AUSTRALIAN
Medicine
The national news publication of the Australian Medical Association

No turn for interns

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VICE PRESIDENT'S MESSAGE

BY AMA VICE PRESIDENT DR STEPHEN PARNIS

Review of national registration scheme must heed doctor concerns

It's now four years since the National Registration and Accreditation Scheme for health practitioners was introduced and, as planned, it is undergoing a post-implementation review.

I've been chairing an AMA working group preparing our submissions to the review. In the last five months we have been actively engaging with the review and the independent reviewer, Kim Snowball.

To date, the working group have made three submissions on behalf of AMA members:

- an initial letter setting out the AMA's broad position on the scheme and overarching principles for medical practitioner regulation;
- a seven-page submission expanding on the key issues the AMA believes the review should consider; and
- a response to the consultation paper released in August.

We've also participated in stakeholder consultation forums that have been held in each State.

One of our key concerns is about the timely and proper triaging of notifications and complaints.

Under the scheme, notifications are used to bring concerns about an individual practitioner's conduct or performance to the attention of the regulator. The regulator investigates to determine if there is a risk of harm to the public, and takes appropriate disciplinary action.

> "AMA members report that the notification process is arduous and lengthy – 31 per cent of investigations are still open after nine months"

By contrast, health consumer complaints seek resolution for the consumer. Unless there is a broader risk to the public, consumer complaints received by Australian Health Practitioners Regulation Agency (AHPRA) are forwarded to State and Territory health complaint entities (HCEs) for resolution.

The review consultation paper proposes a greater standing for the health consumer in the investigation of a notification, and a dispute resolution process for individuals.

The AMA strongly opposes this.

AMA members report that the notification process is arduous and lengthy – 31 per cent of investigations are still open after nine months - and often complicated by poor communication from AHPRA.

Such lengthy processes can be very distressing for the doctors involved, and the long time taken no doubt undermines the confidence of consumers in the effectiveness of the scheme.

With respect to notifications, the AMA has called for:

- improved triaging of complaints and notifications, to keep complaints which divert resources from notifications outside of the scheme; and
- a scheme that is more responsive to medical practitioners, and accountable to the medical profession.

So, it was with disappointment that I read the *AHPRA Action Plan* which was released on 24 September.

It makes reference to a joint Victorian Health Issues Centre and AHPRA report, *Setting Things Right*, which focuses on the consumer experience with the scheme.

The *AHPRA Action Plan* sets out the actions AHPRA intends to take to improve the experience of health consumers.

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Review of national registration scheme must heed doctor concerns

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The review consultation paper covers most of the issues raised in the *Setting Things Right* report.

The *AHPRA Action Plan* therefore not only pre-empts the review's outcomes, it takes no account of the views of health practitioners regulated by the scheme.

Our concerns with the *Action Plan* are two-fold.

AHPRA wants even more information to be shared with people who have made a notification, and its focus is on improving the experience for consumers, when in fact efforts need to be directed to improving the investigation process – that is, the practitioner experience.

Medical practitioners and consumers, equally, want a regulatory scheme that is timely, fair, transparent and effective.

I have written to AHPRA and the Medical Board clearly stating our concerns with the pre-emptive release of the *AHPRA Action Plan*, and the fact that peak practitioner groups were not consulted about the measures in the *Action Plan*.

The AMA is ready to work with AHPRA and the Medical Board to identify ways the scheme can be made more efficient and effective to afford due process for practitioners, and to ensure the National Register provides appropriate information to help consumers make an informed decision when choosing a health practitioner.

I firmly believe this is the only way to maintain the confidence of all stakeholders in the national scheme.

The AMA's submissions to the review can be viewed at: https://ama.com.au/submission-ama-submissions-review-national-registration-and-accreditation-scheme

COMMENT

INFORMATION FOR MEMBERS

AMA Careers Advisory Service

From graduates preparing their first resume to experienced doctors seeking to carve out a new career path in the Commonwealth public service, the AMA Careers Advisory Service is been on hand to provide practical advice and information.

