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AMA public hospital report card:
Public hospitals struggling to meet demand and targets as federal funding declines

AMA President, Dr Steve Hambleton, has called on the Federal Government to increase public hospital funding as public hospitals across the country struggle to meet patient demand and COAG performance targets.

The *AMA Public Hospital Report Card 2014*, released last month, is the only report that provides a consistent analysis of public hospital activity over time. This year, for the first time, the Report Card takes into account Commonwealth funding information from the National Health Funding Pool Administrator (NHFPA).

Dr Hambleton, said the new data shows a decline in Federal funding or public hospitals from what was promised over the reporting period.

"The NHFPA data indicates that the previous Federal Government contributed $134 million less to public hospitals in 2012-13 than its Mid-Year Economic and Fiscal Outlook (MYEFO) commitment for that year," Dr Hambleton said.

"This data shows that some States were worse off, which is counter to the Commonwealth's commitment in Clause 15 of the National Health Reform Agreement (NHRA) that no State or Territory would be worse off under the Agreement.

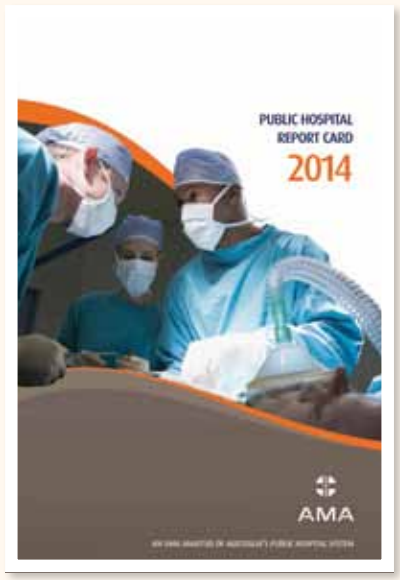
"The AMA is very concerned that the 2013-14 MYEFO document shows that the current Federal Government is now planning to spend around $400 million less on public hospitals over the next three years compared to the planned expenditure set out in the 2012-13 MYEFO document.

"We call on the new Government to restore Federal funding to at least the originally committed NHRA levels to help public hospitals around the country to meet their performance targets and provide timely and quality care for the community."

The *AMA Public Hospital Report Card 2014* shows only marginal improvement in public hospital performance against the performance benchmarks set by all Governments.

No State or Territory met the target for 2012-13 under the National Partnership Agreement on Hospital and Health Workforce Reform for 80 per cent of emergency department Category 3 patients being seen within clinically recommended triage times.

Dr Hambleton said that public hospitals need more funding to produce greater capacity as the ageing population and more people suffering complex and chronic conditions place heavy burdens on our public hospitals.



"When judged against key capacity and performance measures, the Australian public hospital system is struggling to meet the clinical demands being placed on it," Dr Hambleton said.

"This is not the time for public hospital funding cuts. Now is the time to invest in our public hospitals as part of an overall health strategy.

"The AMA recognises that the long-term focus for Australia's healthcare system should be on primary care to keep people well and out of hospital.

"But, until that can be achieved, our public hospitals must have the capacity to provide treatment efficiently and effectively to people needing acute care."

Key findings of the *AMA Public Hospital Report Card 2014* include:

- bed numbers per 1000 of the 65 and over population have remained largely unchanged;
- nationally, only 68 per cent of emergency department patients classified as urgent were seen within the recommended 30 minutes. This is a small improvement over 2011-12. If this rate of improvement were to continue, we could be on track to achieve 2012's target in 2018;
- for calendar year 2012, only WA met (in fact exceeded) the interim National Emergency Access Target. NSW, Vic and the NT did not even meet their baseline for this performance target in 2012.
- nationally, median waiting times for all elective surgery have increased over the last ten years. In 2012-13, the national median waiting time remained unchanged at 36 days, meaning no improvement over the last three years.
- the number of public hospital elective surgeries performed in 2012-13 across Australia was 673,316. This was an increase of around 1.8 per cent over the number of elective surgery admissions in 2011-12 (661,710); and
- 2.7 per cent or 18,180 of the patients admitted for elective surgery in 2012-13 waited for more than a year for their elective surgery.

Dr Hambleton said the full story about waiting times for elective surgery in Australia's public hospital system still remains hidden.

"There are people who are waiting to see a specialist to be assessed for surgery who are not counted in waiting list data," Dr Hambleton said.

"The clock only starts on waiting times for elective surgery when a patient has seen a specialist and is booked for surgery.

"The AMA is calling on COAG to include the hidden waiting list in official data."

The AMA Public Hospital Report Card is available at https://ama.com.au/ama-public-hospital-report-card-2014

TERRITORY TOPICALS – from President, Dr Andrew Miller

Dr Andrew Miller

Vaccinations have probably saved more lives in the last two centuries than any other medical advance. They play a vital public health role but also reflect on and bear reflections from every other facet of our lives and health. A couple of years ago, before an overseas trip, I consulted my GP about my vaccination needs and what followed was a thorough discourse on my health, my plans and my family's health; which resulted in a series of vaccinations (no small undertaking in a needle-phobe such as myself) to bring me back into the 21st century.

There is a move afoot to allow pharmacies to give influenza vaccinations, and perhaps more. Without discussing the infrastructural requirements for any vaccination service; I must question the trivialisation of vaccination programmes into something that "time-poor members of the community would appreciate being able to pop in for a flu-shot at a time that's convenient to them" (Carl Cooper in *CSU News* Tues 4 Mar). This concept of just popping into health care providers makes a mockery of any consideration of holistic care.

Before this is interpreted as an attack against pharmacists I must make it clear that there is a very clear distinction that can be drawn between the professionalism of highly trained pharmacists and the business of pharmacy as it is evolving in Australia. I can see no place for a vaccination service sharing digs with iridologists and reflexologists; except perhaps where another apparent business opportunity is too good to ignore.

