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Medicine

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AMA LEADERSHIP TEAM



President
Dr Michael Gannon



Vice President
Dr Tony Bartone

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PHI – It's all about choice and value ... and trust

BY AMA PRESIDENT DR MICHAEL GANNON

The prevailing debate about the value proposition of private health insurance – with claim and counter-claim, and punch and counter-punch, in the media – is one of the most important health policy discussions of recent times.

It needs a solution. It is a priority for the Government and the Opposition as they head to an election year.

The outcome will have a long-term impact on one of the pillars of the health system – the whole private health sector.

It affects all of us, wherever we work in the health system.

Most importantly, it affects every Australian who needs potential access to health services every hour of every day across the nation, not just people with private health insurance policies.

Anything that diminishes the ability of private hospitals to perform their share of health care places huge pressure and stress on public hospitals and the primary care sector. Private hospitals are an essential contributor to universal health care in Australia.

So, we need this resolved. Now.

The whole debate revolves around what people get when they invest a significant portion of their household income into a private health insurance premium.

It is all about choice and value ... and trust.

Private health insurance is supposed to offer policy holders greater choice when it comes to their doctors and their treatment.

It is supposed to be value for money, but premiums continue to increase year after year – without policy improvement and without greater clarity about what exactly the policy covers.

Trust is being replaced by fear in the minds of patients with private health cover – fear that they will not be covered if they have an accident, fall ill, or require surgery.

The actions of the bigger health insurers are feeding this fear. Bupa has been the worst offender. Their recent actions, primarily their decision that the no-gap or known gap rate will only be paid when a medical service is carried out in a Bupa-contracted facility, is US-style managed care writ large.

If this approach is allowed to go ahead unchecked and unchallenged, the other funds will follow suit and the Australian health system will be turned on its head.

Patients will lose choice of doctor and hospital. They will get less value from their expensive policies. The confusion about what is covered by each and every policy will be more confusing.

Already, too often patients only find out they aren't covered when they go to use their insurance – even sometimes after a surgical

procedure has taken place.

Allowing restrictions to be hidden in fine print is unconscionable. Policies must cover patients for private hospitals, unless they are specifically and clearly identifiable as 'public hospital only' policies.

And patients must be able to use their private health insurance in public hospitals, if they choose to do so.

The Government is awake to the need for a fix in private health insurance. Its review of the sector is in its second year, and will report soon.

Health Minister Hunt has already indicated that insurers will be required to categorise products under gold, silver, bronze, and basic labels, and use standardised clinical definitions, among other improvements.

The insurers must not be allowed to sabotage these reforms, nor should they try. We will call them out.

The insurers have been attempting to shift the focus away from the deficiencies in their products by claiming medical fees are driving high out-of-pocket costs for patients. The evidence says otherwise. The latest APRA statistics show an overall no-gap rate of 88.1 per cent and a known gap rate of 7.3 per cent. Medical fees are not the problem.

The AMA is opposed to egregious fee setting by a small minority. We oppose booking fees that do not relate directly to an MBS service. But whether those doctors like it or not, we will do what we can to discourage it.

We know that MBS rebates have failed to keep pace with the true value of health care and the cost of providing quality services. Equally, we know that substantial out of pocket costs (or even the threat of them) mean that patients defer important clinical care.

Trust is important. At the time the private health insurance issue was gaining prominence in the media in late March, a Roy Morgan poll reported growing distrust in health insurers, with the industry recording a Net Trust Score of minus 2.6 per cent. Yes, they had plunged into negative territory in the eyes of the public.

The Poll's author said that this level of industry mistrust should be of concern to the funds.

More significantly, the Morgan Poll said that *'there is no doubt that when a patient has to pay an unexpected gap at a doctor's surgery or hospital, they do not blame the health professionals, they blame their private health fund'*.

The AMA will continue to take the fight up to the insurers on behalf of the profession and our patients, to ensure the future of our world-class health system.



More vision, action and resources from policy makers please

BY AMA VICE PRESIDENT DR TONY BARTONE

There is no shortage of health issues making headlines at the moment, and not all of the news is positive.

Furthermore, there is often misleading and misinformed comments being made by certain interest groups with their own axes to grind.

But at the end of the day, there are several serious issues that need to be addressed and require the attention of governments and policy makers.

The *AMA Private Health Insurance Report Card 2018* was recently released and revealed ongoing significant variations in coverage from the insurers.

It provides an overview of how private health insurance should work to benefit patients, how complex it is and highlights how proposed new arrangements will result in ensuring less choice and value for policy holders.

There are a lot of policies on offer that provide significantly varying levels of benefits, cover, and gaps. And there are also a lot of 'junk' policies on the market that will not provide the cover that consumers expect when they need it.

Now, the Government has undertaken some important reforms to private health insurance – and the AMA has had input into the gold, silver, bronze, and basic categories of cover that was announced.

But some private insurers are trying to undo much of this work and are moving ominously towards a US style managed care product.

The Federal Government must not allow this to happen.

The *AMA Public Hospital Report Card*, which was also recently released, provides compelling evidence that all of the nation's Governments need to meet in good faith to re-negotiate the COAG 2020-2025 hospital funding agreement if public hospitals are to build capacity to meet rapidly growing community health needs.

Public hospital funding crisis is the responsibility of all Governments and the blame game between the States and Canberra must end.

As our President stressed when we both launched the Report Card in Brisbane, the current funding formula will doom our public hospitals to fail, and patients will suffer as a result. It also shone a light on the hidden waiting list of patients wanting to see a specialist in outpatient departments – often as much as 12 or 18 months and sometimes even more.

The average annual growth in Federal health funding of 2.8 per

cent over the past five years and 4.3 per cent over the decade is too low. Equally, funding by the States has not kept pace with health inflation, with average growth rates of just 3.2 per cent over the last five years and 4.3 per cent over the decade.

The current COAG agreement is a funding formula destined to fail. We need better than that. There needs to be greater recognition by Governments of the vital role public hospitals play in our health system, and fund them accordingly for the long term.

And so much more should be done towards trying to keep people healthier and needing to visit hospitals less.

The quality and productivity of Australia's GPs is up with the best in the world and the latest Productivity Commission Report offers compelling evidence of exactly that.

The Government must provide greater investment and support for general practice, which will in turn help alleviate the burden on our public hospitals – which are also in dire need of greater funding and resources.

According to the Productivity Commission, the number of GP services in 2016-17 was 6.5 per annum per head of population, which is up from 5.9 services per head of population in 2011-12.

About 75 per cent of patients could get a GP appointment within 24 hours in 2016-17. However, we know that there is still significant redundancy in the availability of GP appointments on any given day based on online appointment data.

This news reflects growing demand for GP services and an increase in GP numbers.

The Productivity Commission also found that patients were highly satisfied with their GPs on a number of measures.

It all adds up to the need for Governments to provide the level of support that general practice warrants and which Australian patients deserve.

Governments at all levels can't keep doing things the same way. Long-term solutions are required. More and more Government committees, however, is not the answer.

Our AMA will continue to lobby and fight hard to see some real changes to the way our public hospitals are resourced; to the type of investment given to general practice; to how aged care problems are addressed; to how the medical workforce is built; and so much more.

Business as usual doesn't cut it anymore.



Biennial ballot beckons

BY AMA SECRETARY GENERAL ANNE TRIMMER

As May approaches, so too does preparation for the AMA's biennial elections. Ballots are now being sent for election for the contested positions on Federal Council – 12 in all this year, which is by far the largest number of contested positions for many years. I would like to think this shows an increased interest among members in the policy and advocacy work of your association.

There were 11 positions on Federal Council that were not contested with the following nominees declared elected:

Area representative SA/NT – Dr Christopher Moy

Area representative Tasmania – Dr Helen McArdle

Area representative WA – Dr Janice Bell

Dermatologist specialty group – Dr Andrew C Miller

Emergency physician specialty group – Dr David Mountain

Ophthalmology specialty group – Dr Bradley Horsburgh

Orthopaedic specialty group – Dr Omar Khorshid

Physician specialty group – Dr Matthew McConnell

Radiology specialty group – Dr Makhan (Mark) Khangure

Doctors in Training practice group – Dr Tessa Kennedy

Public Hospital Doctors practice group – Dr Roderick McRae.

No nomination was received from the Obstetrics and Gynaecology specialty group. I will be calling for expressions of interest to fill that casual vacancy in the near future.

The call for nominations for election as President and Vice President will be issued in mid-April, for election at National Conference.

The Notice of Annual General Meeting will be sent to voting members in early April. There are a few proposed amendments to the Constitution, mostly to remove transitional provisions that are now

redundant and related to the move to the new governance structure in 2014. One amendment of note, however, is an amendment to provide for a position on Federal Council for an Indigenous doctor, as discussed with members at last year's Annual General Meeting. The position will be filled by a nominee of the Australian Indigenous Doctors' Association, to give an Indigenous voice to debates on matters impacting those doctors and Indigenous patients.

Policy and advocacy continue unabated with the recent release of the AMA's major annual reports – the *Public Hospital Report Card* and the *Private Health Insurance Report Card*. Both highlight key issues in health financing. While the report card on public hospitals is directed towards Government funding commitments, the private health insurance report card is directed more towards consumers, highlighting the variations between funds and levels of cover.

Elsewhere in this edition of *Australian Medicine* is a report from the Chair of Federal Council, Dr Beverley Rowbotham, on the March Council meeting. Members will get a feel for the breadth of activity undertaken by your AMA.

In mid-year, changes will take place not only with the membership of Federal Council but also the Federal AMA Board and its subsidiaries as directors retire by rotation. In this edition of *Australian Medicine* I am calling for expressions of interest from suitably qualified members to take up one of the two AMA member positions on the Board of the Australasian Medical Publishing Company Pty Limited (AMPCo). This position has been filled very ably by Dr Steve Hambleton for many years. AMPCo is the publisher of the *Medical Journal of Australia* and also has database and digital businesses, requiring the appointment of a member with strong skills and experience in these areas. I look forward to hearing from interested members.

Consumers not happy with private health insurance



AMA Federal Council passing motions condemning the Bupa changes.

Australians are fast losing faith in the private health insurance industry, according to a new independent survey.

The Roy Morgan Private Health Insurance *Net Trust Score Report* has found Australians now rate the PHI industry at the same level as gambling and real estate.

The survey recorded a negative Net Trust Score (NTS) of -2.6 per cent.

Roy Morgan Research Institute chief executive officer, Michele Levine, said the level of distrust is unexpected, given the highly trusted health system it operates in.

"There is no doubt that when a patient has to pay an unexpected gap at a doctor's surgery or hospital, they do not blame the health professionals, they blame their private health fund," Ms Levine said.

"The customer places their trust in the insurer; should they need to make a claim, they trust the insurer to fulfil its policy obligations. So, this level of industry distrust should be of concern to the funds."

Roy Morgan asked more than 2800 people which brands they trust and which they distrust, in three rounds of surveys between October 2017 and February 2018. In March 2018, they asked a further 1600 people which private health insurance brands they trust and distrust.

"When we subtract distrust from trust, we discover that the private health insurance funds with the highest net trust scores are HCF, Teachers Health, and Medibank Private," Ms Levine said.

"There is only one fund in negative NTS territory, and that is Bupa."

The survey results come as the AMA Federal Council passed two motions against Bupa over plans to change to its policies and coverage.

It formally rebuked the private insurer with the following two motions:

1. "Federal Council expresses its concern at recent changes to health insurance products announced by Bupa. These changes threaten member choice and access to health care. Federal Council calls on Bupa to reconsider these changes and to act in the interests of its members and the broader Australian community."
2. "That Federal Council recommends that the AMA advises Australian citizens how they can change their private health insurance."

The AMA has already forced an investigation into Bupa, after AMA President Dr Michael Gannon called on the Government to look into the legality of the private insurer's move.

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

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

"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."

Shortly after 3.95 per cent PHI premium increases kicked in, Opposition Leader Bill Shorten accused the private health insurers of "running amok".

"That's why Labor has a policy that we will cap the increases at no greater than 2 per cent for the first two years if we get elected," he said.

Mr Shorten refused to rule out changing the private health insurance rebate scheme; saying only that he would look at it once in office.

continued on p7...



AMA Report Card on PHI



The AMA has itself revealed the best and worst of PHI coverage, with the release of its *AMA Private Health Insurance Report Card 2018*.

The Report Card is a timely reminder that private health insurance consumers should shop around.

In releasing the Report Card, Dr Gannon warned that changes being implemented by Bupa and pursued by some other health insurers will reduce patient

choice of doctor and hospital.

And they will leave policy holders questioning the value of their significant investment in private health insurance, he said.

“The big insurers are pursuing a US-style managed care agenda to save costs and further increase profits by making it harder for patients to receive care from the doctor they want in the most appropriate hospital for their condition,” Dr Gannon said.