Since the Service was launched in September, AMA Careers Consultant, Kathryn Morgan, has handled dozens of inquiries from members looking for help and advice on advancing their careers, both within medicine and beyond.

The Careers website, which is at: http://careers.ama.com.au/, gives members access to both general and specific careers advice and information. In addition to direct links to external websites and specific sources of information, the Service also offers practical advice for medical professionals as their medical careers advance.

The Careers Service provides information and support relevant to all stages of an individual's career, from medical students looking for assistance preparing internship applications - particularly writing resumes and covering letters - through to doctors in training who want to brush up their interview skills to give them a competitive edge at all-important medical college interviews.

But the Service is not only there for those in the early stages of their medical careers. It has also helped qualified medical professionals looking to apply their skills and expertise in jobs beyond medical practice. Among these have been those looking for non-clinical roles in Commonwealth and State public services that take advantage of their skills and experience.

The Service is constantly updating content on its website, including listings of career-related events being staged across the country, and uses feedback from members to help add and develop resources.

Members are encouraged to visit the website, if they haven't done so already, and we welcome feedback, which can be submitted via the online feedback form on the website.

There will be further updates on developments in the Careers Service in coming months as we develop more ways to assist members along their medical career path.

If you or your colleagues would like to convene a skills workshop facilitated by Kathryn, please contact her at:

Phone: (02) 6270 5410;
1300 884 196 (toll free)

Email: careers@ama.com.au

Grads face intern place shortfall, yet again

Around 240 medical graduates could be left stranded without an intern place next year, undermining efforts to boost the supply of locally-trained doctors and reduce the nation's heavy reliance on offshore recruitment to fill gaps in the medical workforce.

As governments nationwide continue to fumble the issue of medical workforce planning, the National Medical Intern Data Management Working Group has reported a shortage of about 240 internships for medical students graduating this year.

AMA Vice President Dr Stephen Parnis said the shortfall amounted to a "shameful waste" of the nation's hefty investment in medical training.

"There are many communities, particularly in rural and regional Australia, that are in desperate need of doctors," Dr Parnis said. "It is a shameful waste of a vital resource if we have hundreds of medical graduates unable to become doctors because of short-sighted governments."

Medical school is only the first step in the process toward becoming a doctor, and internships – typically provided by public hospitals - are a vital next step in the medical training pathway.

But, though there has been a huge increase medical school places in the past decade, this has not been matched by similar growth in the number of internships, pre-vocational and vocational training places, creating bottlenecks in the training system and leaving an increasing number of trainee doctors stranded and unable to complete their education in Australia.

The problem has been exacerbated by divided responsibilities stemming from Australia's federal system of government – while the Commonwealth is the main source of funding for universities (including medical schools), public hospitals are primarily a State and Territory responsibility.

These divides have so far undermined attempts to develop a nationally co-ordinated approach to medical training – something that the National Medical Training Advisory Network has been created to address.

Dr Parnis lamented the failure of governments at all levels to work together to ensure the medical training system had the resources it needed to ensure the country was producing sufficient doctors to meet future need.

"Every year we get a commitment to medical training from governments, and every year we seem to be getting a lack of commitment to provide sufficient intern positions," the AMA Vice President said. "All governments must sign up to a medical training plan, and stick with it."

Australian Medical Students Association President Jessica Dean warned that, even if the Commonwealth Medical

Initiative delivered an extra 76 intern places in 2015 – as it did in 2014 – this would still leave more than 160 medical graduates without a place.

Under current arrangements, full-fee paying medical students from overseas can only receive an internship once all domestic students have secured a place. In practice, this has meant that these are the students who miss out on an internship after spending an average $250,000 to complete their degree.

Ms Dean said this was not only unfair but nonsensical.

"These students have spent up to six years immersed in Australian culture, learning our diseases, and training in our health care system," she said. "They are perfectly suited to serve in Australia. As regions continue to suffer from doctor shortages, it is nonsensical to be wasting another cohort of medical graduates."

Adrian Rollins

COMMENT

Wealthy countries exploit the poor to plug doctor gaps

Wealthy countries are relying on the recruitment of doctors from poorer nations to fill gaps in their medical workforce due to poor planning and inadequate support, the World Medical Association has said.