I cannot let this column pass without commenting on the "drip on stone" process of non-debate about the future of our health system. This is truly a debate you have when there is no debate. The outcome should be of great concern and I find the lack of traction in the media for arguments against the proposed (or is it?) copayment for GP consultations worrying. As doctors we all know that chronic disease is debilitating in both health and financial terms. And it does not need to be severe or life threatening disease as doctors' bills, allied health bills and pharmacy expenses add up. None of us should accept for a minute that any of our patients should have to decide between paying rent, or food; and buying medication or seeing a doctor. This proposal is a blunt tool, it has no merit outside of an accounting point and as a profession we need to speak out against it. There are other and better ways to future proof our health system. Any changes need to be debated by the community. The debate needs to be open and informed. That the issues are complex should not impede debate; and please let's all park our dogma at the door.

The AMA, VMOA and ACT Health Directorate have now swung into the implementation and oversight phase of the VMO contract negotiations. Our considerations at this time include arrangements for the next negotiation round. Since the new contracts allow for harmonisation of current contracts, the next round will represent an all of profession exercise. The initial phases of the last negotiation were marked by an unattractive scramble as the AMA and VMOA sought the required authorisations to act as bargaining agents. The process served effectively to make us competitors, which we should never be. We have always in the past worked with the VMOA in a spirit of cooperation and mutual respect to ensure the best outcome for the VMOs contracted to ACT Health. The AMA has never sought to exclude other representatives from the process.

In order to prevent such a scramble in the next round, which can only serve to sow the seeds of suspicion and mutual jealousies, we have proposed a change to the legislation to allow for any organisation, currently eligible under the Act, which is nominated by at least one member of at least three of the VMO categories named in the contracts to be appointed as a bargaining agent to the negotiation process. The Act currently requires the Minister to be satisified that an entity is eligible to represent VMOs in this process as a bargaining agent and with suitable safeguards as to their continuing eligibility to represent VMOs. The AMA and VMOA both comply; our proposal does not limit eligibility any more than the current Act, but will help bargaining agents to maintain their focus on negotiations with ACT Health rather than positioning against each other.

Without wishing to diminish this spirit of mutual respect I remain disappointed at some of the scuttle–butt going around about the performance of AMA in the most recent negotiations. It is said that by advocating for physicians and GPs to be paid the same rate as other specialists, those other specialists have in some way lost out. This is complete rubbish. It is true that we were the only group prepared to argue at all for GPs during the process, and the only agent actively arguing for physicians' equity; but this decision was made completely separately from the arbitration on indexation. I consider the indexation arbitration outcome counterintuitive, both the AMA and the VMOA argued vigorously and cooperatively for a more reasonable deal. Neither of us agreed to the ACT Health proposals, but we are all bound by the arbitration decision; a process for which we both gave authorisation.

There is also a nonsense whisper that the AMA went soft on other claims, and that we agreed to an erosion of rights under the contracts. What is fact is that many of the claims made by ACT Health were dismissed as a result of AMA argument before the arbitration process began. A number of ambit claims had been made by others, the expectation was expressed that arbitration would award a middle way on these; but I am sorry to say that reflects a view of industrial relations

that no longer prevails. The AMA did not oppose any claims made for VMOs, nor did it bargain away any of these; but concentrated our arguments on issues of merit that were winnable.

When last I wrote I was on my way to a six day walk through a southern New Zealand wilderness. This involved a memorable journey through amazing alpine and forest landscapes. In particular I found the silence of the huge beech forests disturbing amongst all that natural beauty. The silence reflects mass extinctions of local fauna caused by introduced species. We were granted a rare view of a flock of Mohua, a wren species that is so few in number that it may not last beyond this year. It was a sobering experience sitting on the forest floor watching and listening to these diminutive yellow birds knowing the authorities' expectations of their fate.

One week after tripping gently from rock to rock over these alpine passes, not quite singing about hills and music, but nevertheless feeling on the top of the world, I found myself in the catheter lab at TCH with an occluded LAD. The doctor became a patient. To say that I have found this transition easy would not really touch reality; but as a neighbour of ours philosophised, we should all expect it. I would like to record here my sincere thanks to all the staff in the cardiology unit, cardiac rehab and coronary care units. The high quality and expedient care I received left an indelible impression and a great debt of gratitude; and I have witnessed at first hand just how frantically busy they are, and yet how constantly humane and considerate.

AMA welcomes Minister's willingness to resolve doctor contract crisis

The Federal AMA, AMA Queensland (AMAQ), and other doctor groups welcome the decision of Queensland Health Minister, Lawrence Springborg, to enter into a 'new dialogue' with the medical profession to resolve the Senior Medical Officer (SMO) contract crisis that threatens to cripple Queensland health services.

Mr Springborg and Assistant Minister for Health, Dr Chris Davis, met recently with Federal AMA President, Dr Steve Hambleton, AMAQ President-elect, Dr Shaun Rudd, and SMO leader, Professor John Fraser.

Dr Hambleton said the meeting was productive.

"Our aim was to convince the Government of the overwhelming concerns that senior doctors have with the current contracts, and to agree on a pathway to satisfactorily resolve these concerns," Dr Hambleton said.

"With the cooperation of the Ministers, we achieved that aim.

"It is only the first step. But it is a significant step.

"The Minister assured us that he wanted a strong and productive relationship with all doctors in Queensland Health, and that there should be a fair and just process to resolve our remaining concerns that are the sticking points at the heart of doctor resistance to sign the contracts.

"The Minister committed to a process that will involve the Federal AMA, AMAQ, the Australian Salaried Medical Officers' Federation (ASMOF), ASMOFQ, Together Queensland, and other SMO representatives.

"The first meeting to achieve 'real repair' and a 'real solution' will be early next week.

"We will work constructively with the Government to get a positive result for senior doctors and ensure that the public hospital system has an engaged, motivated, and respected medical workforce."

Legal advice brands Queensland Doctor contracts as "draconian" and "inferior"

Ahead of the meeting referred to above, independent legal advice from prominent Queensland Barrister, Dan O'Gorman SC, confirms that proposed contracts for Senior Medical Officers (SMOs) being offered in Queensland are unfair and draconian.

In advice provided to AMA Queensland, Mr O'Gorman, says, inter alia:

- the contracts in their proposed format will result in SMOs "being employed on terms and conditions that are inferior to those presently in place for SMOs";
- "the contract is a draconian contract of employment";
- "…There is no explanation why the contracts are being introduced at this time when the present employment arrangements for SMOs were not due to expire until June 2015; and the contract, unlike current arrangements, does not provide for a number of matters such as accrued days off, extended span of ordinary hours work; public holidays; rosters for work in an extended span of ordinary hours; overtime; and on-call allowances.

