with other Department areas including the Medicare Compliance and Professional Services Review to ensure that any changes to the schedule are practical for clinicians and do not result in sub-optimal care for patients. We all know a poorly worded MBS item can set up a practitioner to fail, especially when advice mechanisms can be difficult, or indecisive.

Ultimately, what we do not want to see is a confusing MBS schedule, nor do we want to be limited in our clinical decision making. We want – and indeed we need - better targeted, increased investment in a modern MBS Schedule.

I can assure you that we will continue to advocate on these issues and seek more cohesive Government policy in areas such as: sensible compliance, further targeted investment in areas of need, and for the improvements to private health insurance policies, so as to limit the impact of out of pocket costs for patients.

The AMA continues to have wins on behalf of doctors and their patients. Our work is informed through your representatives at State and Federal level. We will continue our endeavours at Council and secretariat level in the months ahead.

DR MICHAEL GANNON
AMA PRESIDENT

Positive and negative medical developments

BY PROFESSOR MICHAEL KENNEDY

> "The acceptance of euthanasia into medical practice has much greater implications than it would superficially appear. Medical students will be entering a profession where intentional patient killing is acceptable practice."

There have been enormous advances in medicine since I commenced practice. The life span of patients with cardiovascular diseases has increased by decades, asthmatics experience spectacular symptomatic and long-term improvement, peptic ulceration is essentially cured, hypertension has been controlled using medications that are well tolerated, some malignancies are cured, and so the list goes on and on.

With these advances it is amazing that the promotion of euthanasia has returned to prominence after having been considered unethical and actively opposed by medical associations in the past. No matter how expressed, it is about doctors being directly involved in the act of killing a fellow human being. Intentional killing is anathema in civilised societies.

Professional bodies need to support doctors acting within the law so it is not surprising they have taken a more neutral stand on the topic as it moves closer to home. More remote bodies such as the World Medical Association are able to maintain an independent profile and completely oppose euthanising patients, however it is expressed.

The acceptance of euthanasia into medical practice has much greater implications than it would superficially appear. Medical students will be entering a profession where intentional patient killing is acceptable practice. Therapeutic guidelines will need to include a specific protocol. Killing protocols still in use in some United State prisons and those used in other countries for euthanasia sometimes fail.

Frequently, patients suffering from neuromuscular degenerative diseases appear in the media supporting euthanasia. The eminent neurologists John Walton and Roger Bannister were among the strongest public and at committee level opponents of euthanasia legislation. There are many drugs now in the clinical trial stage that may considerably improve the outlook of these patients. When penicillin was first used in a patient with terminal sepsis it was described by the administering doctors as a 'miracle'.

Conscience votes in legislative chambers will often reflect the effect it will have on holding one's seat, or even government, in times of close elections. One member of the NSW legislature stated they would vote in favour as that was the 'majority' opinion coming in from the electorate. So much for detailed consideration of the issues.

There is no question that the bar drops once laws are passed. This usually begins in drafting the legislation by altering the time expected for death. Overseas it now extends to children, the demented and the depressed. Public debates on euthanasia are usually well scripted, highly emotional, and sometimes feature high profile public personalities but they never use the word killing.

The English House of Lords select committee undertook an extensive review of the matter before the expansion of palliative or terminal care as a subspeciality. A similar authoritative body should commence a similar review before unacceptable and unnecessary practices undermine the fabric of medicine. Medical Colleges, Associations and Societies should decide to move in this direction and avoid taking the neutral pathway. The profession as a whole should also work towards the banning of medicalised killing in a similar manner to which it opposes capital punishment.

Professor Michael Kennedy is a Consultant Physician in private practice and Conjoint Associate Professor UNSW.

Views expressed in the above article are those of the author and do not necessarily reflect official policy of the AMA.

Freeze Frame

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

> "Despite this, General Practice continues to show itself to be the most efficient and cost effective provider of health care across the health sector."

I was astounded to read the reported comments of the Minister for Health about the effect on General Practice of the next phase of the slow thaw of MBS indexation. While the unwinding of the freeze on patient rebates is welcome, it will not 'transform' General Practice as he reportedly suggested.

The damage to the viability of General Practice has already been done and an increase to the standard rebate for GP consultation of around 55 cents will not undo this. At a time when we needed to invest in General Practice to meet the challenges of an ageing population and the growing burden of complex and chronic disease, practices have instead faced a real cut in the value of patient rebates while costs have continue to rise. This cut is permanent and will forever be a reminder of one of the poorest pieces of Government health policy that we have ever witnessed.

Despite this, General Practice continues to show itself to be the most efficient and cost effective provider of health care across the health sector. In 2015-16 the total recurrent expenditure on General Practice in Australia by the Australian Government was $8.7 billion, compared to its total recurrent health expenditure of $160.2 billion. That means only about five per cent of total recurrent Commonwealth health expenditure is spent on General Practice.

The most recent Productivity Commission Report shows that the number of GP services in 2016-17 was 6.5 per head of population which is up from 5.9 services in 2011-12. This increase reflects the impact of complex and chronic disease in the community and the growing demand for GP services.

The report also highlighted the funding pressure that General Practice continues to operate under with figures showing that Australian Government total expenditure on GPs services per person increased by only 80 cents between 2015-16 and 2016-17.

If the Minister wants to see a transformation in General Practice, focusing on being able to do more to keep patients healthier and out of hospital, then he needs to fight for a better funding deal for General Practice.

It is time for the Government to deliver the funding to support the General Practice that the community deserves. One that is built on the objectives of Bodenheimer's Quadruple Aim ensuring an enhanced patient experience, improved population health, reduced costs and provider satisfaction. Ensuring practices have the resources to utilise the 10 building blocks of high performing primary care is how we will truly transform General Practice to safeguard a high-quality, equitable and sustainable health system into the future.

What we have in General Practice is good, and the envy of many, but we must evolve to meet the growing needs and expectations of the community. While we all must acknowledge the Health Minister's efforts within Government to convince his colleagues to take action on the MBS freeze, he needs to do more. Now is the time for him to stand up for General Practice and leave a more enduring legacy than simply reversing a dud policy.

Is weapons control a public health issue?

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

The spate of United States school deaths, most recently at Marjory Stoneman Douglas High School in Parkland, Florida, on February 14, has elicited a response different from the three which have become standard issue in America.

These are the three ineffective approaches:

First, powerful political figures go only as far as expressing distress and promising victims and their families that they will be mentioned in their prayers, held in their hearts, and remembered.

Second, calls for gun control are dismissed by law-makers as being inappropriate, insensitive and mistaken. Allow for the heat to dissipate, the dust to settle, before considering the supply of guns and ammunition. Pro-gun associations add their voices to the naysayers and spruik 'tweetoids' like: "The only thing that will stop a crazy person with a gun is a sane person with a gun."

Third, public outrage, about both the lethal event and the lack of substantive political action, usually runs out of fuel in two or three weeks; other headlines and concerns take its place – until next time.

On this occasion, though, student survivors took their concerns via demonstrations and public outcry to Washington and won an audience with President Donald Trump. He tweeted:

"Armed Educators (and trusted people who work within a school) love our students and will protect them. Very smart people. Must be firearms adept & have annual training. Should get yearly bonus. Shootings will not happen again - a big & very inexpensive deterrent. Up to States."

Why should gun control feature on a public health agenda, beyond the obvious associated loss of many lives? Is it not purely a 'law and order' matter? Three reasons stand out as to why it should be viewed through a public health lens.

These are the three things public health can do:

First, the attitude towards weapons and their availability reflects not just the attitude of individuals, but of entire communities. To achieve effective weapon control, almost everyone's attitude must change. Fear and alienation require action; few would argue that having your own familiar weapon can be reassuring. So we are addressing public attitudes that maintain a high tolerance of these hazardous devices.