Highlighting the fact that the problems afflicting Australia's medical training system are common worldwide, the WMA General Assembly, meeting in Durban, has accused affluent countries such as Australia of free-riding on the investment made by less well-off nations in medical training by recruiting doctors from overseas rather than ensuring they are training enough locally to meet future need.

In a statement, the General Assembly said many countries, including some of the wealthiest, have experienced a long-standing shortage of physicians because they have not trained enough, and have instead relied on recruiting them from offshore.

In an observation that reflects directly on the shortfall of intern places in Australia, the WMA said that, "young people seeking employment as physicians have often been seriously affected by poor medical workforce planning."

It said many countries solved their need for doctors by recruiting offshore, typically from less affluent regions.

"The flow of international migration of physicians is generally from poorer to wealthier countries," the WMA said. "The poorer countries bear the expense of education the migrating physicians and receive no recompense when they enter other countries. The receiving countries gain a valuable resource without paying for it, and in the process they save the cost of education their own physicians."

Importantly, the WMA said the solution was not to limit the ability of doctors to choose where they work, but to bolster national medical training and workforce planning systems.

"Every country should do its utmost to educate an adequate number of physicians, taking into account its needs and resources," it said. "A country should not rely on immigration from other countries to meet its need for physicians."

The WMA Statement on Ethical Guidelines for the International Migration of Health Workers can be viewed at: http://www.wma.net/en/30publications/10policies/e14/index.html

Adrian Rollins

COMMENT

INFORMATION FOR MEMBERS

Doctor Portal: the doctor's complete online resource

All the resources and information a busy practitioner needs is now just a click away following the launch of the AMA's Doctor Portal website.

Doctor Portal brings together all the tools and resources doctors look for on a daily basis – the GP Desktop Toolkit, the Find a Doctor feature, the CPD tracker, the Fees List, policy guidelines, position statements, practice advice and support – as well as access to AMA publications including the *Medical Journal of Australia* and *Australian Medicine*, all in one convenient location.

No more wasted time digging around through the entrails of the web to find the information you need – Doctor Portal is your one-stop information hub.

Not only does Doctor Portal give you ready access to the information and resources you need, it gives you a way to connect with colleagues near and far through public and private forums.

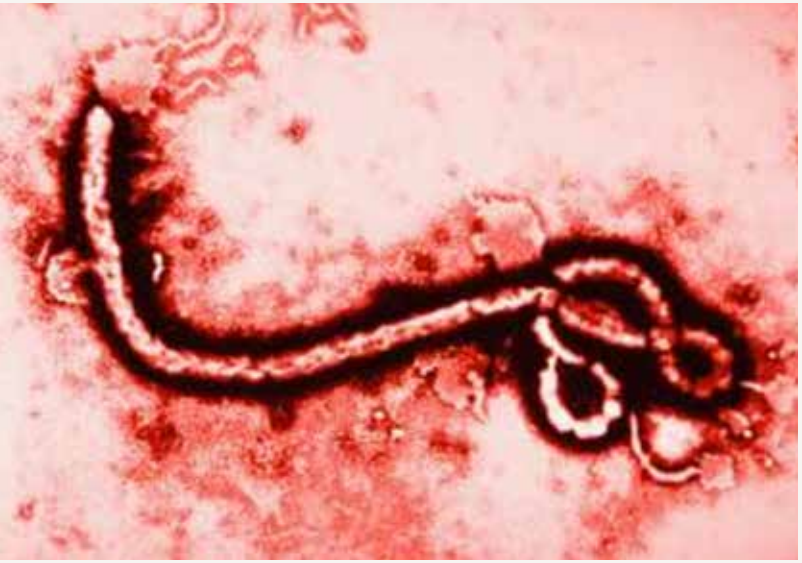
Click on the Doctor Portal link to check out these and other features:

- Content sharing – Doctor Portal allows you to securely share information and ideas with colleagues, providing public and private forums that only other registered medical professionals can access and participate in;
- Find a Doctor – locate practitioners using the Find a Doctor feature, which gives you access to Medical Directory of Australia information, including current practice contact details and a scalable map – perfect for when you are referring patients;
- All in one convenience: Doctor Portal features a refreshed MJA Bookshop, careers and jobs resources and the GP Desktop Toolkit, all at one site;
- Free access: Doctor Portal is a free service, and includes features exclusive to AMA members.