Federal AMA President, Dr Steve Hambleton, said the legal advice exposes the proposed contracts as an attack on doctors and their basic workplace rights and conditions.

"The Queensland Health Minister is treating the hardworking hospital doctors of Queensland with the utmost contempt," Dr Hambleton said.

"Minister Springborg is causing stress, distress, and anger among the entire medical workforce of the State.

"These contracts must be torn up and the Minister must immediately return to the negotiating table to produce fair and balanced contracts in good faith with the people who spend their working life saving lives and improving lives around the clock in the hospitals of Queensland."

The AMA and ASMOF have for months highlighted the unfair nature of these contracts to the

Health Minister and Queensland Health, but these concerns have been ignored.

Meetings at hospitals throughout the State – attended by hundreds of doctors per meeting – have resolved to reject these contracts.

Dr Hambleton said that the Queensland Government must dump the contracts or the Queensland community would face an exodus of doctors from the public hospital system that will make it much harder for Queenslanders to access quality health care services.

‘Unprecedented’ exposure of children to alcohol marketing shows self-regulation has failed

The AMA is calling immediate action following the release of a damning report by the Australian National Preventive Health Agency (ANPHA) showing young people are being exposed to unprecedented volumes of drinking ads.

As support builds for the AMA’s call for a National Summit on alcohol misuse, the ANPHA report found that current regulations on the placement and content of alcohol advertising are failing to protect Australian children and, in some cases, are facilitating their exposure to alcohol advertising.

AMA President Dr Steve Hambleton said the existing regulatory regime was badly flawed because it was voluntary, limited in scope, poorly enforced and without meaningful penalties for breaches.

“Ultimately, it fails to protect young people from continuous exposure to alcohol marketing,” Dr Hambleton said.

The ANPHA report found that young people were being exposed to an unprecedented volume and variety of alcohol marketing, despite industry self-regulation.

Dr Hambleton said one of the most obvious failings was a loophole in the Commercial Television Industry Code of Practice that allowed alcohol to be marketed during live sports broadcasts, exposing many children and adolescents to alcohol advertising.

“We have great concerns,” the AMA President said.

“The sheer volume of alcohol marketing that is reaching our children is extraordinary, showing that industry self-regulation is failing.”

The ANPHA report found evidence that alcohol advertising influenced the behaviour of young people, leading them to begin drinking at an earlier age, and to consume alcohol more frequently and more heavily – establishing patterns of harmful drinking behaviour that persisted later in life.

Dr Hambleton said this made it imperative to curb alcohol marketing to young people.

“Let’s begin to fix the alcohol misuse in this country by starting with our children,” he said.

“The current system of self-regulation is inadequate. We need tough, legislated measures.”

The overall social and economic cost of alcohol misuse to the Australian community is estimated to be in excess of $15 billion per annum.

“This is an enormous impost on the community, and is in addition to the individual stress and harm caused by alcohol misuse,” Dr Hambleton said.

“The evidence is clear. We know what needs to be done to reduce this terrible toll.

“The AMA alerts Prime Minister Tony Abbott and Health Minister Peter Dutton to this opportunity to make one of the structural changes being sought by Treasurer Joe Hockey to reduce the financial impact of alcohol misuse on our community,” Dr Hambleton said.

In its report, ANPHA stopped short of the AMA’s call for an independent statutory regulator for alcohol marketing, but nonetheless recommended a raft of reforms to strengthen regulations and address gaps.

“While the AMA believes the recommendations could go further, ANPHA’s report supports the AMA’s calls for urgent reform and represents a step in the tight direction towards protecting our young people,” Dr Hambleton said.

In 2012, the AMA published a report detailing how alcohol companies were using a wide range of techniques, including promotions through social media, to market their products to young people and recommended tighter regulations on alcohol marketing.

“We need a National Summit on alcohol misuse to ensure we get a comprehensive strategy to reduce alcohol-related harm, of which the exposure of children to alcohol marketing is but one part,” the AMA President said.

The AMA will present its views in a submission to ANPHA as it prepares its final report.

The *Alcohol Advertising: The effectiveness of current regulatory codes in addressing community concern* draft report can be viewed at http://anpha.gov.au/internet/anpha/publishing.nsf/Content/draft-report-alcohol-advertising+

Pilot alcoholic project to empower NSW communities

A new project launched recently will offer NSW residents much needed support to address alcohol-related harms in their local communities.

“The establishment of the Alcohol Community Action Project provides a lifeline to groups across the State that struggle to challenge liquor licensing decisions in their communities. We want to demonstrate in a practical, tangible fashion, the need and value of this service in NSW. In recent weeks we have seen the NSW government announce some welcome measures, but it is also important that members of the public who want to keep their local communities safe, are heard and not hindered by government”, said Michael Thorn, Chief Executive of Foundation for Alcohol Research and Education (FARE).

ACAP project manager, Tony Brown, led community demands for action on alcohol harm in Newcastle in 2008 and was instrumental in the introduction of a new set of conditions including a reduction in late-night trading hours of licensed premises. The “Newcastle Conditions” resulted in a 37% reduction in alcohol-related assaults and a strong and more diverse night-time economy.

The project is jointly funded by FARE and the Australian Rechabite Foundation.

Study shows recycled computers give away our most personal information

A two-month study commissioned by the National Association for Information Destruction has found significant amounts of personal information left on recycled computers. For the organisations recycling their drives, this is a data breach problem. For individuals, some of their most private information is at risk.

The new Privacy Act reforms effective on 12 March 2014 require organisations to be more vigilant with respect to managing and safeguarding people's personal information. The study showed that 15 of the 52 hard drives randomly purchased, approximately 30 percent contained highly confidential personal information. And, while seven of the 15 devices had been recycled by individuals, eight had been recycled by organisations, including law firms operating in Victoria and Queensland, a government medical facility, and a community centre. All of these have a legal obligation to protect the public's information.

"The effective disposal of confidential information is an issue that is easily overlooked", said NAID CEO, Bob Johnson. "We consider it a public service to remind of this vulnerability".