Public health is well versed in the importance of upstream forces causing distortions to health downstream – for example, poverty, perceived unfair financial disparity and poor levels of literacy. Sociological insights into the social causes of the risk factors causing disease are fundamental for public health success.

These school massacres can each be traced to a single gunman, somewhat similar to 'Typhoid' Mary in the early 20th century in America. What was this gunman's social background?

But more broadly, what is America's social background, such that the whole population is so fearful that they feel the need for guns. Estimates (there are no 'gun census' figures) are that there are about 89 firearms per 100 people. Perpetrators of criminal actions, such as at Parkland, live in a social milieu. In a different society, with different levels of fear, and less dependence on weapon ownership for security, they might well have had a different attitude.

Second, public health pays serious attention, not only to the general social background to health and illness, but to the particularity of individuals and the threat they might pose to society's well-being. Although quarantine is little used, the principle of identifying and managing those placing the larger community in danger should be considered. Perhaps it generally is – perhaps the FBI could point to occasions where its surveillance has prevented such mayhem. But might it not be possible to do more in this preventive vein?

Third, public health has a tradition of action which does not tolerate the perpetuation of illness and death. In fact, were John Snow with us – he of the Broad Street pump – he might well object to the first point I made about public health and gun control! He was an empirical interventionist. He considered the facts and acted accordingly. It is said of him that he was sceptical about the prevailing theory that miasmas – bad air – led to cholera and plague; by speaking with citizens in the affected community, he established a connection between those who died of cholera and the use of water drawn via the Broad Street pump and water supplied by the Southwark and Vauxhall water companies. He wrote:

> "The result of the inquiry, then, is, that there has been no particular outbreak or prevalence of cholera in this part of London except among the persons who were in the habit of drinking the water of the above-mentioned pump well.
>
> I had an interview with the Board of Guardians of St James's parish, on the evening of the 7th inst [7 September 1854], and represented the above circumstances to them. In consequence of what I said, the handle of the pump was removed on the following day."

So there is a place for action, indeed for occasional confiscation, in public health! The contribution of the science of public health to the resolution of gun violence might require public health's full range of capacities.

Rural Generalist headache questions

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

We are on the cusp of formulating a National Rural Generalist program. The questions that float to the top are enough to give you a booming headache:

- What is the difference between a Rural Generalist and a Rural proceduralist?
- Has the definition of a Rural Generalist been agreed upon?
- Can we call them specialists?
- Are specialists feeling threatened?
- The Cairns consensus Statement for Rural Generalism has not fully been accepted, why not?
- How can we in Outback tell they are Generalists? Will the credentialing and titles be clear?
- What if there are 6 minute medicine GPs in the Rural location where they desperately need an extended skills generalist? What then?
- Will we lose the newly trained generalist to urban practices?
- Do we need Generalists in the cities?
- Medical bonding is going nowhere, what is going to happen with bonding with the Generalist program?
- How can the training of Rural Specialists be tied into the training of a Rural Generalist?
- Where do Allied health Rural generalists fit in?
- We know Queensland has the most developed Rural Generalist program, which State or Territory is lagging behind? Why?
- There are too many FACEMs without jobs so why are we training Rural Generalists with ED extended skills? Why not get the FACEMs outback?
- Will the Rural Generalist training positions boot out regular GP trainees and specialist trainees from training in the rural facilities?
- How many do we need?
- How many per State and Territory?
- What about the current Rural Generalists without the formal recognition, will they be grandfathered in?
- How can a fellowed GP become a Rural Generalist?
- Are we setting a precedent with our program? Has it been done internationally? Will the world follow us?
- How does private procedural practice fit in?
- In some locations, training capacity and procedural opportunities are squeezed by IMGs and / or procedural specialists and their registrars - how do we ensure that there is a future for the rural generalist in ED, Obs and Anaesthetics especially?
- We now see the Colleges having a greater role in training, the universities having the regional training hubs, the RTOs delivering GP training including rural procedural terms, and the state health departments funding the hospital training terms - looks like a recipe for trouble! How do we sort it out?

I do not have the answers but your answers and comments need to be communicated to the Rural Health Commissioner. Have compassion for him and hope he can tolerate the headaches.

Excellence in Exodus

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

We've got a distribution problem in Australia, across multiple domains. We have a workforce that suffers from a large supply and demand gap for Australia's outer urban, rural and regional patients. We have traded programs that provide positive regional experiences during training for punitive ones that restrict rather than reward. We speak of rural medicine in these stereotypical terms of a life hard done by, with a single GP miraculously providing the anaesthetic while simultaneously taking out the appendix and the baby. None of these approaches is helpful and what's more concerning is that none of them frame medicine in a realistic light.

If you haven't taken a look at the training pathways in Australia at the moment, I'd ask you to spend an hour or two familiarising yourself with the options available to trainees in today's training environment. In the absence of a clear focus on what makes a good pre-vocational trainee and without meaningful accreditation across the pre-vocational space, we have residents being screwed over by a workforce with an insatiable appetite for service provision, and universities that have deftly taken advantage of the anxiety around securing training positions.

Most trainees now have more letters after their names than their bosses, and for what? There's an information divide, between what colleges expect of a good prospective trainee and what pre-vocational doctors think are the desirable qualities in prospective trainees. We've previously described this issue as the CV arms race, and to their credit the Colleges are starting to make moves against it in selection processes. This shift can't come quickly enough. We're drowning in post-nominals when what we really need are high quality medical practitioners.

On top of this arms race, we've built wonderful ivory towers within medicine. You apply to medical school and once accepted, the word of the Faculty is dogma. Then we enter the workforce, and the word of the Health Service is dogma. Once we progress to vocational training, the word of the College is dogma. Fifteen years later you have to ask yourself: exactly who are we serving with this model? With no co-ordination during the transition between these three periods, how can we build a profession that serves the Australian population while also providing a meaningful medical career? Doctors in training scramble over themselves in the belief that 'centres for excellence' are the place to be, spending as many months as possible in these tertiary and quaternary centres to the exclusion of experiences in primary and secondary centres. Excellence is the quality of being outstanding, and I would argue that when you silo your training in a singular centre you are anything but outstanding.

What's interesting about this situation is that if you ask any senior faculty member in any College, or any director in any department in Australia, none of them show much interest in hiring fellows with limited geographical experience. Yet here we are, doctors in training, prioritising sexy, heroic medicine. We often choose fellowships based on how meaningful they are to us, rather than how meaningful they may be to our community. Choosing exodus over excellence makes you a better doctor.

When you move between primary to quaternary you see the full spectrum of the lives of our patients. It's not impossible to appreciate the barriers in rurality without doing time in retrieval medicine, but it's a darn sight easier, more meaningful and more memorable. It's not impossible to understand how medicine works in a resource restricted setting without practising in one, but I'd take the advice of the specialist who has worked in a regional community over the one who hasn't, every time.

We have a workforce that doesn't make sense any more. We have politicians who are intent on building medical schools in their electorates without any regard for the evidence of whether or not they'll help or hinder. We have a pre-vocational group of doctors that are increasingly being thrown to the wolves of service delivery with scant regard for the long-term investment in their training. We have vocational programs that focus on spending time outside of big buildings rather than focusing on spending time inside small ones. This matters because the barriers between these phases of training are all artificial. It's the same ship, we're all in it and there's no-one at the helm.

This isn't a problem that will be fixed by one Government program, or one College decision, or one Vice Chancellor's strategic mission. It will be fixed by us. Every time we prioritise experiential learning over theoretical learning, we fix this problem. Every time we pressure government to do the right thing for our patients, we fix this problem. And every time we talk to our trainees about reality in medicine rather than heroism and fiction, we fix this problem. The solution is in the conversation. So go and take charge of it.