Doctor Portal is continually updated, ensuring that all information is current and you are never left out-of-date.

To explore all that Doctor Portal has to offer, visit: http://www.doctorportal.com.au/

Ebola: 'We need medics, not money'



The clamour for the Federal Government to contribute more than just money to international efforts to tackle the Ebola emergency is intensifying, with the AMA leading calls for the urgent dispatch of portable hospitals and fully-equipped medical teams to the epicentre of the outbreak in west Africa.

The rapid spread of the deadly disease in recent weeks – more than 4000 people have died in the outbreak, out of more than 8000 infected – has highlighted the inadequacy of the global response to date, with military and civilian medical teams from the United States, Britain, Europe and other developed countries only now starting to make a difference on the ground.

Until now, the burden of coping with the world's worst Ebola outbreak has fallen on the shambolic health systems of poor west African countries, UN agencies including the World Health Organisation, and humanitarian organisations including the Red Cross and Medecins Sans Frontieres, which have been overwhelmed by the scale of the crisis.

The US Centers for Disease Control and Prevention has warned that more than one million people could be infected with Ebola by the end of the year unless there is a major step-up in global efforts to contain the outbreak.

Early this month, the Abbott Government lifted its contribution to tackling the international public health emergency to $18 million, to be funnelled through the WHO, the Red Cross, MSF and similar organisations.

But AMA Vice President Dr Stephen Parnis is among a chorus of critics who have condemned the response as inadequate and demanded that the Commonwealth do more.

"We welcome the announcement of $18 million, but we think the Government has to do a lot more work, with a lot more urgency, to make arrangements with international partners to enable Australians to get on to the ground," Dr Parnis said.

He said the CDC's estimates meant that half a million people could be dead from Ebola by the end of the year unless countries like Australia vastly increased their effort to control the disease.

The inadequacy of the Government's strategy was laid bare by MSF Australia when it said the extra funding would not help.

MSF has reported it is currently operating at capacity and cannot deploy more health workers, regardless of extra funds.

Instead, it said, there was a desperate need for more fully-equipped foreign medical teams and facilities to be sent.

Foreign Minister Julie Bishop has so far resisted urgings that it coordinate the deployment of Australian medical workers, arguing that it could not responsibly do so without first putting in place evacuation procedures for any Australian health worker who might become infected with the virus.

Ms Bishop said the 30-hour flight time between Australia and west Africa made any such evacuation a near-impossibility.

"I do not have in place a guarantee that should an Australian health worker – sent there by the Australian government – contract Ebola, they would be able to be transported or treated in a hospital either in the region or in Europe," the Minister said on Saturday. "And until I have that in place we will not be sending Australian health workers."

But Dr Parnis said other countries had already established evacuation arrangements for their nationals, and the Federal Government should negotiate access to these for Australian health workers in case of infection.

He said that, just as Australia was part of an international coalition fighting terrorists in northern Iraq, so it should

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Ebola: 'We need medics, not money'

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work with other countries to combat Ebola, including negotiating evacuation procedures for its nationals.

Dr Parnis said there were dozens of highly-trained health professionals, including from Royal Darwin Hospital's National Critical Care and Trauma Response Centre, ready to go to west Africa as part of international efforts to combat the Ebola outbreak.

But their deployment needs to be coordinated by the Federal Government with the World Health Organisation, and this include make evacuation procedures.

The French Government, through the WHO, has agreed to develop an international protocol for overseeing evacuations, which would in effect mean that foreign health workers of any nationality would be evacuated to the most appropriate place, in accordance with their clinical circumstance.