"It is a noble idea to recycle a computer, tablet or smartphone", said Mario Bekes, Insight Intelligence's Managing Director, "but it's important to know the recycling company has the proper technical expertise and takes data destruction seriously."

The AMA will provide advice to its members on the impact of the new reforms and the AMAs Privacy Policy is available on its website for members to review.

New and revised guidelines from AHPRA

AHPRA has recent released new guidelines for mandatory notification which come into effect from mid-March 2014.

The guidelines "reassure doctors that the aim of the mandatory notification requirements is to prevent the public from being placed at risk of harm. The intention is that practitioners notify AHPRA if they believe that another practitioner has behaved in a way which presents a serious risk to the public."

The guidelines advise that if the only risk is to the practitioner alone, and there is no risk to the public, the threshold for making a mandatory notification would not be reached.

"For example, in a case where the risk is clearly addressed by being appropriately managed through treatment and the practitioner is known to be fully compliant with that, mandatory notification would not be required. Conversely, a mandatory notification is required if the risk to the public is not mitigated by treatment of the practitioner or in some other way," the guidelines state.

AHPRA has also revised its guidelines in relation to advertising that set down the (national) Boards' expectations of registered health professionals in relation to advertising.

The use of testimonials when advertising a regulated health service, or a business that provides a regulated health service, is specifically ruled out.

The new guidelines come into effect on 17 March 2014 and have been the subject of consultation with the community and the professions and were informed by three years' experience with the current guidelines.

A breach of the advertising requirements in the National Law is an offence and carries a maximum fine of $10,000 for a body corporate or $5000 for an individual per offence. A breach of the advertising requirements may also constitute unprofessional conduct and/or professional misconduct and can be dealt with by the national boards through disciplinary mechanisms available under the Law. This can lead to restrictions on the practitioner's registration and ability to practise.

AHPRA's revised guidelines and codes of conduct, and a new social media policy, have also been recently released with an implementation date of mid-March 2014. Members are advised to visit the AHPRA website and familiarise themselves with the changes (www.ahpra.gov.au).

AMA Council of General Practice report

The AMA Council of General Practice (AMACGP) held its first meeting for 2014 over the 22-23 February weekend. The Council considered the AMA's position on a number of significant GP issues including:

- proposal for a co-payment for GP visits and GP financing more generally
- medical deputising services and the existing AMA position statement
- the future role of primary health care organisations in Australia
- teaching in general practice and how it can be better supported; and
- the benefits of integrating pharmacists into general practice.

Dr Suzanne Davey, a Canberra GP, and member of the AMA ACT, Board represents the ACT at the AMACGP provided the following key points from the meeting:

Dr Steve Hambleton, AMA Federal President, addressed the meeting on several issues and:

- advised AMA constitutional reform was necessary so that the AMA could better serve its members and meet concerns regarding corporate governance
- described being part of a panel of 3 reviewing the PeCHR which submitted 34 recommendations to the Federal Government in December 2013. No report has been released yet
- noted the review of Medicare Locals in occupying the non-

hospital health space is also still pending. Chronic care management is the major problem. The Government is investigating coordinated care trials involving patients with high needs to keep them out of hospitals. There may be a role for private health insurers in chronic care management

- advised the issue of the Authority script health line remains unresolved
- Pharmacy Guild wants its pharmacists to be able to give immunisations and the AMA is totally opposed to this. The only thing that the AMA and Pharmacy Guild agree on is the provision of medication sheets as a script in nursing homes
- alerted us to the fact that there would be new medical graduates who would not get a hospital or GP training position
- the current issue of the $6.00 co-payment does not add up economically for the government, because the real health care cost blow-out is in hospital care not general practice. The Australian Government's real expenditure on GPs has only gone up 0.18% per annum since 2007

The Council also discussed the following:

- Pharmacists in general practice setting: the feeling of the meeting was that it was OK to have a pharmacist under the same roof as a general practice, in an advisory capacity about drug use. However, any arrangement that could be perceived as doctors selling drugs on a commercial basis from their rooms, via their employment of a pharmacist, was not acceptable
- Barriers to teaching in general practice were discussed. Note was made that the Coalition has committed to investing $52.5 million to expand existing general practices for teaching and supervision. As one of the activities of Family Doctor Week, the AMA will launch a "barriers to teaching" survey of members
- The "Medical Home" logo is to be used for family Doctor Week, with AMA initials added. There was a discussion as to whether this could be used as an icon to denote AMA GP members
- The topic of GP financing was discussed, keeping in mind that the current government won't raise taxes to fund an increased health budget. It was pointed out that flow-on services from general practice, that is, pathology, radiology, the PBS and referral to specialists, plus the costs of hospitalisation of an aging population was where the health budget is blowing out, not in general practice costs per se. The government is not focused on health outcomes, just costs. It was acknowledged that fee-for-service does not reward longer consultations or the non face-to-face time for GPs, so some type of blended payment is inevitable. The concept of payment for processes rather than outcomes was preferred, as different practices are so disparate. This would require a new model for PIP payments. If the concept of PIP payments is not retained then the PIP money will be lost to general practice. Different parameters for inclusion in the PIP were discussed, such as rewarding aged care home visits which would in turn lead to less hospitalisations. The new PIP should be designed to incentivise quality improvement in health care delivery in a general practice setting
- The AMA does not support the co-payment system because it is based on the premise that many GP visits are unnecessary and there is no evidence to support this. Co-payments will drive more patients to emergency departments
- The role of private insurers in general practice was discussed such that insurers would cover the gap between the scheduled fee and what the doctor charges. Private insurers may be involving in funding aged care visits, health checks and chronic care coordination, to keep their clients out of hospital. The AMA has provided a revised draft for their position statement entitled "Private health insurance and primary care services"
- For discussion at the next meeting is the proposal to increase general practice representation on Federal Council so that it better represented actual numbers of GPs in the AMA.

Suzanne Davey encourages AMA member GPs to contact her regarding any of the above discussion items.