Views from the top of the medical student tsunami

BY VICTORIA COOK, VICE PRESIDENT, AUSTRALIAN MEDICAL STUDENTS' ASSOCIATION

It's a tumultuous time to be a medical student. As Macquarie Medical School opened its doors, and the Murray Darling Medical School proposal resurfaced, last week medical students across the country called their MPs with concerns.

But new medical schools won't be graduating doctors until years after most of us finish. Years behind, these new students won't be applying for our future jobs. So why do we care?

As a medical student who will graduate in 2018, I am right in the middle of the man-made tsunami of junior doctors coming to a ward near you. This influx of medical graduates has been looming for years, and it has not peaked yet.

There are another two schools' worth of graduating classes, Curtin and now Macquarie, yet to join the 'wave'. Yet, hospital systems have an upper limit in the number of training doctors they can feasibly support.

I know this might sound like hyperbole. I'll admit that the natural disaster metaphor might be laying it on a bit strong. What I am trying to say is; students know the uncertainty and pressure that new medical students will face because we already feel it ourselves.

Unlike my international student colleagues, I am guaranteed an internship. But I worry about what comes after. Medicine gets more competitive as each year passes and fears of not getting onto a training program are pervasive.

You will recognise students from this era of medicine by the sheer length of their CV. From day one of med school we hear rumours and hearsay about what the golden ticket to a specialty program is – some say it's a PhD, others say leadership experience, and always, always 'get published'. We add things to our CV like it's a compulsion.

While students run around frantically, forgoing holidays and family gatherings, to do research and extracurriculars, we hear older doctors lamenting this exact CV buffing. They say, exasperated, that panels don't look at CVs anymore because they are all impressive and all the same. They tell us what really counts is your work experience and references.

So students are left asking then, what is the answer. By 2030 there are projected to be 1000 more applicants than available advanced vocational training positions. When candidates overwhelm spots, there must be a way to discriminate.

After medical school, the CV stacking doesn't stop. Universities now offer a plethora of master's courses costing tens of thousands of dollars a pop. Courses in surgery or critical care – more hours of unpaid study, more debt on your balance sheet and hopefully, finally, the criteria that will distinguish you. I've met more than one intern already on their way to another three letters, before the ink on their MD has time to dry.

In other cases, it's not the start of a training program where the pressure lies, it's afterwards with an exit block. No positions for your newly fledged fellowship, no job for your 15 years of hard slog. Government modelling suggests that Emergency Medicine Doctors will outnumber workforce need by at least 1000 by 2030. Doctors will have spent five years or more of their lives studying for a job that doesn't exist, and left with a qualification that isn't transferrable.

Many junior doctors live their lives buried in night shifts and study, or languishing in unaccredited jobs, waiting for the time 'after training' when finally, as a consultant, their job will allow them a semblance of work-life balance. What do they do if that time doesn't come?

As we talk about improving mental and health and wellbeing, it is important to recognise that nothing will be solved until the overwhelming workforce pressure doctors are facing is addressed.

As the Government considers funding yet another medical school, students this week stood up to say enough is enough.

They asked for the focus to move from the simplistic and unsustainable solution of simply producing more graduates, to a more difficult but necessary focus on fixing vocational training. Students said loud and clear that pressure on young junior doctors is already too great, and the opportunities already too scarce.

Young Australians' dreams of being soctors are at risk of being exploited by opportunistic universities and short-sighted political point scoring. It costs too much to do medicine only to end up with nothing.

Ministerial Advisory Committee on out of pocket costs

BY ASSOCIATE PROFESSOR JULIAN RAIT OAM, CHAIR, AMA COUNCIL FOR PRIVATE SPECIALIST PRACTICE

The Council of Private Specialist Practice (CPSP) met on February 15 to discuss a number of important issues facing private practice in 2018. The priority issue for 2018 is to condemn the false narrative that doctors' fees are the cause of most private health insurance out-of-pocket costs (OOPC).

Members may be aware that the AMA is participating as a key stakeholder on the Ministerial Advisory sub-Committee on OOPCs, which aims to identify drivers for patient out-of-pocket costs and explore strategies that may improve the provision of information for consumer choice and, and fee charging practices of medical practitioners.

While the OOPC conversations are largely still in confidence, it's no secret that the Government is exploring medical fee transparency models aimed at consumers, including a 'Trip Advisor' style rating website.

While the AMA has expressed in principle support for fee transparency and informed financial agreement with patients, CPSP rejects outright the health insurers' allegation that doctors are responsible for diminishing the value of private health insurance. This belief oversimplifies a complex, systematic issue and ignores the real culprits of high out-of-pocket costs, which are inadequate MBS and PHI rebates.

Consequently, health reform requires a comprehensive approach.

At the outset, it must be acknowledged that Medicare was never intended to cover the full cost of medical services. At the same time, Medicare and PHI schedules have not been sufficiently indexed to cover the costs of ever-evolving modern practice. Since 2014, the Medicare freeze has cut significant dollars out of the health system. Thankfully, AMA advocacy saw the incremental lifting of the Medicare freeze in 2017. We look forward to the lift on specialist consultations from 1 July 2018. But it is still only a small improvement.

Secondly, private health insurance is becoming increasingly problematic and confusing for the Australian customer - higher premiums with ever-changing and increasing policy exclusions are resulting in significant and unexpected gaps. This is evidenced by the significant number of complaints to the PHI ombudsman regarding PHI insurance policies (rather than about practitioners).

Finally, we need to recognise the complexity of a situation where there are multiple practitioners involved with a procedure, associated with the recent disturbing development whereby no-gap and known gap arrangements are soon to be linked by Bupa as to whether a facility has a contract.

To counter this, the AMA will continue to engage with the Government on the development of an improved PHI system that offers a simplified, more comprehensive set of coverage, with clear clinical definitions, and less caveats and carve outs. This, if achieved, would hopefully restore the public's faith in private health insurance.

Certainly, the profession has kept the faith, and against all odds APRA statistics continue to highlight that the overwhelming majority of medical practitioners bill their patients under a no or known gap billing arrangement (95 per cent). It is difficult to argue with these facts and that the overwhelming majority of practitioners continue to assist patients in limiting their out-of-pocket costs.

That said, CPSP members have acknowledged that their remains a very small cohort of medical practitioners who, through inappropriate billing practices, undermine the broader profession's intent to provide high quality medical services at fair and reasonable costs to their patients. These practices include the use of booking fees, split bills and/or billing for items that are not linked to MBS or AMA scheduled items. CPSP, with the support of the President, have taken a position to curtail this type of billing behaviour.

Of course, all of this work will only be successful if we improve the most critical factor - health literacy. The Australian Commission on Safety and Quality in Health Care reports less than 60 per cent of Australians have inadequate levels of health literacy . We can't expect Australians to navigate the complexity of our health system without the right tools and greater knowledge.

Furthermore, it is clear that the issue of patient out-of-pocket costs is far more complicated than the media have been reporting, and that CPSP will need to work with other AMA committees and the wider clinical craft groups to convey this to key policy makers. The rights of private medical practitioners to set competitive fees in line with their expenses, their expertise and each patients' unique circumstances are well established.

At the heart of the matter is the fact that some members of the private health insurance industry are becoming more profit driven and not taking responsibility for their role in supporting the system. As a result, many customers are leaving for the already overstretched public system. As many have said before, we need both sectors to be in balance in order to have a sustainable health system.

As the AMA, our role in this debate is as much to advocate for the patient as it is for ourselves – a fairer, clearer and better value system that balances the interests of all stakeholders.

The 2020 health care agreement – business as usual with a sting in the tail

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

The AMA expected negotiations on the 2020 health care agreement would be hard fought but hoped the agreement would include increased Federal funding to redress the funding crisis facing public hospitals.

Instead, at the recent Council of Australian Governments (COAG) meeting on February 9, the Federal Health Minister tabled a 2020 public hospital funding offer that gives States no additional long-term hospital funding and yet requires them to do more with it.