“Bupa’s new arrangements, which only provide maximum benefits for patients in hospitals with Bupa contracts, undermine the role of the doctor in providing and advising the most appropriate care – and could ultimately drive up out of pocket costs for patients.

“Public confidence in private health insurance is already at an all-time low. These changes will further devalue policies, which are a major financial burden for Australian families, and will place dangerous pressure on the already stressed public hospital system.”

The Report Card provides an overview of how private health insurance should work to benefit patients, and explains how proposed new arrangements will result in less choice and value for policy holders.

It shows that there are a lot of policies on offer that provide significantly varying levels of benefits, cover, and gaps.

“There are also a lot of policies on the market that will not provide the cover that consumers expect when they need it,” Dr Gannon said.

“If people have one of these ‘junk policies’, they should consider carefully what cover they really need.

“The Government has undertaken some important reforms to private

health insurance to help people understand the different conditions that each policy category – gold, silver, bronze, and basic – will cover.

“The funds must not be allowed to sabotage these reforms.”

The Report Card shows that some insurers perform well overall, and some only perform well for certain conditions.

It reveals that the same doctor performing the same procedure can be paid significantly different rates by each fund, which is often the untold story behind patient out of pocket costs, despite there being high levels of no-gap and known gap billing statistics.

The latest APRA statistics show an overall no-gap rate of 88.1 per cent and a known gap rate of 7.3 per cent.

Dr Gannon said the medical profession is working hard to ensure patients receive value for money.

“Our Report Card shows that the profits of the insurers continue to rise, the growth of policies with exclusions continues to grow, and policy holder complaints continue to rise,” he said.

“We explain what insurance may cover, what the Medicare Benefits Schedule (MBS) covers, and what an out of pocket fee may be under different scenarios.

“We also highlight the frustrating fact that what an insurer pays can vary from State to State – even within the same fund.

“To help consumers better understand what they are buying, we set out the percentage of hospital charges covered by State and insurer, and the percentage of services with no-gap, State by State.

“There is also a breakdown of the complaints received by provider and organisation, which shows that the number of private insurance complaints are significant, and on the rise.”

The data in the *AMA Private Health Insurance Report Card 2018* is publicly available – drawn primarily from the Australian Prudential Regulation Authority (APRA), the Private Health Insurance Ombudsman, and the insurers’ own websites.

The *AMA Private Health Insurance Report Card 2018* is at:

<https://ama.com.au/article/ama-private-health-insurance-report-card-2018>

The Roy Morgan Private Health Insurance Net Trust Score Report is at:

<http://www.roymorganonlinestore.com/Browse/Australia/Health-Insurance/Health-Insurance-Net-Trust-Score/Roy-Morgan-Private-Health-Insurance-Net-Trust-Scor.aspx>

CHRIS JOHNSON

Parliamentary Committee backs AMA on e-cigarettes

Electronic cigarettes containing nicotine will remain banned from sale in Australia, if a powerful Parliamentary Committee has its way.

The year-long Inquiry by the Standing Committee on Health, Aged Care and Sport has released its report into the use and marketing of electronic cigarettes and personal vaporisers.

The Committee has supported the status quo in relation to the sale of e-cigarettes.

AMA lobbying has helped shape the recommendations resulting from the Inquiry.

In July last year, the AMA told the Inquiry there was no compelling evidence that e-cigarettes are successful in helping people to stop smoking, and they should remain subject to strong regulation in Australia.

In its submission to the Committee, the AMA warned that the tobacco industry was aggressively pursuing the potential of new products, including e-cigarettes, which can either maintain or establish a nicotine addiction in users.

“We must not allow e-cigarettes to become a socially acceptable alternative to smoking,” AMA President Dr Michael Gannon said at the time.

“E-cigarettes essentially mimic or normalise the act of smoking. They can result in some smokers delaying their decision to quit, and they can send signals to children and young people that it is okay to smoke.”

The AMA formed a strong position on e-cigarettes in 2015, stressing it had significant concerns about them.

It said they should be subject to the same marketing and advertising restrictions as cigarettes.

In March this year, the House of Representatives’ Standing Committee agreed, but not unanimously.

The Committee has a track record of delivering consensus reports, but this Inquiry led to two dissenting reports – one from the Committee’s chairman, Liberal Party MP Trent Zimmerman.

However, the majority report recommended further research be conducted into the health impacts of vaping before any regulations of the products could be loosened.

The Committee also recommended that a national approach be taken to the regulation of e-cigarettes. The Government should also examine the content of the products’ colourings and flavourings, the Committee said.

It recommended that the National Health and Medical Research Council (NHMRC) fund an independent and comprehensive review of evidence relating to the health impact of e-cigarettes

and that the review should be updated every two years to take into account the findings of new research.

“The Committee recommends that the Department of Health convenes an international meeting of health experts from similar economic jurisdictions to discuss different policy and legislative approaches to electronic cigarettes,” the Report said.

“The Committee recommends a national approach be taken to the regulation of non-nicotine electronic cigarettes. The Committee recommends that the Therapeutic Goods Administrations (TGA) continues to oversee the classification of nicotine and relevant exemptions, and the assessment of any electronic cigarette product as a therapeutic good.”

Last year, the TGA rejected an application to exempt the chemical used in vaping devices from the poisons list.

It remains a Schedule 7 poison and is highly addictive. While it is legal to buy vaping devices, it is not lawful to buy, sell or use devices containing nicotine.

The Cancer Council of Australia and the Heart Foundation have both commended the Committee for upholding the integrity of the TGA and the NHMRC, and have congratulated it for not buckling to pressure from lobby groups.

The AMA has commended the Committee also and is pleased that the lobbying from doctors was seen as common sense.

“The AMA welcomes the majority Parliamentary Committee Report opposing the legalisation of e-cigarettes and vaping,” Dr Gannon said.

“We lodged a strong submission citing the lack of evidence for e-cigarettes as a smoking cessation aid, and the lack of evidence to disprove that e-cigarettes lead young people to take up smoking.

“We strongly support the assessment and research work of the TGA and the NHMRC.”

CHRIS JOHNSON

The Parliamentary Report can be found at:

https://www.aph.gov.au/Parliamentary_Business/Committees/House/Health_Aged_Care_and_Sport/ElectronicCigarettes/Report

The AMA’s submission to the Inquiry can be found at:

<https://ama.com.au/submission/ama-submission-standing-committee-health-aged-care-and-sport-inquiry-use-and-marketing>

The AMA’s Position on Tobacco and E-cigarettes can be found at:

<https://ama.com.au/position-statement/tobacco-smoking-and-e-cigarettes-2015>

Senate hands down its report into pelvic mesh implants

AMA President Dr Michael Gannon has said there are important lessons to be learned from the transvaginal mesh implants issue that has caused a number of Australian women to suffer debilitating side effects.

A Senate Inquiry into the implants has recommended the devices “should only be used as a last resort” after finding that some women were not properly informed about their potential hazards.

Hundreds of Australian women complained of serious and painful side effects after receiving the implants, with some adding that they had not been listened to by their doctors.

The Committee said thousands of women were affected.

The Inquiry found the damage to some women was extensive, with the Committee’s chairwoman Rachel Siewert saying many of them suffered for a long time.

“I hope we never have another inquiry where we see such suffering from witnesses,” Senator Siewert said.

The Committee’s report was released in March and recommended setting up a national register to track all implants; better education for doctors and patients; surgical training for removing the devices; specialist counselling for affected women; and mandatory reporting of adverse events by medical

practitioners.

The controversial vaginal mesh implants for use in pelvic organ prolapse were banned in November last year, following growing public concern.

A class action against one of the mesh manufacturers, Johnson & Johnson, involves more than 700 women.

Dr Gannon said the episode has shown that there are lessons to be learned, especially when things go wrong.

He said there was no denying that some women had been injured, and that their concerns should be taken seriously.

But he added that not all women have problems with the devices.

“This perhaps fails to recognise that the massive number of women that have benefited from mid-urethral sling operations using only a very small amount of tape,” Dr Gannon said.

“We’re facing an environment where it’s going to be harder for women with similar symptoms in the future to avail themselves of a very, very good, very safe operation.”

CHRIS JOHNSON

Australian medics help out after PNG earthquake

A 15-member medical team was sent to Papua New Guinea in March to help with aftermath of the 7.5 magnitude earthquake that hit the Highlands on February 26.

An Australian Medical Assistance Team (AUSMAT) arrived in PNG on March 26 and was deployed to Mendi Hospital in the Southern Highlands Province.

Foreign Minister Julie Bishop said the Australians helped PNG health workers to provide emergency health services, including maternal and child health care, to those in need.

“The specialists will also work with local health officials and humanitarian organisations to address public health issues and reduce the potential for disease outbreaks,” Ms Bishop said.

AUSMAT is one of the few national Emergency Medical Teams globally-verified by the World Health Organisation. The team

going to PNG was drawn from State and Territory-based health services including the Northern Territory, New South Wales, Victoria and Tasmania. AUSMAT is coordinated by the National Critical Care and Trauma Response Centre (NCCTRC) in Darwin.

The support is in addition to Australia’s \$5 million in humanitarian aid.

The United Nations estimates that 270,000 people in the Highlands required immediate humanitarian assistance, including more than 18,000 who are living in evacuation centres.

PNG authorities said 25 out of 77 health facilities in the two worst-affected provinces, Hela and Southern Highlands, had been destroyed or forced to close.

CHRIS JOHNSON



Snippets

Get your flu shots ... but not too early

The AMA has urged people to wait until at least mid-April before getting flu shots, following a push by some pharmacy chains to get the vaccinations too early.

Some big name pharmacies began advertising in March for people to get their shots to avoid a repeat of last year's deadly influenza outbreak.

But AMA Vice President Dr Tony Bartone said getting vaccinated for the flu too early could be counterproductive.

He said the vaccine's effectiveness begins to wear off after three or four months. With the flu's peak season being from July to September, a March shot was too early.

"If we're going to maximise our protection before that effectiveness starts to wane, we want to match the timing of the vaccination with the timing of the peak," Dr Bartone said.

"And for that reason, mid-April onwards is a perfect time to start having your vaccination."

Feed time at Federal Council



Dr Jill Tomlinson and daughter Anna

History was made when the AMA Federal Council met at Canberra in March.

For the first time ever (we think), a baby was breastfed during Council proceedings.

While it made no ripple at all, we here at *Australian Medicine* thought it was so cool that we wanted to let you all know about it.

Dr Jill Tomlinson introduced daughter Anna to the Council on March 16. "She is four weeks old today," proud Mum told *AusMed*.

We are not a hundred per cent sure that Anna didn't vote during the Bupa motions.

Culturally safe waiting rooms

The promotion of designated waiting rooms for Aboriginal people in NSW hospitals has been met with a mixed reaction.

The State's health department undertook research into why Indigenous patients are more likely than non-Indigenous patients to leave waiting rooms without receiving treatment.

The research found that some Aboriginal patients did not feel safe in waiting rooms, sparking calls for "designated Aboriginal waiting rooms" or "culturally appropriate space" for Indigenous patients.

Hanging Aboriginal artwork on waiting room walls could also help, the study concluded.

The recommendations have been both applauded and criticised.

AMA President Dr Michael Gannon said it was good that the concept of cultural safety is entering the popular narrative.

"The truth is that health outcomes for Indigenous Australians are significantly worse than non-Indigenous Australians according to just about every possible metric," he said.

"The AMA strongly supports Aboriginal control when it comes to primary care and when it comes to Aboriginal and Torres Strait Islanders being in larger health facilities like our hospitals, I think we need to do everything we can to make them the appropriate settings for them to seek care."

Doctors have role to play in drug-free sport

To coincide with the XXI Commonwealth Games, played on the Gold Coast this month, the AMA released its revised *Position Statement on Drugs in Sport*, and called on both doctors and athletes to ensure the event was free from any banned performance-enhancing drugs.

AMA President Dr Michael Gannon said the Games provided an opportunity to uphold Australia's reputation for drug-free competition at all levels.

"While some athletes deliberately use prohibited substances to improve their performance, others may inadvertently ingest a banned substance in a prescription or over-the-counter medication," he said.

"Doctors have an important role to play in reducing the use of performance-enhancing drugs in sport, and in helping athletes to avoid unwittingly taking banned substances in otherwise legal medications."

The AMA *Position Statement on Drugs in Sport - 2018* can be read in full at:

<https://ama.com.au/position-statement/drugs-sport-2018>

CHRIS JOHNSON

You've Got Mail

An AMA Director shares here some of the more amusing correspondence he and his staff receive ... with spelling and grammar mistakes left intact.

Politicians are accustomed to receiving hate mail. As a long-time staffer at Parliament House, rarely a day passed by without a phone call, email, or letter from an angry constituent.