Changes to Notification of Cause of Death

The ACT Legislative Assembly recently passed an amendment to the Births, Deaths and Marriages Registration Act 1997 to maximise the appropriate issue of cause of death certificates by doctors and avoid the need for unnecessary coronial investigations. The amendments provide that a doctor must give the Registrar-General written notice of the death and cause of death of a person within 48 hours, if the doctor:

a) was responsible for the deceased person's medical care immediately before the death; or
b) examined the body of the deceased person after the death; or
c) has considered information about the deceased person's medical history and the circumstances of the deceased person's death and is able to form an opinion as to the probable cause of death.

Note: Option (c) has been added to the legislation. Some examples of situations in which it might apply are when the doctor has been able to examine medical records or speak to the deceased person's treating doctor. This option may also apply when the doctor has heard an account of someone who was with the deceased person when the person died, or who discovered the deceased person's body. Additionally, colleagues of treating doctors, as well as forensic pathologists, will be able to issue cause of death certificates.

ACT Government moves to ban sugary drinks in government schools

Sugary drinks will be removed from ACT Government schools by the end of 2014 and in vending machines in public schools by the end of term one, Chief Minister and Minister for Health, Katy Gallagher announced recently.

"The ACT Government has a clear plan to reduce the number of people who are overweight and obese and a key way to achieve that is to reduce the availability of sugary drinks to children," the Chief Minister said.

"The government is taking a firm approach to this plan and will remove sugary drinks from vending machines by the end of this term and then remove them from canteens by the end of this year."

This decision by the ACT Government works towards the commitment in the Towards Zero Growth – Healthy Weight Initiative, launched last year, to develop an ACT Government school food and drink policy with the supporting guidelines that will mandate the implementation of the National Healthy School Canteen Guidelines in ACT Government Schools.

"Fresh Tastes is an exciting program which supports classroom learning about good nutrition and growing, cooking and selling healthy food and drink in ACT schools. Fresh Tastes also provides optional and practical information for parents to help with packing healthy choices into lunch boxes," the Chief Minister said.

Minister for Education and Training, Joy Burch said the phasing out of sugary drinks would be accompanied by increased provision of water refill stations and reusable drink bottles in government schools.

The Chief Minister concluded by encouraging all ACT schools, not just government schools, to take part in the Fresh Tastes program and to embrace the move to take sugary drinks out of canteens and vending machines.

"We must not allow the next generation of children to grow up with the same bad eating and drinking habits that some adults are now paying the price for," the Chief Minister said.

The ban on sugary drinks will not apply to occasional fetes and fundraisers held twice per term, although the government hopes that by sending a strong message about access to sugary drinks, fetes and fundraisers will also look to provide healthier alternatives," the Chief Minister concluded.

AMA welcomes the Government's decision

The AMA welcomes the ACT Government's decision to ban the sale of fruit juice and soft drinks in Canberra public schools.

AMA President, Dr Steve Hambleton, said the ban sends a very strong signal to improve the health and wellbeing of children attending government schools in the ACT.

"Soft drinks and fruit juices can be enjoyed occasionally as a treat but there is no doubt that consuming these products daily is inconsistent with a healthy diet. Positioning these in schools so that they are available everyday sends the wrong message

"Obesity is a major public health issue in Australia and it is important that healthy diet and exercise messages are conveyed to our young people, including in the school environment.

"The ACT Government has done a great job to show leadership in reducing the alarming rates of overweight and obesity in our young people.

"National figures confirm that around a quarter of Australian children are overweight or obese.

"Initiatives such as the sugary drinks ban need to be followed up with action from all governments to reduce the targeted marketing of unhealthy foods and beverages to children, simplify food labelling, and increase opportunities for physical activity among all children and adults," Dr Hambleton said.

A recent Working Paper released by the Australia Institute of Health and Welfare identifies Type 2 diabetes in Australian children and young people identifies as an area of concern. Type 2 diabetes has typically been a disease of older people but is now occurring among children. Overweight and obesity is a known modifiable risk factor in the development of Type 2 diabetes.

AMA tells Food and Grocery Council to stop undermining health star rating system

In a recent statement, Dr Steve Hambleton urged the Australian food industry to stop undermining the implementation of the new five star rating system for food nutrition.

Dr Hambleton said the AMA was very concerned that the Australian Food and Grocery Council (AFGC) had been lobbying against the system on the day that the Assistant Minister for Health's office ordered the new system's website to be shut down.

"Even though they worked closely with the public health sector on the development of the new system, AFGC has lobbied against the consumer-friendly food labels since they were agreed by the Federal and State governments last year", Dr Hambleton said.

"The system's website was to be a major part of the public education campaign to make people aware of the new system and how it works.

"It is important that consumers are fully across the system before the new labels appear on supermarket shelves.

"The health star rating system for food and beverages is a major public health initiative that will place Australia as a world leader in helping to reduce alarming rates of overweight and obesity in Australia.

"It is time the food industry and its peak Council did the right thing and put their full support behind a bold initiative that will help people make healthier food choices and take some pressure off the health Budget," Dr Hambleton said.