State Governments that sign up will commit to a formalised obligation from 2020 to provide integrated care – particularly for patients with complex and chronic disease, and undertake initiatives to reduce potentially avoidable admissions. These activities are a continuation of the trials that four jurisdictions signed up to in late 2017 under Schedule 1 of the existing National Health Reform Agreement.

The financial penalties for safety and quality have been maintained in the 2020 agreement (hospital acquired conditions, sentinel events, avoidable readmissions) but expanded to potentially penalise public hospitals that provide 'low value care'.

As HFEC has contended before, there is no evidence that funding penalties lead to improved health care safety and quality. The argument that a pre-determined definition of 'low value treatments' should be added to the list of public hospital events that incur financial penalties is not a fit for purpose solution to improve public patient outcomes.

The longer term system-wide reforms in the new agreement are even more ambitious: a shift to paying for value and outcomes; development of quality indicators; joint planning and funding at a local level; prevention and wellbeing; enhanced health data including a new data set for community care.

HFEC supports the concept of reforms that encourage an efficient health care system that collects and leverages evidence based data to improve treatment efficacy, patient outcomes and health care affordability. But the analysis must be sophisticated and accommodate the unique morbidities and circumstances of each patient. It must be led by the team of practitioners involved in the patient's treatment. Patients respond differently to treatments so a procedure that is objectively 'low value' for one patient will not necessarily be 'low value care' for a different patient.

The offer in the 2020 funding agreement appears divorced from the current situation our public hospitals are in. The bleak picture portrayed by the data summarised in the 2018 AMA Public Hospital Report Card shows our public hospitals are increasingly required to meet the needs of more and more Australians. Between 2011-12 and 2015-16 the number of separations rose by 3.3 per cent on average each year, more than double the average population growth of 1.6 per cent over the same period. Pressure on public hospitals will only intensify if insured Australians continue to drop or downgrade their policies due to a perceived lack of 'value for money'.

Waiting times for public hospital emergency treatment has worsened. Nationally, one third of the 2.8 million patients who presented to public emergency departments in 2016-17 and needed urgent treatment were not seen within the recommended 30 minutes. It is concerning the patients least likely to leave emergency within four hours are the sickest. It is even more concerning these patients remain in emergency because there are insufficient specialist ward beds to transfer them to. The longer these patients wait in abeyance the more likely they are to incur complications.

Elective surgery performance in 2016-17 was mixed. The majority of jurisdictions still failed to treat all urgent elective surgery patients within the 90-day clinically indicated timeframe. This statistic hides the many more Australians on the 'hidden elective surgery wait list' who sometimes wait years for an outpatient specialist appointment prior to going on an official wait list.

The 2020 Agreement only worsens this situation. It includes an obligation on State Government signatories to ensure access to public hospital services is on the basis of clinical need. On face value this may appear to address allegations of privately insured patients moving up the elective surgery queue ahead of their public patient counter-parts. But this provision might instead mean all elective surgery patients – insured and public – simply wait longer.

The Commonwealth Government had an important opportunity in 2018 to offer an increased level of ongoing hospital funding in the 2020 funding agreement. While some State Governments share the responsibility for under-funding their public hospitals, the Commonwealth offer merely to maintain their existing contribution to 45 per cent of the cost for every additional hospital episode up to 6.5 per cent growth year on year will not drive an increase in public hospital episodes. Unless State Governments can pay the remaining 55 per cent of each additional public hospital episode, the 2020 Agreement will do nothing to help boost public hospital throughput to clear the backlog of unmet demand.

Furthermore, it is hard to see how this new agreement does anything to equip State Governments and public hospitals with the resources needed to build the organisational capacity to collect and leverage evidence based data to improve treatment efficacy, patient outcomes and health care affordability.

Closing the Gap – 10 Year Review

BY AMA PRESIDENT DR MICHAEL GANNON

This year marks 10 years of Closing the Gap.

Sadly, when Prime Minister Malcom Turnbull launched the Government's *Closing the Gap Prime Ministers Report 2018* last month, it came as no surprise that we are not on track to close the life expectancy gap between Aboriginal and Torres Strait Islander people and other Australians.

In fact the Government admitted that it is not on track to close four of the seven targets. Even claiming success over the child mortality target could be optimistic with current Indigenous rates close to the line.

> "With all of the research, reviews and recommendations during this time, how are we still seeing such restricted improvements in outcomes for Indigenous Australians?"

An endless number of authors have proclaimed over the decades, in various iterations, that "the time for action is now". The AMA even titled its 2003 Report Card on Indigenous Health *Time for Action*, affirming that "... concerted action is needed now". But to date, action has been patchy, often uncoordinated and lacking in Indigenous involvement.

The AMA has been producing its Report Card on Indigenous Health for 15 years. In that time we have launched 14 Reports, advocated for Government action on six core issues, and set out no less than 50 recommendations.

Over the same period, there have been countless Government strategies, plans, frameworks, reviews and interventions across every portfolio, all with their own lengthy list of recommendations to address the social issues that disproportionately impact Aboriginal and Torres Strait Islander people.

With all of the research, reviews and recommendations during this time, how are we still seeing such restricted improvements in outcomes for Indigenous Australians?

Disappointingly, the answers lie among the pages of this mounting pile of documents – too many of them lying dormant.

The failure to Close The Gap is disappointing because the Government has had the answers to addressing the continued disadvantage for decades now – long before the Close the Gap campaign held them to account.

The concept of Indigenous self-determination is not new to Australia's parliamentary members, having been on the national agenda since at least the 1970s. However in practice, Aboriginal and Torres Strait Islander communities are still waiting to have their voices heard.

The Close the Gap Campaign Steering Committee also handed down its *Close the Gap – 10 Year Review* report last month, providing a critical review of the Government's efforts to address Indigenous disadvantage. Its first recommendation was that the Government partner with Aboriginal and Torres Strait Islander communities during the 'refresh' process.

Just as importantly, the report called for appropriate levels of funding to address Indigenous disparity. We have witnessed decades of rhetoric about funding for Indigenous affairs. Yet the Government expenditure on Indigenous health, while in dollar terms reaching parity, has failed to become commensurate with clinical need.

It also called for the Government to maintain the current targets set in 2008, but complement these goals with measures and reporting on the inputs to achieving the targets, including expenditure on primary health care; addressing institutional racism; growing the health workforce; and building health enabling infrastructure such as housing.

The AMA has a strong history of advocating for process and policy changes that will end the disproportionate disadvantage we see in Aboriginal and Torres Strait Islander communities. We will continue to call on the Government and industry leaders to unconditionally commit to addressing the social determinants that impact on health outcomes, through the avenues that we know will produce genuine and sustainable change.

It is unacceptable to give up hope of achieving the goals or to claim that the targets are unachievable. We cannot afford to label the situation as hopeless. The lives of Aboriginal and Torres Strait Islander people literally depend on it.

If the time for action is not now, then when is it?

Supporting the generalist workforce

BY AMA VICE PRESIDENT DR TONY BARTONE

> "It's apparent that greater numbers of generalists will be needed in both the city and the bush as Australia's demography changes and complex and chronic diseases become more prevalent."

It's often said that generalist medical practitioners – generalists – have been an important and integral member of the rural medical workforce for decades. I wouldn't argue against this.

But just what is a generalist? This isn't an esoteric consideration given the work now underway on building the long-awaited national rural generalist training pathway.

To some, generalists are simply rural GPs with advanced training skills. The AMA takes a broader view appropriate for the times. Our preferred definition includes GPs, rural generalists and general specialists who maintain a broad scope of practice, which I think reflects the essential clinical and procedural services they provide for patients across Australia.