The emergence of confirmed cases of Ebola outside west Africa – a Liberian man died of the disease in a Texas hospital last week, one of the nurses caring for him has been diagnosed with the disease and a Spanish nursing assistant was gravely ill after helping care for two missionaries repatriated with the infection who later died – has fuelled fears it could spread internationally.

Dr Parnis said the cases highlighted the fact that modern travel and communications meant no-one could afford to ignore the outbreak, no matter how far away it was.

But he emphasised that, while there was a risk the disease could appear in Australia, the nation's excellent health system was well prepared if it did appear.

Dr Parnis said it was in the nation's self-interest, as well as its duty as a good global citizen, to do everything it could to halt the spread of Ebola at its source in west Africa.

"The best protection against having Ebola here is to stop its spread there," he said. "The Prime Minister talks about global events having an effect on Australian national security. I completely agree, and I think that this is a key example of that, and our action or inaction will be remembered."

Adrian Rollins

COMMENT

Ebola infection control workshop

Confirmation that a nurse treating an Ebola patient in a Texas hospital has contracted the disease, and the Ebola scare for an Australian Red Cross volunteer recently returned from the epicentre of the outbreak in west Africa, has highlighted the risk of infection faced by health workers combating the virus's spread.

As health authorities investigate how the Texas nurse caught the virus, US Centers for Disease Control and Prevention Director Dr Tom Friedan said "clearly there was a breach in protocol."

Dr Friedan said that decades of dealing with Ebola outbreaks had shown that the established protocols "work", but that "even a single lapse in protocol can result in infection".

The infection of the nurse, who had been equipped with protective gear, including during periods of often intense care for Liberian man Thomas Duncan, who died from Ebola in a Texas hospital, has raised fears about its possible spread to countries beyond the African continent.

But infection control experts remain confident that health workers wearing protective gear who diligently follow protocols can minimise the risk of contracting the disease.

A workshop to give health workers and others planning to travel to west Africa to contribute to the global response to the emergency a full run-down of infection control protocols and practical preparation tips has been organised by the Australian Response MAE Network.

The free one-day workshop, to be held at the University of New South Wales' School of Public Health and Community Medicine on 24 October, will cover topics including hospital infection control, personal protective equipment, hand hygiene, clinical features of Ebola, updates on experimental drugs and vaccines, and tips of what to pack.

"Given the high rate of health worker infections in the west African outbreak, there is clearly a major occupational health and safety risk," the workshop organisers said. "The workshop is intended to fill gaps in routine training provided by deploying agencies."

For more information, and to register your interest, contact ARM administration at info@arm.org.au

Adrian Rollins

COMMENT

Time for the nation to put a cork in it

The Federal Government is set to come under intense pressure to provide national leadership in tackling the country's drinking problem when the AMA hosts the National Alcohol Summit later this month.

AMA Vice President Dr Stephen Parnis, who is abstaining from alcohol for the month as part of the annual Ocsober fundraising campaign, said that although everyone shared responsibility for reducing the harm caused by alcohol, it was time for the Abbott Government to step up on the issue.

"We don't think that there is one answer to this. It is something where governments and individuals both have responsibility," Dr Parnis said. "But the national Government needs to show national leadership on the issue."

The AMA has organised the summit, to be held in Canberra on 28 and 29 October, to provide a national focus for widespread community concern about the premature deaths, illnesses, assaults, family breakdowns, mental health problems and economic costs that stem from drinking.

Alcohol is second only to tobacco as the cause of drug-related deaths and disease - more than 18 per cent of Australians were drinking at dangerous levels in 2013 according to the National Drug Strategy Household Survey, and the National Health and Medical Research Council has cited research that alcohol consumption cost the community about $15.3 billion in 2004–05, taking into account its contribution to crime and violence, treatment costs, lost productivity and premature death.

There are promising signs that the nation is reining in its drinking habit. The proportion of people imbibing on a daily basis dropped to 6.5 per cent in 2013, its lowest point in 22 years; children are, on average, delaying their first drink until almost their 16th birthday (a significant improvement from the late 1990s) and almost 14 per cent of Australians have never consumed a full serve of alcohol – up from 12 per cent in 2010.