Likewise, whenever the AMA President is in the news, someone sends a missive telling us what they think. Certain issues particularly inflame correspondents, such as vaccinations, marriage equality, firearms and asylum seekers. Others have views about health matters ranging from cannabis use to particular medications they have invented or use that will save humanity.

Almost all correspondents receive a personalised response, and when people make false accusations or claims, the Public Health secretariat provides a detailed response. Letters that are abusive, homophobic or racist do not deserve a response.

A commonality of many of the more disagreeable writers is to use CAPITALS and shout at the AMA; while not using spell check is commonplace.

Here are some more entertaining examples from letters to the AMA:

Winnie thoughtfully worried about the appearance of (a former) AMA President: "You look not very well – at least in comparison with your last interview by another abc reporter. a slight puff /swollen face/forehead...as if your whole head has been submerged in water for a while... that kind of puffiness. of course your hair was not coiffeured suited for an interview ... you need to be v.good to the abc backstage makeup artists, they could be very unforgiving at times...i suppose you should be able to look after yourself as a very seasoned and senior physician, so please do that."

Duncan had a problem with the AMA and doctors in general: "I submit that all your health advocacy is phony. The AMA is not independent, as you claim, because it is funded by doctors, the people you represent."

Kim's letter related to an ABC special on mental health. "One of the songs about mental illness that came on quite early in the evening. This song was putting [those with mental illness] down by trivialising their suffering and symptoms. I was in the bath! at the time so couldn't turn the TV off, otherwise it wouldn't even have lasted for the duration of the song. If there is any influence that you could have in this matter I'd appreciate your assistance."

One of my favourite letters was from a school principal: "I have a boy in Year 1 whose mother gave him an amber necklace and bracelet to wear. The child's teacher asked the boy not to wear these as they did not comply with our uniform policy. As a result, the boy's mother has obtained a medical certificate from

a local doctor which states the beads are part of his medication program. Is anyone in your organization able to outline the scientific theory about such beads as I am of the opinion I am dealing with voodoo medicine rather than verifiable fact."

Sometimes letters are disturbing: "While my wife was pregnant, boxing promoter, [xxx] ,had me KO'd Twice, & this was after his mates had already fractured my skull on the street. I'd gone to them for help, because [xxx], who later -skullfractured 70YrOld [xxx] on the Manly Ferry, was responsible, BUT, he has a Federal Senator for an Auntie? And so the cops commit-ed the worst Corruption to cover for all these criminals..."

Ofentimes we reply with AMA Position Statements or other publications, although this doesn't satisfy everyone: "Dear Mr.Simon Tatz, many thanks for your quick response to my query. could you please provide to me data that proves 'herd immunity' exists.' You have attached a document of 21 pages ... You may have been in a hurry, as you did not answer my query."

Similarly, George took exception: "Dear Simon, thank you for your response. However, what you have provided is a crock of rubbish. Really? Are you serious? This is how the AMA operates. You throw science out the door."

Other writers provide too much personal information: "I offer the assistance of a 50 year cannabis user who has PhD's and has never had a day of mental illness in my life. You keep making these broad statements about cannabis but you have ZERO RESEARCH to back up your comments which are untrue and very naïve about cannabis."

David was one of those writers who was more metaphorical than specific: "You describe a beautiful construction that you in the AMA have built. I am sure you are very proud of it. My main point is to try to draw your attention to the possibility that some of the foundations of your construction are unreliable. It contributed to the leverage we needed to engineer a change in our constitution towards democratic processes. When people enter an adversarial political situation with a platform that is built on unreliable foundations, it is not uncommon for a diet of humble pie to follow. I am trying to warn you about this. I doubt that my advice is welcome, or will be heeded."

Ben wrote to us many times about the "Spiritual Effects of Electromagnetic Radiation", yet for some reason he wasn't convinced by the AMA reply.

My favourite letters are from AMA members who appreciate the work of Federal Council: "I have been a member of the AMA for over forty years. Never before have I felt so proud to be a member. May I congratulate you and your colleagues on your courage to make this strong statement."

.....
SIMON TATZ, DIRECTOR, PUBLIC HEALTH



Communiqué from March Federal Council meeting

BY DR BEVERLEY ROWBOTHAM, CHAIR FEDERAL COUNCIL

Federal Council met in Canberra on March 16 and 17. Debate was robust as always and productive, with numerous Position Statements approved for adoption. These will be released to members and the public over coming weeks.

The President reported, as is our usual practice, in a town hall format, with questions of the President from Councillors and some debate. The President reported that the AMA had maintained a very high media profile over the summer period, with many press releases on summer lifestyle issues. These included avoiding heat stress, drinking in moderation, and driving safely. There were also significant Position Statements released, including the *AMA Position Statement on Mental Health*, which attracted a lot of positive interest from the mental health community.

In the week prior to the Federal Council meeting, the President had released the *Public Hospital Report Card*, highlighting the need for continued investment by Federal and State Governments in our public hospitals.

The major focus of discussion at this meeting was the recent actions of Bupa in announcing changes to its cover, which will impact doctors and patients alike. Federal Council urged the President to maintain his advocacy on the issue.

The Secretary General's report again highlighted the scope of activity underway within the Federal AMA secretariat and the success of AMA advocacy on behalf of members; workforce initiatives; the granting by the ACCC of a further authorisation to permit certain billing arrangements to benefit general practices; discussions with the Department of Health on its review of medical indemnity insurance schemes; the raft of reviews relevant to reforms to private health insurance; the ongoing MBS reviews, and much more.

Federal Council considered a proposal for the introduction of post nominal letters to denote membership of the AMA, a move that has been long in the gestation. Further work is required before the Board considers amendments to the By Laws to make provision for the introduction.

Another key discussion was the change to the format of National Conference this year with the introduction of a day of policy debate. This change is being made in response to feedback from delegates that the opportunity for debate on issues by delegates needed

to be enhanced. Federal Council considered a number of draft policy resolutions put forward by the membership, which will be further refined before distribution to delegates attending National Conference. Participation in the debate on the resolutions will be open to all AMA members attending the Conference, whether as an appointed delegate or fee-paying member.

Public health working groups brought forward a Position Statement on *Men's Health*, and on *Drugs in Sport*. Council debated the issue of funding of access to bariatric surgery in the public health system. It also agreed to establish two new working groups to look at the issues of child abuse and neglect, and health literacy.

The Ethics and Medico Legal Committee tabled a revision to the *Guidelines for Doctors on Managing Conflicts of Interest in Medicine*, which was approved by Council. It is part of a wider piece of work before the Committee, looking at relationships between medical practitioners and industry.

Federal Council approved a new Position Statement on *Diagnostic Imaging*; and another on *Resourcing Aged Care*. The latter is one of the many advocacy documents in development or under review as part of the AMA's expanded work on aged care issues. Council noted the report on the recent AMA survey of doctors' views about providing care in aged care settings, noting the anticipated decline in the number of practitioners providing care.

A recent meeting of the Health Financing and Economics Committee had considered the issue of value based care as a model with the potential to concurrently increase hospital efficiency and improve patient outcomes. Quality data is needed to inform this work within public hospitals.

The Task Force on Indigenous Health, which advises the President on issues relevant to Indigenous health, continues its close involvement with Close the Gap initiatives. Its 2017 report card on ear health continues to be well received.

The various Councils of Federal Council provided their reports. The Council of Private Specialist Practice is monitoring the various reviews of private health insurance, including out of pocket costs and options to manage low value care in mental health and rehabilitation.

The Council of Doctors in Training (DiTs) discussed proposed

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Will you still love me when I'm 84 (or 94)?

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

One Saturday morning 10 years ago, I took a phone call from the nursing home where an elderly, moderately demented relative resided. The facility was humane, professional, warm and near our home. "We're calling to let you know that we are about to send her to hospital." This was unexpected. What was the problem? "She keeps holding her head to one side." Had they considered calling her GP? "He's not available on the weekend." So I visited.

She was, indeed, holding her head at a strange angle, but happily wolfing down her lunch. "Can you straighten your neck?" I asked, demonstrating. She smiled and complied.

What it was all about I have no idea. But I felt pleased to have avoided her admission – ambulance, ED, unfamiliar ward, disorientation, perhaps a fall (with or without fracture), a week or 10 days in an alien place, perhaps an infection?

(Lest you imagine that I am dissing the GP, I'm not. He and his partner provided exemplary palliative care in her final days eight years later and high-quality service for the years in between. It's the system that sucks.)

Recently, the AMA has made an extensive submission to the Aged Care Taskforce concerning residential aged care facilities.

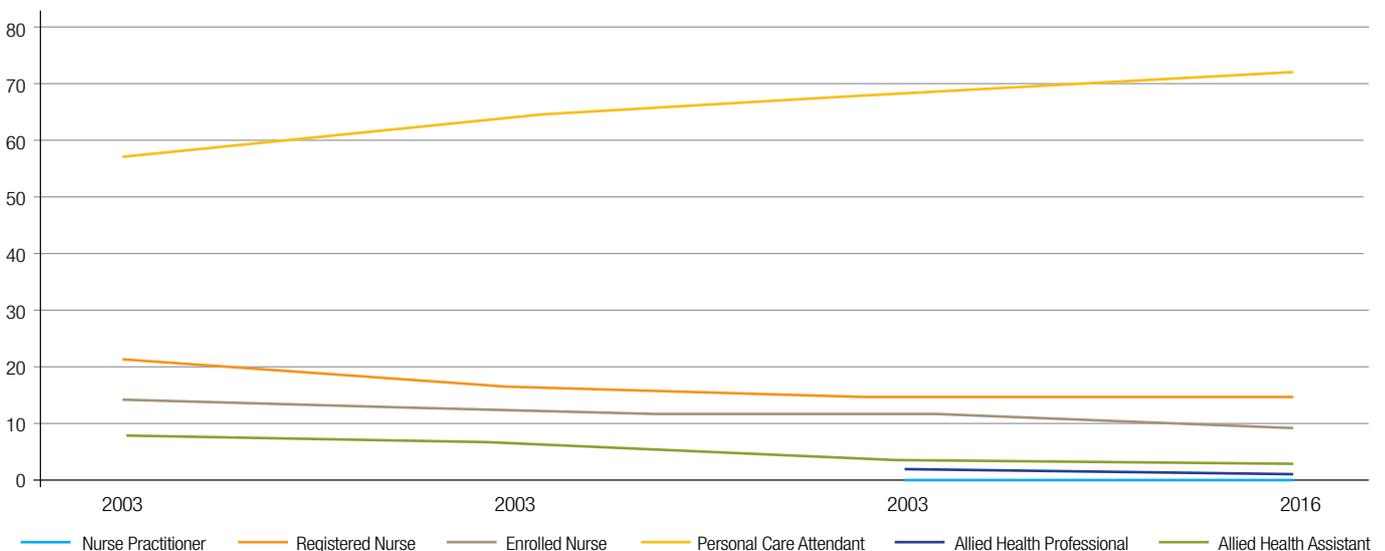
<https://ama.com.au/system/tdf/documents/AMA%20submission%20to%20the%20Aged%20Care%20Workforce%20Strategy%20Taskforce.pdf?file=1&type=node&id=48123>

This document derives largely from the practical experience of doctors doing their best – within the logistic constraints of workload and organisation – to provide care for older people. The AMA's executive summary states:

An Aged Care Commission should be introduced to streamline the aged care system, and should include a role that ensures there is an adequate supply of appropriate, well-trained staff to meet the demand of holistic care to a multicultural, ageing population, and also to ensure the aged care workforce has clear roles and responsibilities.

A Commission, if ever it happens, is an aspiration. Right now, staffing of residential aged care facilities is a disgrace. From the submission: "Our members have reported cases where nurses are being replaced by junior personal care attendants, and some residential aged care facilities do not have any nurses staffed after hours."

The AMA illustrates the worsening problem in the graph below.



The proportion of Full Time Equivalent employee types in the residential aged care workforce. Data source: Mavromaras et al (2016) The aged care workforce, 2016. Department of Health



Will you still love me when I'm 84 (or 94)?

Between 2003 and 2016, personal care attendants have risen from 55 per cent to 72 per cent of this full-time workforce. Registered nurses have decreased from 22 per cent to 15 per cent. Other skilled workers have declined proportionately. Nurse practitioners, a great asset in this context (based on overseas experience in systems such as Geisinger Health <https://www.geisinger.org/about-geisinger>) make up a tiny fraction of the workforce, as do allied health professionals.

We are progressively accepting the need for integrated care between hospitals and the community for multi-morbid, frail patients. The crucial role, in this effort, of GPs and nurse coordinators is coming to be understood, and to some extent, resourced. This redeployment of staff and effort is no small deal – much change to be managed. In the light of this move, now is the time to take account afresh of what is needed to re-fit aged care facilities to participate more fully in providing integrated care.