Many people in country areas are cared for by their local family doctor who runs the general practice and performs minor operations. They might also be treated by a general specialist who can provide the wide range of services that help regional populations to prosper.

Communities continue to rely on generalists for their medical care, though shortages are an ongoing problem. It's apparent that greater numbers of generalists will be needed in both the city and the bush as Australia's demography changes and complex and chronic diseases become more prevalent.

I'm really disappointed when Governments downgrade local healthcare facilities and put restrictions on the scope of practice for doctors and ancillary staff. Unsurprisingly, the generalists practising in the affected areas struggle to maintain their clinical and procedural skills.

Don't get me wrong, credentialing is essential for ensuring patient safety and quality care, but decisions on accreditation arrangements for local facilities are often based on the application of unsuitable metropolitan models.

In the end, local communities suffer when generalists are forced to leave town to maintain their skills proficiency. I've heard and read about the repercussions for patients when they have to travel long distances for medical, surgical, psychiatric and addiction services (to name just a few) that they can no longer access locally.

The AMA is worried about these developments. Led by our Medical Workforce Committee, we released a Position Statement late last year outlining the credentialing, infrastructure and remuneration we believe is necessary to sustain a thriving generalist workforce that gives communities the medical care they are entitled to.

In *Employment of Generalist Medical Practitioners 2017* the AMA advocates for:

- regulatory and accreditation arrangements for rural health care facilities, including decisions to reduce the scope of practice to be determined by the needs of the local community and the capabilities of the local facility,
- a clear evidence base to be established before services are restricted or removed when there are concerns about the safety and quality of care,
- more integrated programs to help generalists maintain and upgrade their clinical and procedural skills, and
- remuneration for generalists to be based on the nature and value of the work they perform.

Make no mistake; the medical workforce is being reconfigured to meet expected demand for services. How we train more generalists and get them to where they are needed is a central part of this process. See for yourself how they can be supported at: https://ama.com.au/advocacy/position-statements

Health on the Hill

POLITICAL NEWS FROM THE NATION'S CAPITAL

Government's NDIS struggles to meet demand

The National Disability Insurance Scheme (NDIS) provides funding packages for people with permanent impairment that substantially reduces their physical, intellectual, cognitive, neurological, sensory, psychological and social functioning. There are an estimated 4.3 million Australians (aged 16 to 65) with disability, however, the majority of people with disability will not meet the eligibility criteria for NDIS funded packages.

People with disability use an eligibility checklist to see if they meet the criteria, and if so, they apply to receive funded support through the NDIS. The NDIS assigns funding to individuals, and service providers/agencies compete in a market environment to attract NDIS customers. Funding is available for 'reasonable and necessary supports' for people with disability to live a life as 'ordinary' as possible. The funding covers:

- aids and equipment such as wheelchairs and hearing aids;
- helping people with personal care (e.g. showering);
- managing finances;
- house cleaning and domestic activities;
- psychological, social and speech therapy and physiotherapy;
- social participation activities such as in clubs; and
- transport to connect with friends and community.

Thousands of Australians, however, are struggling to navigate the NDIS and obtain the right type of care and supports they need. This is particularly so with mental health. In November 2017, AMA's Federal Council held a policy session on the NDIS. The AMA made submissions to parliamentary inquiries and engaged with its members and stakeholders on NDIS issues. The NDIS affects three sections of the AMA: Public Health (including Indigenous Health), General Practice and Workplace Policy and Medical Practice. The AMA's concerns can be broadly categorised into the following issues:

1. The role of medical practitioners (especially GPs and psychiatrists) in providing NDIS assessments; the recognition of medical diagnoses, and the time needed by practitioners to provide these assessments (and remuneration).
2. Access to appropriate medical and psychosocial supports for people with psychosocial disability/mental illness, including for those deemed ineligible for NDIS packages.
3. Aboriginal and Torres Strait Islander people and those from culturally and linguistically diverse (CALD) communities and their specific problems with assessments and access.

One issue of particular concern is the ongoing reports of people falling through the gaps left by the NDIS. To fund the transition to the NDIS, mental health programs, including Partners in Recovery (PiR), Day to Day Living (D2DL) and Personal Helpers and Mentors (PHaMs), are being rolled into the NDIS. This means funding that was in the community for day to day supports and psychosocial services is now with the NDIS. At the last Federal Budget, Health Minister Greg Hunt promised to inject an additional $80 million to fill this gap, which must be matched by State and Territory Governments.

But as the Government transitions this funding to the NDIS, some people who accessed these programs are being deemed ineligible for NDIS packages, and consequently left with little or no help to manage their mental illness. One example is the personal helpers and mentors program, known as PhaMs. Funding for this program is being transferred to the NDIS, but a report from the University of Sydney and Community Mental Health Australia (January 2018) showed that hundreds of people who were accessing PHaMS were not eligible for the NDIS.

What this means is the funding for hundreds, perhaps thousands, of people to support their mental health needs is now with the NDIS, but they are not.

The AMA acknowledges the need to support the NDIS and ensure the Scheme works, but not shy away from valid criticisms and highlighting areas of concern. The transition process to what is one of the biggest reforms undertaken is leaving some people, particularly those with mental illness, without the supports and services they need.

The Government is aware of the problems and has promised to continue to provide similar levels of support through other federal programs until on-going services are in place, through 'continuity of support'. However, what this actually looks like in practice has yet to be articulated. For doctors, it is critical that the Government works quickly to stop patients previously accessing mental health supports from falling through the cracks in the NDIS.

SIMON TATZ
AMA DIRECTOR, PUBLIC HEALTH

Health on the Hill

POLITICAL NEWS FROM THE NATION'S CAPITAL

New vaccines for improved coverage against flu in Australia

Two new ground-breaking flu vaccines will be given to more than three million Australians.

The Federal Government recently said it will provide the new vaccines to those Australians aged 65 years and over who want them.

In making the announcement, Health Minister Greg Hunt said: "This is a direct response to last year's horrific flu season, which had a devastating impact around the world, and aimed squarely at saving lives."

More than 90 per cent of the 1,100 flu related deaths in 2017 were of people aged over 65 years of age. While less than one to two per cent of people who get influenza will end up with a complication from it, it is the elderly who seem hardest hit.

"The medical advice, both from the vaccine producers, the World Health Organisation and the Chief Medical Officer is that the mutation which occurred last year in many countries will be specifically addressed by these new vaccines," Mr Hunt said.

The new vaccines – Fluad® and Fluzone High Dose® – were registered in Australia to specifically provide increased protection for people aged 65 years and older.

From April 2018, both vaccines will be available through the National Immunisation Program following a recommendation from the Pharmaceutical Benefits Advisory Committee.

"Annual vaccination is the most important measure for preventing influenza and its complications and we encourage all Australians to get vaccinated. We encourage all Australians aged over six months old to get a flu vaccination this year before the peak season starts in June," Mr Hunt said.

The Chief Medical Officer, Professor Brendan Murphy, believes the new 'enhanced' vaccines will be more effective.

However, Professor Murphy said: "No flu vaccine is complete protection, the standard vaccine seems to protect well in younger people, but we are confident this will give better protection for the elderly."

The Department of Health believes the new trivalent (three strain) vaccines work in over 65s by generating a strong immune response and are more effective for this age group in protecting against influenza.

There is now a mandated requirement for residential aged care providers to provide a seasonal influenza vaccination program to all staff as well as the Aged Care Quality Agency continuing a review of the infection control practices of aged care services across the country.

Under the National Immunisation Program, those eligible for a free flu shot include people aged 65 years and over, pregnant women, most Aboriginal and Torres Strait Islander people, and those who suffer from chronic conditions.

The following four strains will be contained within this year's Southern Hemisphere vaccines:

- A(H1N1): an A/Michigan/45/2015(H1N1) pdm09 like virus;
- A(H3N2): an A/Singapore/INFIMH-16-0019/2016(H3N2) like virus;
- B: a B/Phuket/3073/2013 like virus; and
- B: a B/Brisbane/60/2008 like virus.