But Dr Parnis said that, welcome though such improvements were, alcohol continued to exact an unacceptably heavy toll on individuals and the community, as medical practitioners could attest.

"Doctors of every persuasion, whether its GPs, paediatricians, oncologists, psychiatrists, we all see just the scale of health problems as a result of the harm caused by alcohol," he said. "It's not just street violence, it's depression, early dementia, cancer, marriage break-ups, lost productivity, children with foetal alcohol spectrum disorder."

The Federal Government has so far resisted calls for it to take national leadership on the issue, deflecting calls for action by insisting it is a State and Territory responsibility.

But Dr Parnis said the summit would show that this was an increasingly untenable position.

He said that, just as the NSW Government had been stung into action to crack down on liquor licensing laws and opening hours by a series of high profile and deadly alcohol-fuelled assaults on Sydney streets, so the Federal Government would find itself coming under increasing pressure to take some responsibility.

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Time for the nation to put a cork in it

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The summit will be addressed by a number of national and international public health and alcohol experts, and is expected to recommend a number of practical actions governments, industry and community groups can take to reduce alcohol-related harm.

The AMA has already urged that a loophole in national laws that allow alcohol to be advertised during live broadcasts of sporting events be closed.

“Alcohol is drenching Australia,” Dr Parnis said. “It is everywhere and its harms are everywhere.

“We want to de-saturate the country so that we can enjoy a drink without all the attendant harm.”

He said it was wrong to accuse the AMA and others concerned about the health effects of alcohol of trying to turn Australia into a teetotal society.

“Many of us enjoy a drink,” he said. “But we think Australians are sensible enough about it to know the difference between a social drink and the sort of damage that is being done as part of the current drinking culture.”

Adrian Rollins

COMMENT

Alcohol’s deadly impact: a personal story

AMA Vice President Dr Stephen Parnis with his mother Christina

For AMA Vice President Dr Stephen Parnis, there is a deeply personal aspect to his campaign to rein in the nation’s drinking culture.

As an emergency physician at a major metropolitan hospital, he regularly sees patients seriously ill or injured as a result of alcohol, and he has witnessed first-hand the damage alcohol can inflict on families and across generations.

His maternal grandmother Jean died when she was just 46 years old after a long battle with alcoholism, a loss that has deeply affected his mother.

“Mum’s an amazing person, because she endured personal tragedy, and translated it into building a wonderful family of her own,” said Dr Parnis.

His family’s troubles with alcohol extend back even further, to the aftermath of World War One, when his great-grandfather returned from fighting in the conflict only to die aged 35 in 1923 when, while drunk, he fell under a train, subsequently dying of his injuries.

“I’m not just an emergency physician,” he said. “I’m also a father of three kids and I am very conscious of setting a good example for them.”

He said most Australians were concerned about the harm caused by excessive drinking, and the AMA National Alcohol Summit was a way to spread knowledge about the damage caused by alcohol and add to the impetus for action from governments, industry and the community.

Adrian Rollins

COMMENT

AMA President to lead national discussion of GP changes

A raft of policy changes rocking general practice and the delivery of primary health care will be the focus of a webinar being hosted by AMA President Associate Professor Brian Owler and Chair of the AMA Council of General Practice Dr Brian Morton next week.

A/Professor Owler said the webinar was an opportunity for AMA members to hear directly from the Association's leadership about its advocacy on behalf of GPs during a turbulent period in health policy, as well as to provide their ideas and feedback.

"The 2014 Commonwealth Budget contained a number of significant changes to general practice," the AMA President said. "[These] included the co-payment proposal, GP training, primary health networks and the incursion of private insurers into general practice."

A/Professor Owler said the AMA had been active on all these fronts as it sought to support quality care, protect the interests of patients, and improve support for GPs.

"We have been using the challenges posed by the Budget to highlight the critical role of GPs and the urgent need for appropriate investment in quality general practice," he said.

In its counter-proposal to the Government's plan for a $7 GP co-payment, the AMA argued against the move to slash $5 from the Medicare rebate for GP, pathology and radiology services, urged that concession card holders and children younger than 16 years be exempted from any upfront charge, and instead suggested a $6.15 payment for those patients who could afford it.