The AMA document also explores the context within which

residential aged care is provided. It points out that, in 2013, 32 per cent of the Australian population (5.8 million people) were born overseas. “This presents a major challenge in the form of incorporating different cultures into aged care, and communication with individuals [including families] who may have low levels of English literacy.” But this observation weakens when you consider the 2016 census figures that show that the percentage of the population not speaking English at home is only around 21 per cent.

<http://www.abs.gov.au/ausstats/abs@.nsf/Lookup/by%20Subject/2071.0~2016~Main%20Features~Cultural%20Diversity%20Article~60>

Care for older Aboriginal and Torres Strait Islander people is another cultural challenge we have done little to accept.

The submission concludes by re-stating the centrality of workforce – adequate education, adequate funding, and adequate numbers. This is the problem demanding immediate attention.

Communiqué from March Federal Council meeting

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reforms to bonded medical workforce schemes. The AMA has been active in influencing changes to the schemes which the Council of DiTs has strongly endorsed. The Chair of the Council of DiTs reported on the very successful AMA Medical Workforce and Training Summit held on 3 March 2018. The Summit brought together more than 70 important stakeholders in medical workforce and training to discuss the concerns of the AMA and many others in the profession with the distribution of the medical workforce, the long-standing imbalance between generalist training and sub-specialisation, the workforce position of different specialties and the growing evidence of a specialty ‘training bottleneck’ and lack of subsequent consultant positions.

The Council of General Practice tabled two Position Statements for approval. The first dealt with *General Practice Accreditation* and the second provides a *Framework for Evaluating Appropriate Outcome Measures*.

Federal Council supported a motion put forward by the Council of General Practice to endorse funding of universal catch-up vaccines through the National Immunisation Program for anyone living in Australia wishing to become up to date with clinically appropriate NIP vaccinations, irrespective of age, race, country of origin and State or Territory of residence.

The Council of Rural Doctors reported on its recent meeting with the new Rural Health Commissioner, Professor Paul Worley and discussions on the national rural generalist pathway.

The final item of business, but by no means the least important, was the adoption by Federal Council of a position statement on the *National Disability Insurance Scheme*, which followed a detailed discussion on the Scheme at the November meeting of Council.

Federal Council now prepares for the National Conference and its last meeting with its current membership in May. Elections are underway for several positions on the Council, evidence of increased member interest in its work.



Bringing pharmacists into the fold

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

It has been almost three years since the AMA put forward its proposal to make non-dispensing pharmacists a key part of the future general practice healthcare team. Our advocacy on this issue has not wavered and since we launched our policy more evidence has accumulated to support the valuable role pharmacists can play when they are integrated into the general practice team.

“With chronic disease on the rise, and an ageing population, it is estimated that there are more than 700,000 patients with co-morbidities who would benefit from a review of their medications.”

General practice pharmacists would enhance medication management and reduce hospitalisations from adverse drug events (ADEs). An independent analysis from Deloitte Access Economics (DAE), which was released with the AMA's proposal, showed that integrating pharmacists into general practice would deliver a benefit-cost ratio of 1.56. If general practices were supported to employ non-dispensing pharmacists as part of their healthcare team, they would be able deliver real cost savings to the health system, of \$1.56 for every dollar invested.

An in-house pharmacist would be able to assist GPs address overprescribing and medication non-adherence by patients. We would see better coordination of patient care, improved prescribing, improved medication use, and fewer medication-related problems. Hospitalisation rates from ADEs would fall and our patients' quality of life would be improved as would their health outcomes.

A recently released research article in the

International Journal of Clinical Pharmacy, titled *Pharmacists in general practice: a focus on drug-related problems*, shows that where pharmacists are working within a general practice that their recommendations are more readily accepted by practice GPs.

This bears out research published in 2013 titled *An evaluation of medication review reports across different settings*, which had similar findings. Access to the patient's medical file and the relevant clinical information within when conducting a medication review enabled recommendations that were more targeted and less conjectural. The recommendations from these better-informed reviews resulted in greater acceptance of the pharmacist's recommendations by the GP.

With chronic disease on the rise, and an ageing population, it is estimated that there are more than 700,000 patients with co-morbidities who would benefit from a review of their medications. This figure represents just the top 10 per cent of patients who could benefit from having their medications reviewed. In-house pharmacists could be a valuable resource for patients in understanding their medications and how to use them.

With over 230,000 medication related admissions to hospitals every year at a cost of \$1.2 billion per annum and patient medication non-compliances estimated at 33 per cent, the time has well and truly come for action on this front.

With another trial; utilising non-dispensing pharmacists in 14 medical centres across the greater Brisbane area; winding up, the AMA Council of General Practice is looking forward to hearing the interim results.

With increasing evidence that where pharmacists are integrated within general practice patient care is improved, the AMA continues to advocate for Government funding to make this an everyday reality for general practice and for patients.



May I introduce you to Esther?

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

Starting on this page and spilling onto others, you will read a confronting story of Esther. Elements of this story ring true. We rural doctors will recognise Esther immediately. The Canadian version of Esther's story has been Australianised by author Dr Janelle Trees, an Aboriginal GP. She tells me the story is all too true, she agrees it is appropriate to share it with you. I beg you to soldier on past the first few paragraphs no matter how offensive it reads.

Esther first came into being in Sweden in the late 1990s. It is a story based on an elderly woman caught between bureaucracies, receiving fractured and non-patient focussed care. In the process of her acute admission to hospital, she repeated her story 36 times, received care that was focussed on systems, care that was "Not best for Esther". The Swedish Healthcare took this sad story and made system-wide changes. The changes always focussed on the question: "What is best for Esther?"

They now have a non-hierarchical voluntary network of over 7000 members from health and social services. The outcomes are staggering. For example, in 2004, hospital admissions fell from 9300 to 7300, the number of unnecessary days in hospital decreased from 1113 to 62 in 2011. The Esther Project received a national Swedish award for quality improvement.

Then last year, the NorthWest Territories (NWT), Canada took the story and put a First Nations spin on it. This is the story I was

shown by an executive from Stanton Hospital, Yellowknife. I have been given permission to share it with you. There is no known author. The story is so engrained in NWT Health that everyone knows Esther.

I don't know that there is a firm plan established to incorporate Esther in the culture of Stanton, but because her story is 'preached' from the highest levels, and the trickle-down method is in place.

In contrast, Kent in the UK, and Singapore are now planning to follow the Swedish model, focussing on patient-centred, coordinated care for the elderly.

The First Nations focus resonates with me. I love how Dr Trees has Australianised it. Sadly the Indigenous health issues, poverty, social situations, and the 'stuck' mindsets are the same despite 15,000 km and 75-80 degree difference in temperature.

So now, rural doctors, I challenge you. Take Esther to your next staff meeting; invite Esther into the lunch room; write about Esther. Find at least two or three Esthers. Did you know Esther is both a boy's name and girl's name?

Start small, always ask Esther for opinions, follow a patient's story from beginning to end, talk about improvements.

And always ask: "What is best for Esther?"

Esther (in Australia)

Esther is exhausted. She can hear her two little grandsons in the kitchen scrounging for something to eat. She knows she should get up, but knows the throbbing headache she has now will be pounding once her feet hit the floor. "They'll manage," she says to herself. Manage or perish is kind of how it is around here.

She promised herself this month's cheque wouldn't be used to buy grog. She would have kept that commitment if her youngest son hadn't showed up yesterday. Another bad week for Junior. He struggles with depression that gets so bad she worries he will someday just put an end to his life. She has seen so many young men in Port Good Hope commit suicide she shudders to think what her son may do if things don't turn around for him.

Esther knows alcohol isn't the solution to her son's depression and she knows her sugars will be bad today after everything they drank last night. At least there is no reason to prick my finger, she thinks. I know what the number will be.

She remembers she's supposed to go to the clinic today. Marie called to tell Esther about the appointment they have for her. Something about a new diabetic program. Esther's heard that before. The doctors and nurses at the clinic are more concerned about my blood sugars than I am. They don't have the rest of the stuff to worry about that I do. Finding money somehow to pay this month's rent and buy a new electricity card to keep the power on and that damn collections agent threatening to take the ute back if I don't come up with my payments before the end of the month. Let him come and try and find that truck. Good luck.

She hears the toddlers pulling a chair up to the kitchen cupboard looking for cereal to eat. She really should get up; those boys are too little to be climbing. "Why are they here with me?" she wonders. The memory is unclear but she thinks her daughter dropped them off late last night. Her son-in-law bought some alcohol from Albert the grog runner and Elizabeth was

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Doctor trainees exam failure a symptom of a larger disease

BY DR CHRIS WILSON, CO-CHAIR AMA COUNCIL OF DOCTORS IN TRAINING

Along with approximately 1200 physician trainees around Australia and New Zealand, I recently sat one-and-a-half exams in the space of two weeks. The spectacular failure of the computer-based exam and the effect on trainees, hospitals and, by extension, patients has been well documented. The circumstances surrounding what happened that day are currently the subject of an independent inquiry by the Royal Australasian College of Physicians (RACP), however it's not what happened on the day that interests (and concerns) me, but the lead up to it.

“The exam failure should be viewed as a symptom of a larger disease; a warning for an organisation that has lost its way.”

The exam failure should be viewed as a symptom of a larger disease; a warning for an organisation that has lost its way. It was the culmination of a troubled relationship between a College and its trainees.

Our Colleges exist to provide a platform for life-long medical learning. They exist to maintain a standard of knowledge and practice within the profession that our patients can trust is exceptionally high. Fundamentally though, they are training providers and should, by extension, have trainees at their core. The RACP exam didn't fail when the computers wouldn't log in, or when the timers didn't stop during the lunch break, or even when access was still available to the part A exam during part B.

The exam was already cooked when the RACP failed to hear and acknowledge the concerns its trainees had in the new process.

RACP trainees have felt ostracised by their College for some time. Our trainee committees, filled with dedicated doctors in training giving of their own time, are haphazardly supported at best. With little to show for the hard work of committees over the years, the larger group has become disengaged, with most preferring to just put their heads down and get through training.

The RACP, while very publicly exposed by the exam failure, isn't alone in its issues. The AMA Council of Doctors in Training (CDT)

holds a 'trainee soapbox' every year to hear current issues from trainees representing each of the different specialty groups. Consistently, we hear the concerns of trainees going unheeded by their College. We hear of strained communication lines between trainees and those meant to oversee their training. Most worryingly, we hear of trainee representatives being censored by their College. Obviously, not every problem faced by trainees is of a College's making, or indeed within their power to address, however, it should always be a place where trainees can raise their concerns without fear of jeopardising their training or career.

When trainee concerns are heard, we often see little more than lip service in response. Trainee wellbeing becomes a tick box exercise in engaging an external counselling provider, not by addressing the underlying issues. Flexible training to maintain work/life balance becomes a policy statement, rather than a review of rigid assessment processes. Emails saying 'we hear you' are great, but what are you actually doing about it?

It's not all doom and gloom though. The experience of the Royal Australasian College of Surgeons (RACS) shows us that if you genuinely listen and engage with trainees, positive outcomes can arise from difficult situations. The RACS Operating with Respect program was born from highly publicised bullying and harassment faced by surgical trainees. It has become a requirement not just for trainees, but for all RACS members. Other Colleges have now partnered with RACS to use Operating with Respect to spread the word that bullying and harassment have no role in modern medicine. A healthy and robust interaction between a College and its trainees has created tangible change within our hospitals.

In recent times we've watched Colleges look to expand their spheres of influence, however, they would all do well to remember where their core business lies. After events earlier this year, the RACP especially must rebuild bridges with its trainees. We must demand more than box-ticking exercises - we need to see tangible changes in the way they connect with trainees and how trainee concerns are addressed. We've already seen positive steps in this direction in the RACP's willingness to listen and take on board the advice from the AMA CDT immediately after the failed exam. We intend to continue working with the RACP to help the organisation meaningfully engage with its trainees again.



Young Aussies and Bupa? Why bother?

BY ALEX FARRELL, PRESIDENT, AUSTRALIAN MEDICAL STUDENTS' ASSOCIATION, AND JOEL SELBY, AMSA PUBLIC RELATIONS OFFICER

“For medical students, this is a double-edged sword. Not only do the Bupa changes affect them personally, now they will also reduce their ability to function as service providers in a healthcare system that provides universal access, regardless of means. ”

It will not be surprising to readers that the changes recently announced by Bupa have caused anxiety among patients and outrage among the medical community in equal measure. However, one aspect rarely mentioned is the fact that young Australians are particularly short-changed by private health insurance.

Medical students experienced the Bupa changes from two perspectives – as young Australians long disillusioned by what the private health sector can offer them; and as future doctors despairing for what this means for the workforce we will inherit.

According to the APRA statistics for September-December 2017, the largest net drop in coverage was for people aged 25-29. A total of 11,170 people in this age bracket gave their funds the flick. A further 10,505 people aged 30-34 did the same.