Medical tourism – an emerging ethical dilemma

By Marie Mansfield

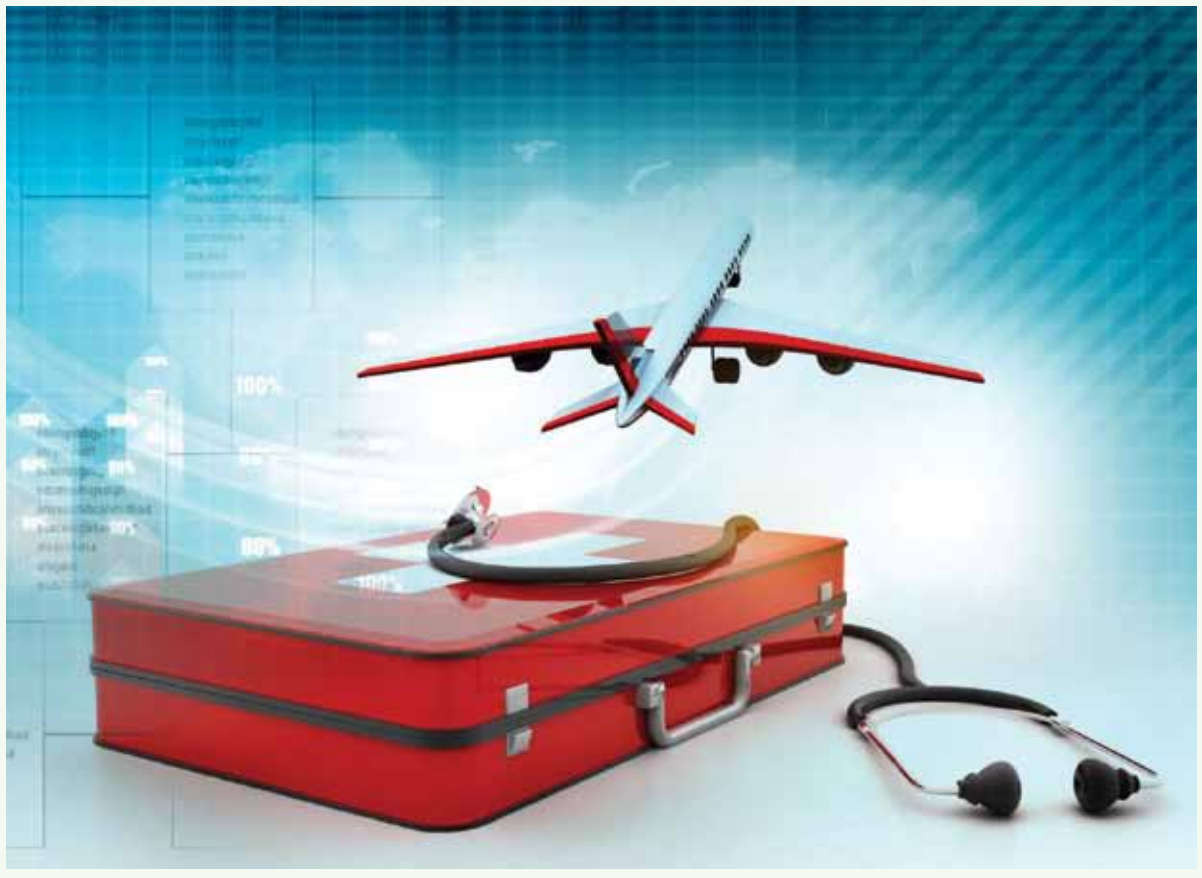
"But Doctor, I can't work with my knee like this and I can't afford to take more time off. I know a friend who had surgery in India and he's alright. Should I go to somewhere else to get my knee done?"

It seems radical to think Australians are leaving one of the best health care systems in the world to receive medical care in developing countries that have many social issues including provision of health care to their own people. However this situation is being seen more commonly around the world and is likely to become more commonplace in Australia with increasing waiting times for surgery and increased costs for private health care. Around the world these pressures as well as burdens from unaffordable health insurance in the US and lack of local availability of some treatments are pushing patients from affluent countries with highly developed health care to Asia, South America, Central America and South Africa.

Medical tourism is defined here as travel for the intent of receiving medical care outside the traveller's national health jurisdiction (although there are varying definitions). The services sought by patient travellers vary according to what is available in their home country, ranging from minor dental procedures, cosmetic procedures, joint replacements and heart surgery. Although worldwide statistics on numbers of patients travelling for health care are unavailable or unclear, it is known that there has been an increase in demand for these services and this is likely to continue in the future with increasing investment in the industry.

There are many reasons why patient travellers choose to receive care outside their own nations. Dental care in particular has been highlighted as a significant reason for travel for Australian patients given there is no provision for access to dental care via Medicare. For other countries without a universal health care system, treatment can be prohibitively expensive leading patients to seek care elsewhere at a more affordable cost even with health insurance. Common to many countries is the lack of access to many treatments whether they be experimental or illegal (such as bariatric surgery, stem cell therapy and physician assisted suicide) leading to patients travelling overseas.

Of course, increasing numbers of foreign patients for hospitals in developing countries can have benefits to the community. Increasing demand for medical tourism services has led to the development of governmental agencies to promote this industry (and thus improve the local economy) and improvement of local medical service. This includes government investment in the health care system getting accreditation for local hospitals from the WHO and other international bodies. Governments and local hospitals have also arranged partnerships with well-known developed nation universities (e.g. Johns Hopkins, The Mayo clinic, Duke University) to establish medical schools and training programs hence improving the quality of care available in these countries. Increased fee-paying foreign patients will also attract local specialists and surgeons back to their home country and hence reduce the "brain drain" of local citizens migrating to other more profitable nations to practice. The return of these doctors aims to improve the quality of care for local patients and patient travellers.



Given the quality of medical care potentially available it is understandable to expect an increase in demand for overseas medical services. This is particularly true for jurisdictions where health care is very expensive. The US is a prime example of this with some health insurance agencies and corporate bodies looking to provide more foreign care in an effort to reduce costs. This idea has had a mixed response as patients from developed nations could be forced into cheaper health insurance for overseas care that is not of the same quality as home. The NHS is even considering outsourcing medical care to India in order to reduce waiting lists at home and Japanese companies are beginning to outsource medical care for their employees due to the increasing pressures on the local health care system. International trade agreements foster the movement of international patients further promoting medical tourism.

It is unclear however if local patients receive all these supposed benefits from improvement to the quality of local health care. Government investment in the private sector has potential to negatively impact local health care provision. In India for example, the government has invested greatly in improving services for foreign patients including medical visas, tax exemptions and land provision. By having a fee-paying system for foreign patients and higher classes, medical tourism has effectively encouraged a two-tiered health care system that caters well for the needs of the higher classes that can pay but is limited in the care that is given to local patients without the means to afford this treatment. Similarly, increasing pay and conditions for working in the private sector may be contributing to difficulties in retaining staff in the public sector therefore further degrading the quality of care received by poorer local patients. It could be argued that by making higher quality care less attainable for local patients, it is denying them the right to "the highest attainable standard of physical and mental health" as stated in Article 12 of the International Covenant on Economic, Social and Cultural Rights.

With all these factors, it is difficult to know how to advise patients about medical tourism. The subject may not come up as many patients feel embarrassed about seeking health services overseas and may not want to talk about it or consult doctors about this. This has significant implications on return if patients experience complications as they may prolong the time taken seek health care worsen their condition. There is a lack of data about how many patients from Australia travel to access health services and an equal lack of data about how many of these patients experience complications and require further treatment on returning home. This makes it difficult for patient travellers to make informed decisions about their health care and has been highlighted as an area for further research by many. It is also unclear how much information is required for consent in different countries and therefore how much information is available and understood by patients before undergoing these procedures. A lack of health literacy on the part of the patient has been highlighted as an area of concern by professionals dealing with medical tourism.