In addition, the AMA has condemned cost-cuts that will radically alter the deliver of GP training, including the abolition of General Practice Education and Training, the replacement of regional training providers with commercial for–profit operators and the scrapping of the Prevocational General Practice Placements Program.

A/Professor Owler said these were all major changes that could have far-reaching effects on the delivery of primary health, and he and Dr Morton were keen to canvass the views of AMA members.

The webinar will be held from 7pm on Thursday, 23 October.

To register, contact mgrybaitis@ama.com.au

Adrian Rollins

COMMENT

INFORMATION FOR MEMBERS

Free tool to track registration requirements

The AMA has developed a free online tool to help doctors to keep track of the information they need to meet the Medical Board of Australia's annual continuing professional development (CPD) requirements.

Each September, practitioners, when renewing their Medical Board registration, may be required to provide evidence they have complied with the Board's CPD requirements.

The AMA CPD Tracker has been developed to enable doctors to progressively gather and organise the information needed to substantiate declarations made to the Board about CPD, so that evidence can be quickly and easily produced on demand.

The AMA CPD Tracker can be used to:

- List courses completed, including the organisation that accredited the CPD activity;
- Store all certificates of completion;
- Keep a log of practice-based reflective activities, including clinical audits, peer reviews and perfomance appraisals; and
- Log hours spent on online learning, reading journals, teaching and other activities.

The system keeps a tally of hours, enabling practitioners to keep track of what needs to be completed before the end of the registration year.

The Tracker has been developed taking full account of the requirements set out in the Medical Board's Continuing Professional Development Registration Standard.

The service is free to AMA members. Non-members can subscribe for an annual fee of $250.

To register for the product, please sign up here.

If you want wealth, you need health

Medical experts from the around the world are set to converge on Melbourne next month to ensure health issues are high on the agenda when the leaders of the world's biggest economies meet next year.

The World Medical Association, in conjunction with the Federal AMA and AMA Victoria, will host the H20 International Health Summit on the eve of the G20 meeting in Brisbane to highlight the importance of health to a strong and productive economy.

WMA Chair of Council Dr Mukesh Haikerwal said that it was "quite concerning" that health was often neglected by world leaders when they gathered to discuss economics and trade.

Dr Haikerwal, a former AMA President, said the H20 Summit was aimed at ensuring health issues were given their rightful attention when the G20 leaders gathered in Turkey next year.

"The WMA Council has sought to be proactive and to emphasise that health is not a bottomless pit of unproductive expenditure that has to be reined in, but a positive and worthy investment," he said. "Health of nations is a core component of the wealth of nations."

Dr Haikerwal said Australia was a good example of the economic benefits that flow from a healthy and productive workforce.

"Economics is important because you need money to pay for things, but you cannot run an economy without healthy people, and if you are in an environment where the health system works well, people tend to be more innovative and creative," he said.

> "... Australia was a good example of the economic importance of a good health system and a healthy population"

In his speech to the summit, Australian Institute of Health and Welfare Chief Executive Officer David Kalisch is expected to highlight that Australia has achieved world-class outcomes while spending about the developed country average on health.

The economic benefits of medical research spending is due to be the focus of a presentation by leading HIV researcher Professor Sharon Lewin from the Peter Doherty Institute for Infection and Immunity. Professor Lewin is expected to show how investing in research has helped turn HIV from a diagnosis that was once a death sentence into a chronic condition that can be effectively managed.

Dr Haikerwal said these and other presentations from the H20 Summit, including by AMA President Associate Professor Brian Owler, Professor Thomas Feeley of the Harvard Business Schooland International Committee of the Red Cross Chief Surgeon Dr Robin Coupland, were aimed at convincing G20 leaders that health was an important part of discussions about economic growth and trade.

Among other issues to be discussed at the H20 Summit will be non-communicable diseases.

Dr Haikerwal said that it was often not understood that traumatic injuries like amputations and broken bones were only part of the medical needs that arose in emergency situations created by natural disasters or conflict, and that much of the work carried out by humanitarian organisations like the Red Cross centred around ensuring continued care and treatment for people with serious chronic conditions such as diabetes, HIV and mental illness.