In 2017, Choice, an independent consumer advocacy group, made waves by claiming that singles under 30 earning under \$90,000 annually are better off without insurance at all.

Of course young people aren't buying into private health insurance. Frustration with 'junk policies' is at an all-time high, with students tired of paying for schemes that don't translate into coverage for the essential health costs that they will actually face over their lives.

Young people were already leaving their funds in droves when it was announced that from April premiums would rise by 3.95 per cent, far above the inflation rate and average annual growth of wages. Faced with paying more for the same policy, it would have

been fair to wonder, why would any young Australian bother with private health cover at all?

For many, the last straw has come as Bupa, the largest private health insurer in Australia, announced its intention to downgrade policies, introduce exclusions, no longer provide a no-gap benefit in public emergency admissions, and only pay its higher-gap scheme benefit in Bupa-contracted hospitals.

For medical students, this is a double-edged sword. Not only do the Bupa changes affect them personally, now they will also reduce their ability to function as service providers in a healthcare system that provides universal access, regardless of means.

Bupa's claims that it is not trying to dominate the insurance marketplace ring hollow. Like Henry Ford's claim that a customer could have any colour they like as long as it's black, it is ironic that Bupa claims its customers can have as much choice with no-gap coverage as ever, as long as they visit a Bupa-contracted facility. If Bupa succeeds in this venture, other insurers will follow, and the consumer choice that we rightfully value will be up for sale.

Private health insurance is a crucial part of the medical system, and provides much-needed relief on the public sector, but customers, particularly sick patients, deserve a fair go. There is a reason that comparisons to an Americanised healthcare system are rejected so strongly by Bupa's lobbyists – the Australian public knows instinctively that commercialised, managed care will benefit no-one but the insurers themselves.



We must advance with advance care planning

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

As empirically driven pathways, processes, evidence, risk management and two- and five-year survival rates increasingly frame our work as doctors, intangibles of care (such as self-determination, aligning with patient wishes, empathy and compassion) seem to stand in devalued juxtaposition because of their inability to be quantified and therefore justified.

Whereas we can comfortably freewheel in daily routines based on scientific rigour and repetition of process, entering difficult discussions with patients and their families, and navigating through the woolly world of patient emotions can seem uncomfortable and time consuming.

In situations where patients may be near the end of their lives, if we are honest with ourselves, it may mean that it is easier to stay on the safe path of offering one more round of treatment than entering the difficult discussions that are needed with scared and confused patients and their families. The bravery and patience that is required by a doctor to initiate and walk patients through end-of-life discussions will never be recorded in outcome measures and will remain without a value in history.

That is until we become patients ourselves – or someone close to us does.

It may only be then that we realise the value of empathy, patience and emotional intelligence in a doctor. We remember that a patient is not merely a diagnosis, and that blind adherence to guidelines, processes and outcomes are poor substitutes for wisdom and kindness.

National Advance Care Planning Week (16 to 20 April), is a time to reaffirm that our job as doctors is to offer appropriate options and to align care with the values, aspirations and goals of our patients.

Advance care planning is a critical but clearly underused tool in seeking to fulfil this aim.

From the *AMA Position Statement on End of Life Care and Advance Care Planning 2014*:

Advance Care Planning – A process of planning for future health and personal care whereby the person's values, beliefs and preferences are made known so they can guide decision-making at a future time when that person cannot make or communicate his or her decisions.

11.1 It is important that advance care planning become part of routine clinical practice so that patients' wishes and preferences for health care, particularly end of life care, are known and met.

Forms with varying names, such as Advance Care Directives and Advance Care Plans, comprise documents on which patient wishes and preferences, sometimes including the appointment of substitute decision-makers, can be recorded.

Encouraging advance care planning from early on can have great benefits in bringing all parties – the patient, family, carers and health team – onto the same page regarding future care of the patient. Later on, this can reduce the lingering distress and guilt that family members may suffer in having to make difficult decisions. In addition, it can reduce the conflicts that can occur between the health team and family members when a patient loses decision-making capacity and where, because we as doctors cannot read minds, risk imposing our own values on legally and ethically complex situations.

The bottom line is that we, as doctors, need to genuinely promote advance care planning. We should urge patients to understand that they cannot blame doctors for providing care that they do not want if they do not tell us. And we should tell patients about the wonderful gift they can give to their families in lifting the burden of grave decisions, and in reducing the guilt that their loved ones may live with into the future.

But most of all, we need to do this because this is a fundamental rights issue for our patients. Advance care planning gives a patient self-determination beyond the point at which they can no longer speak.

Doing this can help in allowing us to work as we should - with our patient (and their wishes) as our first concern. It may also help in balancing the rigour of process with much needed humanity in our daily work.

**Dr Chris Moy is an Ambassador for National Advance Care Planning Week which is being run by Advance Care Planning Australia. <https://www.advancecareplanning.org.au/acpweek>*

Be sure to refer to the advance care planning forms and documentation relevant to your State or Territory on the Advance Care Planning Australia website: Advancecareplanning.org.au



AMA advocacy in diagnostic imaging funding and practice

BY DR ANDREW MULCAHY, CHAIR, AMA'S MEDICAL PRACTICE COMMITTEE

Diagnostic imaging may not always enjoy a high profile in the media but the AMA actively and continuously advocates on behalf of its members who provide diagnostic imaging services.

Some of the AMA's activities are reported publicly, such as the AMA's response to the Federal Parliament Senate inquiry into access to diagnostic imaging equipment. The AMA lodged a comprehensive submission covering the Government's funding and regulation of diagnostic imaging equipment and the impact on equitable patient access. The submission was guided by the Medical Practice Committee with particular input from MPC member, Professor Makhan (Mark) Khangure, who is also the radiologist specialist representative on the AMA's Federal Council.

“Other activities are more ‘behind the scenes’ but equally important in ensuring the AMA uses every opportunity to influence Government funding and regulatory decisions.”

The AMA was subsequently invited to provide evidence directly to the Senate Committee, which led to Professor Khangure speaking to Senators at a hearing held in Perth and sharing his knowledge and expertise from working in both the public and private sectors.

Diagnostic imaging also featured publicly and prominently in the AMA's 2018-19 Budget Submission to the Federal Government. The AMA called for realistic funding and support for diagnostic imaging services under Medicare as one of its key priorities.

Other activities are more ‘behind the scenes’ but equally important in ensuring the AMA uses every opportunity to influence Government funding and regulatory decisions.

The AMA continues to monitor the Federal Department of Health's implementation of the Medicare Benefits Schedule (MBS) Review, a mammoth project begun in 2015 to assess

more than 5,700 MBS items to ensure they are aligned with contemporary clinical evidence and practice. Work to assess diagnostic imaging related MBS items is a large component of this task. The AMA's focus is to ensure the review is conducted transparently and appropriately.

The AMA is a member of the Diagnostic Imaging Advisory Committee, which provides advice to the Federal Department of Health on Medicare funding and regulatory policies relating to diagnostic imaging. This is a long-running standing committee, separate to the MBS Review, which meets twice a year, providing the AMA with the opportunity to advocate specifically on behalf of radiologist and other specialist members providing diagnostic imaging services funded under Medicare. MPC member, Dr Gino Pecoraro, is the AMA's current representative.

The AMA is also a member of the Diagnostic Imaging Steering Committee, which provides advice to the Australian Digital Health Agency to ensure that the development and implementation of shared electronic records protocols related to diagnostic imaging services are appropriate and effective. Professor Khangure represents the AMA on this committee which meets four times a year.

Early this year, the AMA attended a stakeholder consultation meeting to discuss the Department of Health's new ‘risk-based’ model of Medicare audit and compliance activities and its impact on medical practitioners providing diagnostic imaging services. The Department proposed a range of methods for identifying and remedying potentially non-compliant claiming of Medicare benefits. The AMA supports fair and transparent compliance processes and recommended educational approaches as a first step, with the goal of minimising unnecessary and invasive audits of individual practices or doctors.

Finally, as flagged in an article in this column last year, MPC has developed a new Position Statement on diagnostic imaging to formally bring together and promote the AMA's full suite of diagnostic imaging policies. The Position Statement was endorsed by Federal Council last month and will be launched soon.

The AMA welcomes members' views on advocacy priorities and strategies. If you have any comments or suggestions to make, please email them to president@ama.com.au



Graduate supply and public hospital funding – when will the Government get this the right way around?

BY DR ROD McRAE, CHAIR, AMA COUNCIL OF PUBLIC HOSPITAL DOCTORS

As I write, Victorian salaried doctors are voting on its recommended Enterprise Bargaining Agreement, and other jurisdictions are in advanced negotiations in the new industrial relations frameworks. Relevant reports will follow.

My attendance at the sobering March 3 AMA Workforce and Training Summit convened in Melbourne, together with inspection of AMA's 2018 *Public Hospital Report Card*, explains my continued exasperation at the consistent failure of Government to introduce realistic, necessary policy responses that deal with the now clearly apparent multiple medical training pipeline obstacles and poor public hospital access. Currently we have too much medical graduate supply and insufficient funding for appropriately training our junior colleagues in a manner that will meaningfully lead to reasonable public access to public hospital services.

The Summit attitude was constructive with about 80 national stakeholders combining to produce many broadly supported actions which AMA can prosecute. The Summit's challenge was to consider what measures are needed further 'downstream' in training provision to ensure sufficient high quality training places in all medical specialties as they are needed for community benefit. While I fear the problems we now face are actually fast becoming too entrenched to solve, the Summit made it apparent that the medical profession is looking to the AMA, and within it your Council of Public Hospitals Doctors (CPHD), to lead the case for major reform. Accordingly, CPHD will be guided by the outcome strategies of the Summit, and will press to further inform and influence our health policy makers.

Two certain consensus points emerged from the Summit: stop opening new medical schools, and start rationalising resources towards regions and specialties where they are most needed. Government has regularly failed to fully listen to AMA's advance warnings that there is real structural constraint to training capacity and that substantial ongoing investment is necessary to maintain training standards. Additionally, we need to urgently find sustainable, equitable paths to tackle the maldistribution of doctors (particularly across rural settings) and the shortages or bottlenecks arising in some craft areas.

I observe that it was AMA advocacy that achieved for most medical school graduates (and including many International Medical Graduates) guaranteed internship after graduation when, incredibly, Government had not actually originally factored this in to its expansion decision. Just another Federal/State divide. And, let's not forget, the massive increase of new graduates doesn't actually have true tsunami characteristics of quick destruction by ingress then receding as fast as it came, enabling an early, planned, rebuild. Instead, there is actually a permanent rising of

the water table, overwhelming teaching infrastructure capacity, which means patients in public hospital beds.

The point is, we are graduating medical students in numbers far in excess of the OECD average without ensuring the adequate provision of the essential training places, both prevocational and specialist. This is at the same time that Commonwealth funding investment is not keeping pace with population growth. Any economist would reel.

In my December 2017 *Australian Medicine* piece, I discussed the 'doing more with less' implications of the Commonwealth financially penalising public hospitals who report acquired conditions, sentinel events and avoidable readmissions, otherwise known as possible healthcare outcomes (as if we are exercising choice to not provide optimum care now!). Added to that is the idea of penalising 'low value care' based on what are imposed and unsophisticated definitions, all with the aim of minimising financing, and a country mile from favourable health outcomes. This Commonwealth approach is in conjunction with them not offering any additional long term hospital funding via its 2020 State Agreement.

So, we have no additional funding despite AMA's 2018 *Public Hospital Report Card* establishing there has been a 3.3 percent year-on-year average increase in separations (that's called increased productivity), that one third of urgent emergency department patients are not seen within the recommended 30 minutes and that most States' urgent elective surgery is not performed within the 90 day clinically indicated timeframe (that's called increased demand). Don't get me started on the sometimes years of a patient waiting to be seen in outpatients before actually being counted on an elective waiting list! And they want to claw back already insufficient funding when a complication happens. That economic management is called madness. If only health care really was like slapping a motor vehicle together on a production line; but it just is not.

The Summit's Report will help us work together to develop initiatives to build a sustainable, well-trained, well-qualified and accessible medical workforce. The AMA's Report Card is true evidence-based advocacy about hospital performance and the need for Government funding support to improve public access. Both suggest the public health climate is ominous with Government offering less funding but at the same time pressing for improved outcomes and offering more graduates but with no clear, coordinated, training pipeline management. Government must listen to us because of the implications for the community's fair access to appropriate public hospital services, and for the career aspirations of our best and brightest.



Health on the Hill

POLITICAL NEWS FROM THE NATION'S CAPITAL

AMA welcomes ice inquiry report



The Joint Parliamentary Committee Inquiry on Law Enforcement has released its Inquiry into Crystal Methamphetamine (ice) Report.

It has recognised drug and alcohol addiction to be a serious illness and should be treated as such.