First and foremost, the role of the doctor has always been "do no harm". However, patient autonomy to choose how they receive health care should be respected. To satisfy both legal and ethical obligations, the most important course of action is to encourage patients to research their options both at home and overseas in particular the qualifications of doctors and the quality of the hospital if they are considering overseas health care. The AMA and ADA do not recommend medical tourism but also encourage patients to thoroughly research their options if they choose to go overseas for treatment. Patients should also be warned of the risks of overseas medical care including multi-drug resistant infections, increased risk of DVT and consequences of potential complications. Complications that follow can be difficult to retrieve particularly cases of surgical complications often requiring further expensive surgery and often a degree of permanent deficit. For the patient traveller, there are always risks associated with medical treatment and these risks may be exacerbated by travel. Unfortunately, if these risks are borne out, regulation in this area virtually non-existent. There are limited avenues for redress for patients experiencing complications and it is difficult if not impossible to pursue legal action across borders. Treatment of complications raises further ethical concerns about the distributive justice of treating these patients out of the public purse when they chose to leave the country for these treatments.

A major concern is the lack of continuity of care after treatment overseas and documentation gap that can negatively impact on care in their home country. While patients have a right to request their medical documentation from the treating doctors overseas, they are often unaware of this and can come home without records of what treatment they received. The treating hospital and physician may also be unwilling to give documentation and are uncooperative to requests from home doctors regarding tests results and operations reports. Patients should be informed that they have a right to ask for this information and difficulty in obtaining these records could be an indication of poor quality of care.

Doctors also have a role in improving medical care at home and reducing the "push factors" that entice patients to travel overseas for treatment. Dental procedures are a major reason for travel largely driven by the lack of public funding for dental care. The medical community has a role in advocacy for patients to improve access to health care services that are otherwise unattainable.

Medical tourism has been heavily invested in by governments and the private market. Given the large market for these services the challenge it poses to doctors in Australia and providing care for their patients is going to continue. There are ethical concerns about patients travelling for health care on many levels and it can be difficult for both patients and doctors to reach a satisfying decision all round. Encouraging patients to make informed choices about their health care is probably the most important action doctors can take on this matter and upholds legal and ethical standards to ensure optimum patient care. On a community level, advocacy for improving health care delivery at home is also important for reducing the push factors that drive patients to travel.

Marie Mansfield is a Year 3 student at the ANU Medical School. References are available from the author.

AMA reveals flaws in Australian Centre for Health Research co-payment proposal

AMA President, Dr Steve Hambleton, recently wrote to Health Minister, Peter Dutton, outlining significant flaws contained in the paper issued by the ACHR advocating a GP co-payment. This comes amid a flurry of media reports around the Government's interest in finding ways of curbing the rising costs of health care in Australia.

Health Minister, Peter Dutton.

The AMA sought independent economic advice with respect to the ACHR proposal, which highlighted significant flaws in the assumptions relied on by the ACHR. The analysis showed that the co-payment would not deliver the projected savings, while the proposed freeze on rebates would see around $1.1b ripped out of patient rebates.

The AMA believes that the growth in Government expenditure on rebates for GP services is very moderate and well able to be sustained and, in fact, should be better funded. The Productivity Commission's 2014 Report of Government Services shows that the Australian Government's real expenditure on GP services has risen just $2.80 for each Australian over the past five years.

Eligibility for PIP teaching payments clarified

The Commonwealth Department of Health has advised the AMA that practices that receive support via Rural Clinical Schools, which are funded by the Australian Government under the Rural Clinical Training and Support (RCTS) program, are considered eligible for PIP teaching payments.

"The PIP teaching payment guidelines outline that practices are ineligible for PIP teaching payments if *'the supervising GP is paid for teaching activities through other Australian Government funded teaching programs'*. This restriction is in place to ensure that the Australian Government does not make multiple payments to a practice for the same activity.

"The Department recognises that practices that receive payments or support via third parties that are funded by the Australian Government should not necessarily be ineligible for PIP teaching payments and has undertaken to consider these on a case-by-case basis where not clear.

"With regard to practices that receive support via Rural Clinical Schools, which are funded by the Australian Government under the Rural Clinical Training and Support (RCTS) program, these are considered eligible for PIP teaching payments.

For further information on PIP teaching payment members should:

- refer to the PIP teaching payment guidelines available at humanservices.gov.au/healthprofessionsals then Incentives and Allowances > Practices Incentives Program > Forms and guidelines; or
- contact the Department of Human Services via email at pip@humanservices.gov.au or phone on 1800 222 032.

Healthcare access at risk unless Government invests in general practice training

Access to affordable and timely healthcare in both rural and urban settings will be at risk if the Government fails to invest in general practice training, according to Australia's general practice leaders.

At the United General Practice Australia (UGPA) meeting held in Melbourne recently, GP leaders agreed that greater support of the general practice profession will lead to improved health system efficiency; a role that Australian general practice is already excelling in.

The most recent Medical Workforce 2012 report released by the Australian Institute of Health and Welfare (AIHW) showed a decline in the supply of GPs, despite recent increases to GP vocational training, whereas other specialty areas demonstrated overall growth and for the first time outnumbered the total figure of GPs in Australia.

UGPA is asking Government to show a commitment to general practice in the upcoming federal budget by investing in the expansion of programs that provide international medical graduates (IMGs) with adequate supervision and support by increasing community based general practice placements and vocational training numbers to a minimum of 1700 per annum by 2017.

Australians should feel confident in accessing primary healthcare services – regardless of location and timing – that an appropriately trained doctor will meet their healthcare needs. This must be backed by an increase in training places to ensure appropriate supervision provided at the vocational training level is delivered if specialty recognition has not been met.

General practice is the most efficient and cost effective way to deliver quality patient care and successfully manage the rising burden of chronic and complex disease; treating the issue before secondary and tertiary care services is required.