Allen Cheng, Professor in Infectious Diseases Epidemiology at Monash University, has warned: "Despite the common perception that the flu is mild illness, it causes a significant number of deaths worldwide. To make an impact on this, we need better vaccines, better access to vaccines worldwide and new strategies, such as increasing the rate of vaccination in childhood."

AMA President Dr Michael Gannon welcomed the Government's announcement because it was targeting vaccine coverage for "a particularly vulnerable group".

MEREDITH HORNE

Research

Three golden rules for a healthy diet

Which one wins – a healthy low-fat diet or a healthy low-carbohydrate diet?

When it comes to weight change, neither apparently.

The study, published in the *Journal of the American Medical Association* (JAMA) has found no significant difference between the two diets even after being on them for 12 months. It also found no relationship between weight fluctuation and a participant's DNA testing.

Importantly however, the study did find that people who cut back on added sugar, refined grains and highly processed foods while concentrating on eating plenty of vegetables and whole foods — without worrying about counting calories or limiting portion sizes — lost significant amounts of weight over the course of a year.

Professor Christopher Gardner, the Director of Nutrition Studies at the Stanford Prevention Research Center who led the study, said there is no single diet that fits everyone.

"I continually see three factors that come up again and again: get rid of added sugar; get rid of refined grain; and eat as many vegetables as you can," Professor Gardner said.

He argues that the study has shown the diet argument is often focused on the wrong things, like which type of diet.

"We are battling points on the fringe of this whole debate without getting to the core," he said.

The large clinical trial included 609 adults aged 18 to 50 years without diabetes, with a body mass index between 28 and 40, where participants were randomised to the 12-month healthy low-fat diet or a healthy low-carbohydrate diet.

"We really stressed to both groups again and again that we wanted them to eat high-quality foods," Professor Gardner said.

The low-fat group was told to avoid refined carbohydrates like soft drinks, fruit juice, muffins, white rice and white bread – even though they are low fat. Instead they were advised to eat more nutritionally beneficial foods like brown rice, barley, steel-cut oats, lentils, lean meats, low-fat dairy products, quinoa, fresh fruit and legumes.

The low-carb group was trained to choose nutritious foods like olive oil, salmon, avocados, hard cheeses, vegetables, nut butters, nuts and seeds, and grass-fed and pasture-raised animal foods.

Australia is ranked the fifth highest in the Organisation for Economic Co-operation and Development's (OECD) latest obesity rankings. Projections show a steady increase in obesity rates until at least 2030. Currently more than one in two adults and nearly one in six children are overweight or obese in OECD countries. OECD adult obesity rates are highest in the United States, Mexico, New Zealand and Hungary, while they are lowest in Japan and Korea.

Speaking on radio recently, AMA President Dr Michael Gannon said the AMA would continue to call for a tax on sugar-sweetened beverages because it is designed to change behaviour.

"We have a situation now where it's often cheaper to purchase one of these drinks than it is to purchase water," Dr Gannon said.

Further information about the study can be found https://jamanetwork.com/journals/jama/article-abstract/2673150?redirect=true

AMA's Position Statement on Nutrition was launched earlier this year and is available here: https://ama.com.au/position-statement/nutrition-2018

MEREDITH HORNE

Ground-breaking research leads to better autism test

A world first test, developed through an international cooperative effort, could lead to earlier diagnosis of autism spectrum disorders.

British scientists have developed a blood and urine test that can detect autism in children, and they say it is the first of its kind.

The University of Warwick researchers said their test will allow earlier diagnoses and therefore earlier and more effective treatments.

They worked in collaboration with the University of Bologna in Italy, as well as with the University of Birmingham in the UK.

Children of varying age groups were tested from these locations.

Because there are so many symptoms of autism spectrum disorders (ASD), diagnosis can be difficult in the early stages of its development.

But the scientists discovered a link between ASD and damage to proteins in blood plasma. By examining protein in blood plasma, they found children with ASD had higher levels dityrosine – and oxidisation marker – and advanced glycation end-products – sugar modified compounds.

TO THE EDITOR

Serendipity?

I well know anecdotal and personal stories are anathema to the scientific process. However, 'my accurate story is different'. In 2012, I developed severe life endangering throat cancer, successfully treated at RPAH as a public patient, with radiotherapy and cetuximub. In 2017, I sustained colon cancer, also successfully treated by surgery. I am aged 90. Never used alcohol, never smoked, vegetarian, weight 60 kg, walked 30 minutes every day for a lifetime. Regular prophylactic medical checks by a specialist twice a year for more than 20 years.

I worked in my same GP surgery at North Ryde, a Sydney suburb that abutted directly onto a public laneway. Along the laneway were electrical cables, also on the same poles for cable television. Now, I sat for 60 years within roughly three metres (possibly less) of the wires and cables. All such wires carry an electromagnetic field – always with the query of whether it possibly being carcinogenic. I never considered that though (even after having watched the Australian made film *The Castle* several times). I believe this possibly caused or contributed to my two unrelated cancers. I would appreciate views of your readers, as this has always been a highly contentious issue among doctors and medical statisticians. I wonder how many other people 'out there' have similar exposure, with a 'cancer diagnosis' just waiting to be made?

Dr John F Knight AM
NSW Senior Australian of the Year 2017
Founder and Chairman
Medi-Aid Centre Foundation
North Ryde, NSW

Right to put the spotlight on private health insurance

The news about Bupa is timely. With large numbers of people discontinuing their private health insurance, the AMA and consumer advocate organisations, such as *CHOICE*, should be revealing that companies such as Bupa and Medibank Private have shareholders, who receive a dividend each year, and they sponsor major sports such as tennis, cricket and golf. Such activities use large amounts of members' contributions, which could be used to provide more comprehensive cover for their health needs.

It is time for the AMA and other consumer advocate organisations to point out that non-profit health insurers provide much better value, and the federal government should be urged to make all health insurers non-profit.

Some 40-50 years ago health insurers were branches of church and community groups such as lodges – IOOF, Hibernian, etc. – and other societies and employers which were non-profit. The Doctors' Health Fund is a good example of such an insurer. A return to non-profit status would reduce the current trend to 'Americanise' our health services.

Dr John A. Crowhurst B.Pharm., MB BS, Dip.(Obst.)RCOG, FANZCA, FRCA.
Consultant Anaesthetist (Ret.)
Linden Park, SA

Research

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"Our discovery could lead to earlier diagnosis and interventions," said lead researcher Naila Rabbani from the University of Warwick.

"We hope the tests will also reveal new causative factors.

"With further testing we may reveal specific plasma and urinary profiles, or 'fingerprints', of compounds with damaging modifications.

"This may help us improve the diagnosis of ASD and point the way to new causes of it."

Findings of the research have been published in the journal *Molecular Autism*.

The next step of the program is to repeat the study with further groups of children.

CHRIS JOHNSON

Taiwan wants back in as a WHA observer

Taiwan has put out a call for international support for it to be allowed to participate in this year's World Health Assembly, the decision-making body of the World Health Organisation.

Between 2009 and 2016, Taiwan had been invited to attend the WHA as an observer. No invitation was sent last year.

In 2017, pressure from Beijing resulted in the WHA refusing to invite Taiwan to attend the forum, which was the 70th World Health Assembly.

Taiwan's application to observe most of the WHO's technical meetings was also declined.

When asked during a media conference at the time why Taiwan was not invited to 70th WHA, the head of WHO Governing Bodies Timothy Armstrong said it was due to an "absence" of a cross-strait understanding.

"Negotiations are still ongoing," he said. "Anything is possible."

So Taiwan is seeking an invitation to this year's WHA.