The AMA has welcomed the findings, which also state that demand for drug and alcohol treatment services often outweighs capacity.

And there is a need to tailor services to suit a variety of needs, including post care services.

The importance of accountability for those bodies who fund alcohol and drug treatment services was also stressed, as was the need to rebalance funding across the National Drug Strategy.

AMA President Dr Michael Gannon said the AMA believes that any substance dependence is a serious health condition, and that those impacted should be treated like other patients with serious illness and be offered the best available treatments and supports to recover.

“We welcome the recommendations that recognise the stigma associated with addiction, and seek to increase compassionate responses, including media reporting,” Dr Gannon said.

“This is essential if we are going to encourage people to seek treatment.”

The release of the report also serves as a timely reminder of the

statement made by the Head of the National Ice Taskforce, Ken Ley: “That we cannot arrest our way out of the problem.”

The AMA supports the recommendations to monitor and ultimately reduce the time take for people to access appropriate treatment. It is also great that the importance of pre- and post-care is recognised.

“The AMA is particularly pleased to see the recommendation that the Department of Health work with Primary Health Networks (PHNs) to improve their tender processes for drug and alcohol treatment,” Dr Gannon said.

“We believe that the PHNs must be accountable for the services, wait times and the quality of the drug and alcohol treatment services provided in their jurisdictions.”

The approach (established under the National Ice Action Plan) is new and the capacity of PHNs to oversee the effective and equitable delivery of drug and alcohol treatment services is yet to be fully established.

The report recognises the importance of culturally and linguistically appropriate drug and alcohol treatment for Aboriginal and Torres Strait Islander people. This work should include efforts to increase the Aboriginal and Torres Strait Islander drug and alcohol workforce, it noted.

The report contains a recommendation to collect data on the use of illicit drugs in correctional facilities which will provide some valuable insights, but it is vitally important that rehabilitation and treatment services are available to those people who are in the corrections system noting drug and alcohol addiction is often a key contributor to incarceration.

“We must also recognise the link between mental health and addiction, and the report misses an important opportunity reiterate this and advocate for increased linkages between the sectors,” Dr Gannon said.

“The Inquiry Report is certainly on the right track in many areas relating to drug and alcohol addiction.

“This is in stark contrast to the Government’s current efforts to pass legislation (Social Services Legislation Amendment Drug Testing Trial Bill 2018) that will drug test welfare recipients.

“This punitive measure will increase the stigma associated with drug addiction, and is not supported by evidence. The reality is that it will increase the demand for drug treatment services that are clearly under significant pressure. Throwing money at the trial sites won’t fix the problem.”





Health on the Hill

POLITICAL NEWS FROM THE NATION'S CAPITAL

The AMA encourages Social Services Minister Dan Tehan to read the Inquiry report to better understand the problems in the sector, and withdraw the random drug testing proposal until such time that we can improve the capacity of the sector to meet demand for drug treatment.

“We must not do anything to increase the delays for those individuals actively seeking treatment,” Dr Gannon said.

“Referring those who test positive under the welfare trial will do this.”

The AMA Submission to the Joint Parliamentary Committee on Law Enforcement Inquiry into crystal methamphetamine can be found at: <https://ama.com.au/submission/ama-submission-joint-parliamentary-committee-law-enforcement-%E2%80%93-inquiry-crystal>

The AMA Submission to the Senate Community Affairs Legislation Committee’s Inquiry into the Social Services Legislation Amendment (Welfare Reform) Bill 2017 can be found at: <https://ama.com.au/submission/ama-submission-senate-community-affairs-legislation-committees-inquiry-social-services>

AMA Position Statement on Methamphetamine can be found at: <https://ama.com.au/position-statement/methamphetamine-2015>

AMA Position Statement on Harmful substance abuse, dependence and behavioural addiction can be found at: <https://ama.com.au/position-statement/harmful-substance-use-dependence-and-behavioural-addiction-addiction-2017>

CHRIS JOHNSON

Senate Inquiry says cyberbullying is a health issue

The AMA welcomes the recommendations of the Inquiry into the Adequacy of existing offences in the Commonwealth Criminal Code and of State and Territory criminal laws to capture cyberbullying.

Many of the recommendations are consistent with AMA submissions and policy.

AMA President Dr Michael Gannon said the AMA was pleased to see the inquiry state, in no uncertain terms, that bullying is a public health issue.

“Framing bullying as a public health issue reiterates the need to invest in prevention and early intervention opportunities, rather than merely punishing offenders once bullying has occurred,” Dr Gannon said.



“The AMA acknowledges that increasing the penalties for cyber bullying fails to address the root of the problem, or prevent the harm done by cyber bullying.

“Initiatives which seek to educate children and young people about the real and tragic harms caused by cyber bullying provide a far more productive way forward.

“The notion of a duty of care being imposed on social media platforms is a welcome acknowledgement of the increasing amount of time that children and young people are spending in these online and virtual spaces.”

As young people spend an increasing amount of time inhabiting these virtual spaces, the providers of these platforms should be bound by the same duty of care that we have come to expect from physical service providers such as restaurants, cinemas and sporting centres, Dr Gannon said.

The AMA acknowledges the effectiveness of the eSafety Commissioner could be improved by making it easier for the Commissioner to access relevant data from local and overseas-hosted social media services.

The AMA remains broadly supportive of the role of the eSafety Commissioner in reducing the harm associated with cyberbullying, noting the importance of continued monitoring and evaluation of this position as it evolves.

“We have previously identified the role of schools and parents in educating children and young people about the dangers of physical and cyber bullying,” Dr Gannon said.

“This should also be complemented by strategies which seek to build resilience, coping strategies and help-seeking behaviours in young people who experience bullying.





Health on the Hill

POLITICAL NEWS FROM THE NATION'S CAPITAL

“Many young people who experience bullying are reluctant to report their experiences. Interventions which rely on self-reporting of bullying instances can only have limited success.”

It is estimated that about one in four Australian students experience bullying.

General Practitioners can provide a confidential and safe avenue for children and young people to discuss any bullying they have experienced, or for parents looking to support their children with these challenges.

“Viewing bullying as a public health issue acts as a pertinent reminder for all Australians to consider the way in which our own behaviour contributes to a culture in which children and young people learn that bullying is acceptable,” Dr Gannon said.

CHRIS JOHNSON

Tuberculosis continues to threaten regional health security

During a World Tuberculosis Day speech delivered in the Senate in March, International Development Minister Concetta Fierravanti-Wells sought to highlight the devastating outcomes tuberculosis is still having globally, including in Australia's region.

TB is the world's top infectious disease killer. In 2016, 1.7 million people died from TB – almost 4,700 each day.

Twelve of the world's 30 highest TB burden countries are located in our region, accounting for nearly half of all cases of drug-resistant TB and TB deaths worldwide.

“Turning the page on TB – once and for all” is a Federal Government priority, Senator Fierravanti-Wells said.

In the 12 months to December last year, there were 10 million movements out of Australia. Two million Australians visited Pacific island countries and Oceania and another 3.1 million Australians visited South-East Asian countries.

“Thirty highest TB-burden countries are located in our region and account for nearly half of all cases of drug-resistant TB and TB deaths worldwide,” the Minister said.

“Papua New Guinea, which is four kilometres to our north, has a major TB problem and, in particular, a drug-resistant TB problem. That not only puts PNG at risk; it also puts Australians at risk.”

In 2014, Australia's National Notifiable Diseases Surveillance System received 1,339 TB notifications, representing a rate of



Map showing countries with the highest TB burden near Australia.

5.7 per 100,000 population

However, the Department of Health notes Australia's overseas-born population continued to represent the majority (86 per cent) of TB notifications and Australia's Aboriginal and Torres Strait Islander population continue to record TB rates about six times higher than the Australian born non-Indigenous population.

The Department estimates the cost of treating a single patient with drug resistant TB can be up to \$260,000 in Australia.

“TB not only affects individuals, but it also cripples communities; disrupts tourism, trade and investment and sets back regional economic growth and development,” Senator Fierravanti-Wells said.

The Minister said that in June last year, the Government announced a new partnership with the World Bank, targeting drug resistant TB in vulnerable communities in PNG.

Another way that Australia is contributing to the fight to end TB is through research.

With one in four people with TB not getting treatment through public health programs, WHO Regional Director for the Western Pacific, Dr Shin Young-soo, continues to urge Governments to do more.

“The TB rate is coming down in the region, but it's not happening fast enough. We need to do much more to achieve our goal of ending the epidemic once and for all,” he said

MEREDITH HORNE



Research suggests Australians confused about sun protection

Fewer than one in 10 Australians understand that sun protection is required when UV levels are three or above, according to research by the Cancer Council and QIMR Berghofer Medical Research Institute.

Melanoma is the third most common cancer in Australian men and women. Australia and New Zealand have the highest melanoma rates in the world with Queensland incidence rate of 71 cases per 100,000 people (for the years 2009-2013), vastly exceeding rates in all other jurisdictions nationally and internationally.

Melanoma is the most common cancer in young Australians (15-39 year olds) making up 20 per cent of all their cancer cases.

Heather Walker, Chair of Cancer Council Australia's National Skin Cancer Committee, said the latest National Sun Protection Survey results showed a clear gap in Australians' knowledge. Forty per cent of Australians are still confused about which weather factors cause sunburn.

"This new research shows that Australians are still very confused about what causes sunburn, which means people aren't protected when they need to be," she said.

"In summer 2016-17, 24 per cent of Australian adults surveyed incorrectly believed that sunburn risk was related to temperature, while 23 per cent incorrectly cited conditions such as cloud cover, wind or humidity.

"It's important for us to reinforce the message that it's ultraviolet radiation that is the major cause of skin cancer – and that UV can't be seen or felt. It's a particularly important message this time of year. In autumn, temperatures in some parts of the country are cooling, but UV levels right across Australia are still high enough to cause serious sunburn and the skin damage that leads to cancer."

Professor David Whiteman, Head of the Cancer Control group at QIMR Berghofer Medical Research Institute, said despite years of public education, encouraging Australians to protect their skin was an ongoing challenge.

"These findings show that very few Australians know when to protect their skin from the sun's harmful rays," he said.

"This is clearly a concern as it's likely that Australians are relying on other factors, like the temperature or clouds, to determine when they need to slip, slop, slap, seek shade and slide on sunglasses.

"There is overwhelming evidence that, if used correctly, sunscreen prevents skin cancer – yet at the moment many Australians don't even really understand when it's required, and many are neglecting to use it altogether. We also know from previous research that 85 per cent of Australians don't apply it correctly."

Late last year, the Cancer Council National Sun Protection Survey showed that overall the proportion of adults slipping on clothing to protect themselves from the sun has decreased from 19 per cent to 17 per cent in the last three years.

The Cancer Council believes there is a need for Government to continue to invest in skin cancer campaigns to ensure adults remain vigilant about reducing their UV exposure.

"Australia hasn't had Federal funding for a skin cancer prevention campaign since 2007 – this latest data suggests adults are becoming complacent about UV and demonstrates the urgent need for a refreshed national campaign," Professor Sanchia Aranda, Cancer Council Australia Chief Executive Officer said.

Cancer Council's SunSmart app provides local UV alerts and sun protection times and can be downloaded free on the App Store or Google Play.

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MEREDITH HORNE

British study finds more than one third of cancers could be avoided with lifestyle changes

A landmark study by Cancer Research UK found that being overweight is a contributing factor to cancer – and it's growing.

Excess weight now caused 6.3 per cent of all cancer cases, rising from 5.5 per cent in 2011.

The latest figures, calculated from 2015 cancer data, were analysed in the study to examine preventable cancers and to find ways individuals can help to minimise their risks to develop cancer.

Sir Harpal Kumar, Cancer Research UK's chief executive said: "This research clearly demonstrates the impact of smoking and obesity on cancer risk. Prevention is the most cost-effective way of beating cancer and the UK Government could do much more to help people by making a healthy choice the easy choice."

Cancer Research UK's research found more than a third of all cases of cancer were avoidable – some 135,000.

Smoking in the United Kingdom still remains the biggest preventable cause of cancer despite the continued decline in smoking rates.





Research

Tobacco smoke caused around 32,200 cases of cancer in men (17.7 per cent of all male cancer cases) and around 22,000 (12.4 per cent) in women in 2015, according to the research published in the *British Journal of Cancer*.

Cancer UK Research said one of the biggest messages that they thought should be taken from the research was more action was needed to tackle the “health threat” of obesity.

Professor Linda Bauld, Cancer Research UK’s prevention expert, said: “Obesity is a huge health threat right now, and it will only get worse if nothing is done.

“The UK Government must build on the successes of smoking prevention to reduce the number of weight-related cancers. Banning junk food TV adverts before the 9pm watershed is an important part of the comprehensive approach needed.”