UGPA acknowledges the Government's recent investment in rural infrastructure grants and urges the Government to direct the grants to general practices that can demonstrate the greatest community impact to ensure the optimal outcomes of this program are achieved.

Members of UGPA agreed that increasing the number of general practice training places is a positive initiative, provided clinical supervision capacity issues and appropriate infrastructure to facilitate high quality training were adequately addressed.

(UGPA comprises the Royal Australian College of General Practitioners (RACGP), the Australian Medical Association (AMA), the Australian General Practice Network (AGPN), General Practice Registrars Australia (GPRA), the Australian College of Rural and Remote Medicine (ACRRM), and the Rural Doctors Association of Australia (RDAA).)

REMINDER:
Time is running out for inclusion in the **2014 Directory of GPs with special interests**

Entries in this directory will close on 28 March 2014 and must be on the form provided. Additional forms are available on the website: **www.ama.-act.com.au**

REMINDER:
Entries for inclusion in the **2014 Specialist Directory close on 30 April 2014** and forms are available on the website: www.ama-act.com.au. Specialists who were included in the 2013 edition will have their entry repeated unless contrary advice is received.

There is no charge for an alphabetical listing but the opportunity to advertise is provided and sizes and charges can be found on the website.

DEADLINE FOR ENTRIES 28 MARCH 2014

2014 DIRECTORY OF GPs WITH SPECIAL INTERESTS

… a publication of the AMA ACT

AMA (ACT) LIMITED

This new directory of GPs with special interests will be published as a service to ACT General Practitioners and will be distributed with the annual Specialist Directory and the new **Directory of Allied Health Professionals** during Family Doctor Week 2014. Entries must be on this form and returned to the address below no later than 28 March 2014. Late entries will not be accepted. Entries in the directory are at no cost and AMA membership is not a requirement for entry in the directory.

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Fax: 6273 0455

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I am/am not interested in taking a display advert to accompany my listing in the directory.

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AHPRA registration number: _____

Note: In order to be included in this directory,it is mandatory that you are a medical practitioner currently registered with the Australian Health Practitioner Regulation Authority (AHPRA)

NOT FOR PUBLICATION

Contact Phone: _____

A proof of your entry will be sent prior to printing. Please indicate preferred method to receive this:

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Heart and stroke risk: a catalyst for conversation

NPS MedicineWise is reminding health professionals that while various media reports have recently linked statins to a variety of adverse events and questioned their efficacy, these drugs remain one of the most effective strategies for reducing the risk of cardiovascular disease (CVD).

The latest edition of Medicinewise News – Heart and Stroke Risk: a Catalyst for Conversation has been distributed this week to 65,000 doctors, pharmacists and other health professionals around Australia.

It examines the latest evidence about determining absolute CVD risk, and treatment options including statins.

Clinical adviser at NPS MedicineWise, Dr Andrew Boyden, says that CVD is largely preventable but is still the most common cause of death in Australia.

"Statins are the most effective lipid-modifying drugs, but the benefit of a statin is greatest for those at greatest absolute risk of a cardiovascular event, including those with established CVD," he says.

"It's important that statins are used in the people for whom the benefits are most likely to outweigh the potential harms. For most people at high risk of heart attack or stroke, the benefits of lowering cardiovascular disease risk with a statin generally outweigh the risk of possible adverse effects."

Guidelines recommend that absolute CVD assessment should provide the basis of CVD risk assessment and treatment. The latest edition of MedicineWise News provides a reminder for health professionals on how to determine absolute CVD risk (including who needs assessing and how). It includes a step by step guide to drug and non-drug treatment, and key points about the importance of managing lifestyle factors in all patients.

The mailout to health professionals also includes a copy of the Statins – Frequently Asked Questions fact sheet for patients.

"NPS MedicineWise is urging health professionals to ensure they are up to date with the latest evidence and guidelines and work in partnership with their patients to manage their risk of CVD," says Dr Boyden.

Medicinewise News – Heart and stroke risk: a catalyst for conversation is being distributed by post this week.

To read it online, or to print additional copies of the Statins – Frequently Asked Questions fact sheet for patients, go to www.nps.org.au/medicinewise-news-heart-and-stroke.

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ACT Primary Health Care Innovation Grant Fund: applications closing soon

The Primary Health Care Innovation Grant Fund (replacing the former GP Development Fund) is open for applications but interested GPs will need to act quickly as applications close at 5.00 pm on 21 March 2014.

In the 2009 report "General Practice and Sustainable Primary Health Care – The Way Forward", it is stated that "Canberra is well placed to explore new models of care and become a centre for innovative ways of providing primary health care to the general community". In line with National Healthcare Agreement, this includes the goal that 'Australians receive appropriate high quality and affordable primary and community health services.

It is anticipated that the initiatives funded under the Primary Health Care Innovation Grant Fund may also be able to support the reduction of demand for acute services and the improvement of the quality of life for population groups in the ACT.

The Primary Health Care Innovation Grant Fund will give funding priority to applicants who seek to support innovation in areas such as:

a. Models of care
b. Leadership/Management
c. Teaching
d. Research
e. Training
f. Information Technology

In addition, applications that show innovative approaches to improving access to primary health care services for population groups who are marginalized or disadvantaged will be encouraged, as well as projects that involve collaboration of multidisciplinary providers.

ACT Health's Reconciliation Action Plan 2012–2015, requires that grants processes reflect a requirement for initiatives that contribute to reconciliation and closing the gap, and improving local Aboriginal and Torres Strait Islander health.

Further information is on the ACT Health website and appplications should be lodged at https://acthealth.smartygrants.com.au/CHCIGF and queries can be directed to Rachel Pickrell on 6205 2371.

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Dr Roberts specialises in hand and upper limb surgery. He came to Canberra on rotation for 6 months in 1990, enjoyed it so much he decided to settle here with his family and has been here ever since.

He is active in teaching, having been involved in the establishment of the musculoskeletal component of the Australian National University Medical school.

He is involved with humanitarian Orthopaedics, visiting Sri Lanka after the 2004 tsunami, and regularly volunteers as part of the Orthopaedic services provision for the Pacific Islands Project.

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Entries for inclusion in the **2014 Specialist Directory** close 30 April 2014

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