"Taiwan was not invited to attend the 70th World Health Assembly as an observer in 2017. For many years, however, it has participated in the WHA and WHO technical meetings, mechanisms and activities; steadily contributed to enhancing regional and global disease prevention networks; and dedicated its utmost to assisting other countries in overcoming healthcare challenges in order to jointly realise WHO's vision that health is a fundamental right," it says in a statement.

"Therefore, there is widespread support that Taiwan should be invited to attend the WHA.

"Located at a key position in East Asia, Taiwan shares environmental similarities for communicable disease outbreaks with neighbouring countries and is frequently visited by international travellers.

"This makes Taiwan vulnerable to cross-border transmission and cross-transmission of communicable disease pathogens, which could lead to their genetic recombination or mutation, and give rise to new infectious agents.

"However, because Taiwan is unable to attend the WHA and is excluded from full participation in related WHO technical meetings, mechanisms, and activities, it is only after much delay that Taiwan can acquire diseases and medical information, which is mostly incomplete. This creates serious gaps in the global health security system and threatens people's right to health."

Taiwan has also been keen of late to highlight its international successes in both medical breakthroughs and global assistance.

In recent years it has transformed from aid recipient to assistance provider. It has established many disease prevention systems. Taiwan insists it needs the WHO to protect the health of its own people, but that it can also contribute greatly to global health protection.

"With an interest in making professional health contributions and protecting the right to health, Taiwan seeks participation in the 71st WHA this year in a professional and pragmatic way, in order to become a part of global efforts to realise WHO's vision for a seamless global disease prevention network," its statement says.

Interestingly, the WHO's own constitution states:

"The enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being without distinction of race, religion, political belief, economic or social condition."

CHRIS JOHNSON

“We are not growing tomatoes”

BY DR MICHAEL RYAN

A couple of hours north of Melbourne is the picturesque wine geographé of The Pyrenees. Named by surveyor Thomas Mitchell, it reminded him of the Pyrenees region in France. Vines were first planted in the region in 1848 by Mr Mackereth and later the property acquired by clergyman Mr Dawson. The vines were unceremoniously pulled out perhaps underlining the clergyman’s philosophy or merely reflecting the push for grazing country.

The area is 350-400m above sea level. It is desirable for viticulture with 1392 heat ripening days, a slow ripening season and an average of 20 degrees over summer. This puts it into the cool climate spectrum comparing favourably with Coonawarra at 1365 units. Fortuitously, due to the elevation and slopes, frost is a rare event. Rainfall varies from 500-600 mm per year and falls mainly in winter.

The Blue Pyrenees estate is 450 hectares in size with 150 hectares under vine and is a fine example of the allure of cool climate wines with goal of finesse. The estate was first owned and developed by French company Chateau Remy in 1963. Sparkling wine and distilled wine spirit in the form of brandy was the direction.

Ungi Blanc, known as ‘White Hermitage’ was used for ‘Champagne’ and Doradillo was used in Brandy making. The Doradillo didn’t quite have enough sugars for fermentation and hence distillation. John Robb from the Hunter steered the original development of the vineyard and later Collin Preece enhanced the sparkling wine program.

The devotion to quality Methode Traditionnelle sparkling wine is exemplified by the harvesting of grapes under lights in the cool of the evening. This allows a vibrancy with balanced acidity to dominate the product. Sparkling wines are made, including sparkling Rosé and Shiraz.

French wine makers have been integral to the estates development. The dry grown approach has been welcomed allowing the vine to struggle and hence concentrate flavour and acids. The Blue Pyrenees Estate has a large lake courtesy of a mining incident that released subterranean water whilst sinking a shaft. The French winemaker Vincent Gere was very keen on dry grown vines and despite having plentiful water he commented on the use of too much water – “Gentleman, we are not growing tomatoes”.

Head wine maker Andrew Koerner has done his Roseworthy degree and worked in prominent wine making positions for Hardys, Rothbury and Rosemount. Chris Smales is the other wine maker and studied at Charles Sturt University and they both have a fierce loyalty to the concept of elegant wine. Sean Howes is the viticulturist and keeps the vines in tune with experience in the Yarra Valley, Tunisia, Sicily and Italy.

Sparkling wine consumption was on the rise and a large part of the estate has been devoted to this. Hence the quantities of Chardonnay and Pinot Noir. After the Doradillo was pulled, Red varieties were planted and include Cabernet sauvignon, Shiraz, Merlot, Cabernet Franc and Pinot Noir. Sauvignon Blanc and now some Viognier have been planted.

Blue Pyrenees Estate has an excellent cellar door and café. There are some cellar door only wines and these are all available in the café by the glass. Some of the big hitters include the Blue Pyrenees Champ Blend Blanc, the Richardson Reserve Shiraz and the Cellar Door Pinot Noir.

WINES TASTED

1. NV Blue Pyrenees Luna

This is regarded as their ‘House Style’. A portion of last year’s base wines are added for complexity. Light yellow with pink tinge. The bead is fine. The nose has some strawberry, citrus yeasty notes. Nice plush front palate with the bead and acidity lingering. Nice with oysters. A party starter.

2. 2017 Blue Pyrenees Bone Dry Rosé

Light pink colour. Hints of strawberries and rose petals with a hint of spice. The palate is juicy and smooth as a result of malo-lactic fermentation. Nice balanced acidity and dryness. I enjoyed this with some Spanish mussels.

3. 2014 Blue Pyrenees Shiraz

Dark red purple hues. The nose of violets dark plums and spice are typical of elegant cool climate wines from the region. The palate is broad, and fruit driven with soft tannins. The finish is dry and lingering. This is a well-made wine and amazing for sub $20. Have with lamb ragout. Cellar seven years.

4. 2013 Blue Pyrenees Estate Red

73 per cent Cabernet Sauvignon, Merlot 19 per cent, Shiraz 4 per cent. Dark garnet colour. Voluptuous berries with cassis notes dominate. Earthy tobacco and oak spice linger. This wine flows effortlessly across the anterior palate, surfs up a mid-palate layer of intensity and relaxes with firm balanced tannins.

Canadian military pattern trucks

BY DR CLIVE FRASER

During World War II under-utilised Canadian automotive factories produced 815,729 military vehicles for the Allied war effort.

Half a million of these vehicles were British-designed light trucks fondly known as Blitzes.

As a child in the 1960s I can remember seeing hundreds of them parked in old Commonwealth Government stores.

As they were designed to travel cross-country many of them went on to serve in the outback, mining and forestry applications.

It wasn't so long ago that Tangalooma tourists would be taken to the Moreton Island sand blow in an ex-army Blitz.

After all Moreton Island had been equipped with artillery to protect the shipping channel to Brisbane from Japanese invasion.

A colleague with a collection of military vehicles owns a C60L from 1943.

My colleague was also born in 1943 which makes them both 75 years of age and neither have any retirement plans and both seem built to last.

The C60L was made in the Chevrolet factory in Oshawa, Ontario.

And, if one Blitz is never enough my colleague also has a 1942 F60L which was made in the Ford factory at Windsor, Ontario.

During the war there was a remarkable degree of co-operation between the competing automotive plants with most body parts being interchangeable.

The main point of difference was that the Chevy Blitz had a 216 cubic inch OHV six cylinder engine producing 85 horsepower (63 kW).

The Ford Blitz had 238 cubic inch side valve V8 producing 95 horsepower (71 kW).

Both had four speed non-syncromesh transmissions.

Neither needed a heater because the engine was sitting in the middle of the cabin.

Driving a Blitz does require a tutorial before venturing off.

The main issue is that on first inspection there are only two pedals, an accelerator and a clutch.

The brake pedal is out of view and high up under the dashboard above the accelerator pedal.

The transfer case has high and low ranges as well as a shaft for a power take-off driving a winch.