The research found that the third most preventable cancer in the UK was overexposure to UV radiation from sun or sunbeds. This directly caused about 13,600 cases of melanoma skin cancer a year, 3.8 per cent of all cancer cases.

Other preventable causes of cancer included drinking alcohol

and eating too little fibre.

Cancer Research UK was keen to point out however, that is not a simple exercise to point to one thing alone to stop cancer. It was more an endorsement of the idea that many cancers were potentially preventable.

Professor Mel Greaves, from the Institute of Cancer Research, in London, said there was still many areas to be explored further in how to reduce cancers.

“If obesity could be avoided, the impact on cancer rates is uncertain - but they would almost certainly decline significantly,” Professor Greaves said.

“Given the currently high rates of obesity in young people, this represents (like cigarette smoking) a major societal challenge beyond the bounds of the medical arena.”

A copy of the study can be found at: <https://www.nature.com/articles/s41416-018-0029-6>.

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MEREDITH HORNE

INFORMATION FOR MEMBERS

CALL FOR EXPRESSIONS OF INTEREST

Appointment as an AMA member director of AMPCo Pty Limited

Australasian Medical Publishing Company Pty Limited (AMPCo) is a wholly-owned subsidiary of Australian Medical Association Limited (AMA). It publishes the *Medical Journal of Australia* and manages digital businesses including the Medical Directory of Australia and doctorportal.

The Constitution of AMPCo provides for a board of up to five directors with an independent chair, at least one other independent director, and two directors who are AMA members. The directors are appointed by the board of AMA against skills criteria that meet the needs of the company.

Dr Steve Hambleton, a long-serving AMA member on the AMPCo board, steps down mid-year by rotation and the AMA board is now seeking expressions of interest from suitably qualified AMA members for consideration for appointment.

The skills criteria for appointment include:

- Experience as a director of a commercial entity and/or qualification as GAICD
- Understanding of risk management and corporate governance
- Experience in/understanding of digital businesses
- Experience in/understanding of publishing in the context of a peer-reviewed medical journal of a member association
- Alignment with the AMA's vision and values.

The AMA board encourages expressions of interest from members who reflect the diversity of the AMA membership.

Appointment will be for an initial period of two years, with the potential for a further appointment. A small fee is paid to the director.

Expressions of interest should be sent to the Secretary General, Anne Trimmer, by email at ama@ama.com.au by close of business on Friday 27 April 2018. Queries can be made by phone on 02 6270 5460 or by email.

Unlocking the potential of girls

There are 600 million adolescent girls aged 10 to 19 living in the world today and 500 million of these are in developing countries.

In Plan International Australia's new report, *Half a Billion Reasons*, CEO Susanne Legena says it is critical to invest in adolescent girls to create the necessary economic and social conditions to achieve the 2030 Agenda for Sustainable Development.

However, Plan believes this group is missing from Australia's international development strategy despite being essential to a more prosperous future in developing countries.

"The world talks about focusing on 'women and girls' in aid and development, but in practice investments still target adult women or younger children, and adolescent girls aged 10 to 19 fall through the gap," Ms Legena said.

Plan argues in the report, placing adolescent girls at the centre of aid and development enables benefits that can change the course of a girl's life and a nation's economy, reducing her risk of poverty and inequality and unlocking the demographic dividend that can accelerate a country's economic growth.

Health issues are a central part of the report's focus.

Pregnancy-related complications are the leading cause of death for adolescent girls aged 15 to 19.

Plan believes there is overwhelming evidence that when adolescent girls have access to sexual and reproductive health information and services it can be life-saving. However Australian Government funding for family planning has halved over three years, from \$46 million in 2013/14 to \$23 million in 2015/16.

Australia's geographical significance to developing countries in *Half a Billion Reasons* cannot be overlooked.

PNG is described as one of the most dangerous places to be a woman or girl, with sexual and physical violence having reached epidemic levels. Programs are desperately needed to address this crisis, even though PNG is one of the primary recipients of Australia's aid and development.

Childhood marriage threatens girls' lives and health, and it limits their future prospects. Adolescent pregnancy increases the risk of complications in pregnancy or childbirth. In the Solomon Islands, 22 per cent of girls are married by the age of 18 and 3 per cent married by the age of 15.

Almost one quarter of all teenage girls in Timor-Leste will fall pregnant and have a baby by the time they are 20 years old. In addition, some 19 per cent are married by the time they are aged 19, indicating a deep stigma and shame around early pregnancy.

Education is also listed in the report as central to changing lives of adolescent girls in developing countries. The World Bank has shown that for every year an adolescent girl remains in school after age 11, her risk of unplanned pregnancy declines by 6 per cent throughout secondary school.

Adolescent girls and young women make up 76 per cent of young people around the world who are not in school, training or employment.

In PNG, Plan estimates only 18 per cent of adolescent girls attend upper secondary school. In the Solomon Islands only 22 per cent of girls attend upper secondary school despite there being 50 per cent of young women aged 15 to 24 who are unemployed.

Plan in the report has called on the Government to develop a stand-alone action plan to achieve gender equality for adolescent girls through Australia's foreign policy, trade, aid and development.

The United States has a road map, *Global Strategy to Empower Adolescent Girls*, produced in 2016 to tackle the barriers that keep adolescent girls from reaching their full potential. Plan believes the Department of Foreign Affairs recently produced Foreign Policy White Paper was a missed opportunity to tackle issues faced by adolescent girls.

"Whether we are trying to empower girls to further their education, avoid child marriage, access family planning services or escape gender-based violence, we cannot improve girls' realities without first acknowledging that their challenges and needs are unique," Ms Legena said.

A copy of Plan's report can be found at: <https://www.plan.org.au/~media/plan/documents/reports/girls-report-2018/full-reporthalf-a-billion-reasonsdigital.pdf?la=en>

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MEREDITH HORNE

Move afoot in the US to slash nicotine levels

The United States' Food and Drug Administration (FDA) has taken a giant leap towards reducing nicotine in cigarettes in order to make them less addictive.

Described as a "historic first step" by the FDA itself, the agency has opened a regulatory process to cut nicotine levels in cigarettes.

FDA Commissioner Scott Gottlieb said new rules would be in place to make the nicotine levels in cigarettes minimally addictive and even non-addictive.

The FDA notice was published in the Federal Registrar and included new data (which was FDA-funded) published in the *New England Journal of Medicine*, based on an intended policy outcome.

While the Commissioner flagged that the process would be a long one, he said it would result in an "undeniable public health benefit".

The FDA analysis found that by reducing nicotine levels in cigarettes, the smoking rate in adults could fall from the current 15 per cent to just 1.4 per cent.

The data showed that such a result would also mean 8 million fewer tobacco related deaths across America by the end of the century.

The plan is to cut nicotine levels to 0.4 milligrams per gram of tobacco filler.

The Nicotine Notice is still open for public comment and the FDA is after views on what the maximum nicotine level in cigarettes should be.

It also wants to know if a new limit should be introduced gradually or all in one go – or not at all.

The potential for illicit trade in high-nicotine cigarettes is also being considered, as is whether addicted smokers would smoke more low- nicotine cigarettes in order to get their fix.

In the US, the *2009 Tobacco Control Act* gave the FDA the power to regulate tobacco, but not to ban it.

CHRIS JOHNSON



Doctors, practice managers, registered nurses and other medical industry professionals from around Australia are invited to attend the **Annual AMA Queensland Conference in New Orleans from 23-29 September 2018.**

The program will feature high-profile American and Australian speakers on a range of medical leadership and clinical topics in an exciting, and unique location. RACGP points will be on offer.

To find out more about the conference program or to register, please contact:

Neil Mackintosh,
Conference Organiser
P: (07) 3872 2222 or
E: n.mackintosh@amaq.com.au

Download a conference brochure from the events calendar at www.amaq.com.au



Australian Medical Association Limited ABN 37 008 426 793

AMA

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.

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.

Esther (in Australia)

... from page 16

worried for the children's safety. If I don't get my fat arse out of bed, they might fall and that would be awful.

Esther pulls back the blanket and slowly gets up. The room spins for a while, her head feels like it's going to explode, her mouth is dry, the sweat under her arms dripping. She steadies herself on the edge of the dresser until her head clears and then heads towards the kitchen.

Later in the morning, Esther is feeling a little better. She found some kangaroo meat to eat and had some tea so her heart isn't racing quite so badly and she is no longer sweating. She needs to get to the clinic. Maybe one of those lazy home care workers could pick me up, she thinks. They pick up Doris when she needs a ride to the clinic. Why not me, I need a ride. "You're not on our list," they'll say. How do you get on the bloody list, anyway? Helps if you're a friend of a relative, I suppose. She looks out the window, the sun is bright and the air looks still and hot, no wind. She will walk to the clinic even though it will mean she'll be late for her appointment again. So sue me, she thinks – who cares other than you if I'm late or on time?

Esther's surprised by what she sees at the clinic this morning. There is a big sign over the receptionist's desk saying the Homelands Health Centre exists to serve the people of Port Good Hope so they can achieve physical, mental and spiritual wellbeing as individuals, families and community. Humph, that's a new idea. They are going to serve me? Seems to me with all of these appointments they set up for my diabetes that I'm serving them with my blood!

Another surprise, that counsellor I've been trying to get my son to see is here in the waiting room just visiting. I don't think I've ever seen him outside of his office in the two years he's been in Port Good Hope. I wonder what's going on.

Marie asks me if my phone number has changed lately. I don't remember her ever asking me that before. I do have a new number. My daughter Bella thought I should cancel my home telephone when I took over the contract on her mobile phone. I tell Marie the new number and turn to go sit in the waiting room. "Esther?" she calls, "would you like a cuppa while you're waiting?" Wow, they really are going to serve me.

Arlene is the nurse's name. She says we've met before but I can't remember them all. Arlene is quite excited today. She says the staff are working on three new programs that are being created to work in each individual community. Diabetes, addictions, and home care are the three, Arlene says. "We're meeting with everyone in Port Good Hope that has high blood sugars or diabetes," she explains. "We want to know from each person what is the most important aspect of their health – mental, physical or spiritual health. Which is most important to you, Esther?"

I don't know what's she's talking about – health? I don't know if I've ever really thought about my health. They told me I was diabetic when I was pregnant with my second child. I had another four after

that, all huge babies that looked so odd in the nursery they have at the hospital for babies who aren't doing so well when they're first born. What's my goal for health? How do I even begin to think about that? I would like to say to her, I want enough money that I don't have to worry every month if I can pay my bills. I would like to tell Arlene that I'd like someone to take my son out on the land so he can feel the peace and know he is worthy. I'd like someone to help me look after Marla. She's driving me crazy with all of her demands. I know she's lonely and scared. Hell, I'm scared.

"I don't know what I want," I tell the enthusiastic nurse. I'm so tired. "My kids aren't doing well," I say. "They are always at me to rescue them. How can I rescue them when I can't even take care of myself?"

"Tell me about your kids, Esther" she says.

An hour later I emerge from the nurse's office with red eyes and a list of ideas. Arlene and I have made a list of options for my kids and for me. As I stood up to leave, Arlene says to me "Is there anything else I can help you with today?" I want to know what they're putting in the tea around here – the staff seem to really care.

"No," I say, "I really appreciate you listening to my story, I can't remember the last time someone just listened to me." She promises to meet me at my mother's house on Friday so we can talk to her about some options too. Junior is just getting up when I get back to the house. He doesn't look good. Doesn't smell very good either. "I think there's enough water for a shower," I say to him. He looks at me with eyes that are barely open and heads for the shower.

I call my mother. "Marla," I say. "The nurses at the clinic are looking at how they can improve home care, they want to talk to you".

"I don't get no home care, I'm not on the list," she says.

"I told her that and I told her you weren't doing so well all alone. She says they are going out and meeting all the Elders and talking about options. I told her we could meet at your house on Friday." I wait for her to process this message. She will be pleased to have someone visit but she won't say so.

"What do they want to talk to me about?" she grumbles.

"Options," I say. "It's the new word they are using with everyone. They say they want to talk to you about what options you might like. I don't know what they're talking about. I know you wanted to know how you get them to give you a ride sometimes. I also know you would like to play bingo again. Maybe those are some of the options."

"When on Friday?" she says with more interest.

"Eleven," I reply.

Junior emerges from the bathroom smelling like soap, a big improvement over the smell he went in with. His eyes are a little clearer. I boil water for tea. "The nurse at the clinic says they are



Esther (in Australia)

starting a men on the land program," I tell him.

"Nurses don't know nothing about the land," he says. "I don't need any nurses hounding me in town or out on the land".

"It's for young men with addictions. Charlie is working with the counsellor to set it up," I say. "I think you should think about it." He gives me a dark look and heads for the bedroom, slamming the door behind him. I pour the water for the tea and think about Charlie.

Charlie had a worse time at the Mish than me or any of my brothers or sisters. Charlie seemed determined to bury himself with grog. He's been through more treatment programs than you could count. It looks like once he figured out how to manage his drinking back here in Port Good Hope he was ok. If he's part of a program for young men here in town, I think Junior would do well to give it a try. Junior really missed out on having a strong man to look up to. The older boys had my dad before he passed. Junior only had his deadbeat drunk dad to follow around and drag him home when he passed out.

"How can I help you today, Esther?" Kindness again, what's up with these people? I'm back at the clinic today. This time I'm seeing the social worker for the first time. My kids won't have anything to do with her because she's the one that takes your kids if you're caught drinking. Normally you have to go see her at the other building – no one likes to go there because they think you have to be crazy or a drunk to see anyone there. Arlene told me the social worker would see me anywhere I wanted her to – my house, the clinic or the wellness centre. I figured the clinic wouldn't stir up any talk. I'm always going to the clinic for my diabetes.

"The nurse says you might be able to help me with the bills I can't pay," I say. I didn't believe Arlene when she said the social worker might be able to help. I know they've helped Elders with forms to fill in but I've never heard of them working with people who have bad debts.

"Well, let's start with looking at the money you have coming and the money you have going out every month," she says. I've brought some of my bills and cheque stubs so she can help me figure out what I might be able to do to get out from this mess I'm in. Arlene surprised me when she said that sorting out my bills so I didn't have to worry about running out of electricity or getting evicted from housing was a good start on a goal for my health.

"Marla, why are you still in bed?" I say. The nurse, counsellor and home support worker are in the living room. I think my mother is doing this on purpose. "Get up, we have people here," I say to her in Kriol.

"Magdalene, we're here to learn how things are going for you. We have a few questions and then we hope you will ask us lots of questions. My name is Arlene, I'm one of the nurses at the clinic. I share my job with a nurse named Claudia. You may have met her, she has an Adelaide accent. This is George, he's a

mental health counsellor and you probably know Monette, the home support worker."

My mother nods and sits in her favourite chair. I bring her some tea with lots of sugar, just the way she likes it. Arlene says they've been going around interviewing all the Elders in the community and anyone else who will need some help at home, to keep them safe and well in their own homes. My mother is one of the last ones they are interviewing. With all the information they've collected they will be looking at the programs and services that people think they need and then make some decisions.

It's not just the health centre staff that will be making the decisions. There's going to be a committee made up of three people from the community and three from health and social services. I won't hold my breath. I've seen many committees try and do things differently for the people.

What I like from the interview with my mum was the counsellor speaking up about ideas he has to help Elders deal with abuse. Elder abuse is a big problem in Port Good Hope. Everyone knows when the pensions come into their accounts and then all of a sudden the children and grandchildren come for a visit. My son Elwood is bad for this. Marla wants him to come for a visit but not just to humbug her for money. She depends on him to get the roo skin she needs to make her beaded vests. She can't say no to him but she can't get through the month any better than I can if she gives him any money.

Some of the ideas the committee is thinking about is a day program for Elders at the wellness centre. Hot lunch and bingo with fruit and vegetables for prizes is the idea they are thinking about. Marla perked up at that idea. Marla asked how many times a week they would play bingo.

The clinic people also said they might get out of transportation support all together. The clinic staff plans to be making more visits to people's homes so there won't be as much need to bring Elders to the clinic. It takes up too much time of the home support workers and it's too hard to provide it to everyone. The clinic is partnering with the land council office to see if this is a service the council could take over.

No one has asked me about my blood sugar all week. I know it's down from where it usually is. I can feel it. The social worker gave me some ideas of how I can pay my bills and Junior has an appointment with Charlie and the counsellor to see about the men out on the land program.

If Marla goes to bingo even twice a week it will mean two days that she's not calling me complaining about her back or her shoulders or whatever other body part is aching. I finally feel like maybe I could think about my health now. What would my goal be? I'd like to be able to paddle a canoe again. Maybe I could even teach my grandsons.

TO THE EDITOR



Funding of the public sector is vital albeit intangible

I have read the recent superb article on public hospital funding by Chris Johnson with great interest (*Australian Medicine* March 19, 2018 *Business as usual not good enough for public hospital funding*).

As a Consultant Radiologist, I work full-time in a public tertiary centre after having worked for 20 years in another system entirely public funded. I was a Consultant in the UK before working in Australia. I love my career in medicine.

Your sentiment (that of AMA President Dr Michael Gannon, who is quoted in the article) is strongly felt. The UK will suffer for outcomes and investments but couldn't stretch the public dollar any further. There has been much brow-beating. We have produced quality research and are ever resourceful around cost savings.

The continued funding of the public sector is vital but intangible. It is grossly under-valued. The smaller units operate in isolation and 're-invent the wheel' without much sharing of good practice. Tertiary centres rarely instruct.

In my personal experience, the public sector does most of the time-consuming training of medical students and registrars – tomorrow's doctors. The public sector deals with the most difficult and severe cases that the private sector has no interest in and positively ignores. The most needy don't seem to have private health cover.

Friday afternoon – bank holidays. The public system is 'open all hours' at whatever cost. The private sector will judge profitability around out-of-hours work. The private sector doesn't appear keen on running Consultant-heavy multi-disciplinary meetings that are unfunded for those involved but in reality save thousands of dollars around unnecessary patient care, unnecessary operations, needless investigations and potential complications. The medical literature and evidence base is deficient here for sensible guidance. There is no financial incentive.

However, if as a patient, you attend a private provider as opposed to a public environment, you will be more likely to see a Consultant 'at the front door' who might avoid a hospital

admission through clinical experience and expertise.

Undoubtedly, some clinical scenarios – myocardial infarction, trauma and stroke – will need urgent unpredictable input while the private sector books out-patient care and over-investigates the fringes of medical need. Some conditions can benefit from a period of observation before a myriad of expensive tests are booked in parallel. There is little priority of investigations. It's everything now! Paradoxically, volumes of needless work will generate significant incomes in many environments.

Publicly, more junior individuals will assess the most needy, admit to beds and order downstream costly investigations while they await any senior input. With so many providers, joined-up patient care is a diminishing reality. Conflicting interests abound. Some services are duplicated locally in a costly fashion without any scrutiny or accountability. What is a tertiary centre but a 'dumping ground' for cases the private sector can't deal with?

To many, the current system could be perceived as doctor-centred service without a patient-facing, single funded streamlined approach. If the efficiency of the NHS had decent financial investment it would be unbeatable. Obvious gains are evident without a quick fix. Juniors have known it no other way and more and more accept the inequalities.

Who can intervene with a feeling of disorientation in such a complex setting?

Name withheld by request

Vax movies in clinics

Re Dr Gannon's article on vaccination in *Australian Medicine* (March 19, 2018 p3 *Vigilance on vaccinations and the vacuous*). I believe that one of the reasons parents object to vaccination is that nowadays they have never seen a child in a full-blown attack of the relevant illnesses. I have long thought that one approach to overcoming the problem would be to have movies available at our health centres depicting these illnesses, which could be shown to parents and others as needed. I am unsure if something similar is available on the internet.

Dr Tom Gavranic (retired)



Hold the horses

BY DR CLIVE FRASER

2018 Ford Mustang



Doctors nearing retirement often have a desire to buy cars that would have been impractical during earlier stages of their career.

Top of the bucket list for many would be the purchase of a current generation Ford Mustang.

Having grown up in the 60s and 70s, I knew that a Ford Mustang was always something special.

After all, Mustangs featured in three James Bond films, *Goldfinger* (1964), *Thunderball* (1965) and *Diamonds Are Forever* (1971).

Back in 1967, a handsome home-grown Tony Ward drove a Mustang in the much-loved Australian TV spy series *Hunter*.

As the good guy working for COSMIC (aka ASIO), John Hunter would need a fast set of wheels to have any chance of catching the evil Kragg.

Fast forward to 2018 and Tony Ward would now be driving a sixth generation V8 Mustang convertible.

He would have by-passed the 2.3 litre four cylinder option because he would have said that driving that car was like "kissing his sister".

But the 2.3 litre Ecoboost engine produces a sprightly 233kW power and 432Nm torque.

On paper it is more than adequate and uses 25 per cent less fuel, but 85 per cent of Mustangs sold are V8s.

With twice the number of cylinders the 5-litre V8 does look the goods under the bonnet and has 306kW and 530Nm.

In this 50-something demographic most owners already have some degree of presbycusis.

While the standard exhaust system on the V8 does have a nice note, hearing loss does encourage many Mustang owners to replace the factory exhaust with after-market mufflers that have more burble.

At 4.8 metres in length, there is no shortage of room inside the Mustang's cabin and the switch gear has some nice chrome-plated retro features.

The speedometer is in metric and miles per hour and specifically mentions ground speed just in case anyone decides to become air-borne.

For convenience it would be nice if Ford could work out an easier way to move the front seats forward to climb into the rear, but perhaps the comfort of rear seat passengers is not usually a priority for Mustang owners.

Unfortunately, the current Mustang only has a two-star safety rating on ANCAP.

This wouldn't worry the likes of James Bond or John Hunter, for whom being shot or poisoned by foreign agents is a far more dangerous threat.

Later this year the Mustang will undergo a significant upgrade.

Instead of six speeds the automatic will have ten ratios and the V8 motor will have 33 more kW.

The dashboard will be all digital and to address safety issues the up-dated Mustang will come standard with autonomous emergency braking (AEB) with pedestrian detection, adaptive cruise control, lane departure warning and lane keeping assist.

The extra fruit will mean that prices will rise between \$4,000 and \$9,000 depending on the model.

So would I buy a Mustang now or wait a few months?

My career has been about delaying gratification so I'll hold the horses and wait a little longer to join the Pony Club.

Safe motoring,

Doctor Clive Fraser

doctorclivefraser@hotmail.com

Getting out of your comfort zone at the National

BY CHRIS JOHNSON



What's in this tent?



Steve Poltz



Ryanhood



Mick Thomas and the Roving Commission

Cruising from tent to tent and stage to stage at a music festival will always turn up a surprise act.

A musician or band you didn't know about, or one you didn't know was even on the program. That's the beauty of festivals – they can take you out of your comfort zones and lead you into uncharted territory.

Finding new music at a music festival is an adventure in itself.

The National Folk Festival (NFF) in Canberra over the Easter long weekend was no let down when it came to that.

With literally hundreds of acts performing over five days, discovering new music was a cert.

Here are just a few. Check them out online ... or when they are next performing at a venue near you.

The **Northern Folk**, from Melbourne were a real find. Think Mumford and Sons... but maybe better. Eleven musicians turning folk songs into stomp rock, with brass included.

Acoustic duo **Ryanhood** from Boston were sponsored at the NFF by the USA Embassy and they were infectious. Mixing guitar and rocked up mandolin with fine vocals, these guys had audiences stomping. They even paid tribute to their favourite band Midnight Oil by covering a song or two of theirs.

Steve Poltz is a favourite of mine, but he was new for people I was with. And they couldn't believe what they were seeing and hearing This Canadian-turned-Southern-Californian is a genius.... even if a little unhinged. Switching from beautiful ballad to crazy narrative in an instant, Poltz had his audiences right where he wanted them. His performances were funny, sad, beautiful and mesmerising all at the same time. Simply stunning.

One great surprise was to see the legend from Fremantle **Lucky Oceans** (yes, the same Lucky Oceans who for years was the voice of Radio National's Daily Planet until ABC managing director Michelle Guthrie decided to can all music shows on RN) play pedal steel guitar with brilliant songwriter **Harry Hookey**.

From Ireland was **Susan O'Neill**, who performs under the name **SON**. U2's Bono loves her work and with good reason. Using a loop to present her powerful guitar, trumpet and vocals all at once, she filled every pavilion and tent she played in. Mesmerising songs combined with stage presence and beautiful musicianship made for an unexpected treat.

I wasn't sure what to expect from **Mick Thomas**, whose songs I have cherished since his days leading Wedding Parties Anything, now fronting his new outfit **The Roving Commission**. But it was outstanding. Thomas is a master at song writing and performance. Great shows.

Most acts performed a number of times across various stages throughout the weekend, so it was easy to get a taste of lots of varied music.

The NFF, or the National as it is affectionately referred to, once again showcased musical genres from around the world – and some of the best home-grown acts.

All designed to broaden your musical tastes and horizons.

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Sat 15 - Sun 16 Sept, Radisson Blu

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Learn how to identify practice, professional and personal risks and develop systems, strategies and arrangements to manage them.

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Sat 25 Aug, Hilton Adelaide

SYDNEY:

Sat 15 Sept, Radisson Blu

AMA Fee: \$990 (inc. GST) normally \$1,045

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Sat 17 - Sun 18 Nov
Intercontinental Sanctuary Cove Resort

AMA Fee: \$990 (inc. GST) normally \$1,595

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