After the war many Blitzes were fitted with jib cranes and

became tow trucks.

My dear Uncle Bob served as a mechanic in the British Army in 1943 working on Blitzes in the North African campaign.

He became adept at improvisation in the desert as patching up the Blitzes kept supplies moving up to the front line.

One day he was bashing a shaft with a hammer when he was distracted by another worker.

He turned slightly, but kept swinging the hammer only to end up striking a blow to his forearm which smashed his watch.

With no end in sight to the war and Bob not carrying a spare watch he was resigned to not knowing the time of day for the rest of his deployment.

The next morning he woke up to see that someone had drawn a cartoon of him smashing his watch and had pinned it above his workbench.

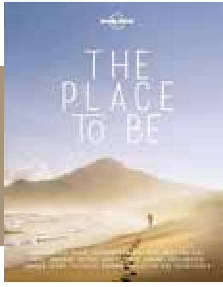
The caption read: "Bob, killing time!"

Whilst long departed I think that my Uncle Bob would be smiling if he knew how many Blitzes were still on the road.

Safe motoring,

Doctor Clive Fraser

doctorclivefraser@hotmail.com



Lonely Planet's *The Place to Be*

Published by Lonely Planet. Hardback $39.99

REVIEWED BY **CHRIS JOHNSON**

A book to help you feel exceptionally well

Lonely Planet has recently embarked on a project to launch a series of beautifully produced, hard bound coffee table books with a specific travel theme.

The latest in the series is all about feeling good – that is, travelling to places that will add to one's wellbeing simply by being there.

Put simply, it is about travel destinations to "make you feel awed, inspired, joyous, adventurous, serene, exhilarated, amused, alone, fulfilled, passion, reflective and enlightened".

At least that's what it says on the front cover of *The Place to Be*, and even a cursory flick through the 304 pages lets you know that the cover says it all.

The Place to Be offers readers 240 travel destinations that in turn suggest where to go in search of experiencing a particular emotion. Each chapter explores a single feeling, with 20 travel destinations and experiences for each emotion and state of mind.

Places range from wild and natural spaces, to modern and ancient cities, with Lonely Planet's travel writers explaining when to go and how to get there, and the best routes to discovering these feelings.

It is a novel idea and one that works. The pictures alone – stunning, as is always the case with Lonely Planet publications – are almost enough to make you feel better than you were before you picked up the book.

And the descriptions of each destination are tempting teasers that make you want to discover these places and indulge in the experiences they offer firsthand.

It is an easy read, with longer sections devoted to some of the more inspiring destinations and experiences.

Read about the California redwoods; the cherry blossoms of Japan; the orangutans of Borneo; the cafes of Italy; serenity on the Cyclades; the savannahs of Africa: the waterfalls of South America; the music in New Orleans, Havana, Vienna; and much more.

Australia is represented in the book by 13 different destinations:

Daintree National Park, Noosa, Margaret River, MONA, Kangaroo Island, Uluru, the Red Centre, Henley-On-Todd Regatta, Big Things Road, Melbourne, Sydney, the Kimberley, Cradle Mountain – Lake St Clair National Park.

The publishers say they want readers and travellers to think about their next journey in a whole new light.

"Whether we go for a weekend or a year, most of us travel to see unforgettable sights and enjoy new experiences. But, ultimately, we travel in search of a feeling," they write.

"That feeling might be a sense of awe or wonder that we don't receive in our daily routines, or it might be a cosseting feeling of calm.

"Drawing on science, art and literature for the key to unlocking each emotion, this book is a reminder of how powerful new places can be for mental and physical wellbeing."

That's all great, but let's remember it is only a book. It is not, and does not profess to be, a cure or remedy or anything close to a replacement for medication.

It's just a book to help make you feel good.

Tips from a music traveller

BY CHRIS JOHNSON

As the airport shuttle approached my hotel in Auckland's CBD I gazed out the window to see a large neon sign on the front of a building that screamed Real Groovy Records.

It was midnight and it was all lit up.

It must be some sort of night club, I thought. It is surely not a record shop, selling actual records – vinyl records.

No record shop I know has enough money to waste on letting a giant neon sign burn all night. And none actually stays open until midnight.

A quick Google search revealed that no, it wasn't open at that hour; but yes, it really was a record shop.

The very next day I was there, hunting for LPs.

Downstairs was a treasure trove of records that kept me consumed for an hour. I found a few gems, including a mint condition live album of Bob Dylan and the Grateful Dead that had for so long eluded me.

The excursion got me to thinking about how often I have mixed business and leisure travel with quick diversions into record shops.

It is the disease of vinyl lovers. But as vices go, I'll stick with this one.

I returned from Tokyo just a few years ago with an original 1965 red vinyl copy of *The Ventures in Japan* and a great story to go with it.

I once found some of the coolest blues and jazz albums in a music store in Taipei, was awestruck another time by the sheer vastness of records on display in a Hong Kong store, and let's not even get started on London and L.A.

But having said that, Australia has some exceptionally good record stores, much to the delight of music lovers who prefer that pure, rich sound you can only get by playing a vinyl disc through a quality hi fi system.

So, to help any record lover out there with their pursuit of all things vinyl, I am listing a few of my favourite Australian stores.

For me, bigger doesn't mean better. I am just naming smaller, crammed stores that are designed to be rummaged through.

And I am mostly highlighting here those which focus mainly on secondhand records (where the gold can be found).

And while there are hundreds of record stores around Australia, I can only talk about some I have visited. I am leaving many out.

Melbourne is a record hunter's Mecca and I could name dozens of stores, but I like The Searchers Records and Books in Fitzroy for its eclectic range, Northside Records (still in Fitzroy) for soul and funk music, and Licorice Pie Records in Prahran for its name alone (think about it).

Sydney too is a paradise for secondhand records and I love to venture out to Newtown to visit Egg Records and Repressed Records. Down the road in Erskineville is Revolve Records, a tiny store that is jam packed with one of the country's best range of rare find used records.

In Sydney's CBD you can't go past Birdland Records for jazz, Utopia Records for hard rock, and Mojo Record Bar for a niche selection of music and a cool bar in the basement.

Shoot up to the Blue Mountains to Katoomba's The Velvet Fog for an incredible range of used records that are immaculately presented.

Hobart's Music Without Frontiers is a small store with lots of new stock, but it is so worth a visit if you are after the hard to find.

Soldas Music is a great place in Hobart for used records.

In Brisbane, the Record Exchange in the CBD is a must-see. Its range is pretty impressive and there is a huge room behind the counter to search if you can't find what you want on the shop floor. Nearby, Rocking Horse Records is not too bad either.

If visiting Canberra, venture to the southern suburbs to find Dynomite Records in Kambah. Yes, they use an 'o' instead of an 'a' so they can place a graphic of a round record in the word Dynomite. This store is a true find. It has as much stock as any of the secondhand stores in Sydney and the prices are great.

Over to Adelaide and it's worth a trip to Port Adelaide to discover both Porthole Records and Mr V Music. Wolfies Records in the Adelaide Hills is a good find too. But you can't go past Rerun Records in the Adelaide CBD for a wide range of classic rock.

Perth's 78 Records and Dada Records, both in the CBD, are institutions in the West and for good reason. But don't forget Fremantle. The Record Finder and Junction Records are two very well stocked record stores down by the dock.

Further south (and a little east) in WA suburbia is a wonderland of used LPs at Replay Records in Kenwick.

Visits to country towns can turn up magic little record stores too. I will name just one, Championship Vinyl in Braidwood, NSW. This store is a delight. Sitting above an antique shop behind the town's main street, the climb up the stairwell is highly rewarding. Records are very well presented and the range is outstanding.

There are so many more stores to discover. Happy travels.

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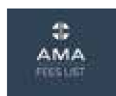

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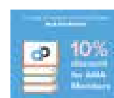

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