One of the presenters in this area will be Dr Henry Brodaty, a dementia expert at the University of New South Wales. Dr Haikerwal said this was important because often mental health was ignored in international discussion of chronic diseases.

Other topics for discussion at the H20 meeting will include consideration of the social determinants of health and the health impacts of climate change.

The H20 Summit will be held at the Hotel Windsor, Spring Street, Melbourne, on 13 and 14 November.

For more information, visit: https://register.eventarc.com/26303/event-name

Adrian Rollins

COMMENT

AMA IN THE NEWS

Your AMA has been active on policy and in the media on a range of issues crucial to making our health system better. Below is a snapshot of recent media coverage.

Print/Online

When doctors need healing, *The Age*, 26 September 2014

An alarming number of medicos suffer from mental illness. Yet, ironically, stigma about the condition is rife in their profession. AMA Vice President Stephen Parnis has admitted that the past approach to supporting the mental illness of the medical profession has been fragmented.

Doctor pleas for help fighting Ebola, *The Daily Telegraph*, 27 September 2014

An Australia physiologist who has just returned from battling Ebola in Sierra Leone has made a desperate plea for Australia to send workers to help combat the virus. The AMA has also stepped up its pressure on the Government.

Bupa ventures into primary care with GP clinics, *Australian Financial Review*, 30 September 2014

Health insurer Bupa will open its own branded GP clinics in its first major foray into primary care, following Medibank's controversial pilot program. AMA President A/Professor Brian Owler said he would keep an eye on the trial to ensure Bupa GPs were not favouring preferred providers in their referrals and acting contrary to clinical needs.

Super accounts get skinny to pay for weight-loss op, *The Age*, 1 October 2014

Thousands of Australians are taking money out of their retirement nest eggs to pay for weight loss surgery and other life-saving medical treatments not covered by Medicare. In July, AMA President A/Professor Brian Owler said 89 per cent of medical treatments did not have any out-of-pocket costs, but acknowledged that some doctors charged "excessive fees".

Cancer treatment on target, *Canberra Times*, 2 October 2014

More than 90 per cent of malignant bowl, breast, and lung cancer patients in the ACT received surgery within a recommended 30-day period. AMA Vice President Dr Stephen Parnis said cancer surgery was typically regarded as urgent, and it was pleasing most surgeries were provided within recommended timeframes.

Smoke speech fire, *Canberra Times*, 2 October 2014

Liberal Democratic senator David Leyonhjelm has vowed to stand up for the rights of the less than one in five Australians who choose to smoke. AMA Vice President Stephen Parnis said the reality is that smoking causes long, drawn-out painful deaths for thousands of Australians every year.

Agencies set to fight Ebola as Bishop sends money instead, *The Australian*, 3 October 2014

One of the world's frontline humanitarian agencies has rejected Australia's excuse for not putting boots on the ground in Africa's Ebola hot zone. The AMA revealed at least 20 local doctors have offered to go to work in Guinea, Sierra Leone, and Liberia.

Radical surgery, *Australian Financial Review*, 4 October 2014

Medibank Private, the Federal Government-owned insurer, is looking for ways to increase profits ahead of a $4 billion-plus privatisation. AMA President A/Professor Brian Owler said the push by insurers is a Trojan horse through which managed care will be introduced.

Price of pills is a $400m rip-off, *The Daily Telegraph*, 7 October 2014

Australia is paying up to 21 times more than Britain for 19 of the 20 most commonly used prescription medicines seven years after a Government policy was meant to end the rort. AMA President A/Professor Brian Owler said he was flabbergasted when he was told taxpayers spent $15 billion protecting pharmacists.

Medicare co-payment fears NSW hospitals will be swamped by 500,000 extra patients, *Sydney Morning Herald*, 8 October 2014

An extra 500,000 people a year would choke NSW emergency departments at a cost of $80 million if the Federal Government proceeds with its GP co-payment, according to NSW Health analysis obtained by NSW Labor. AMA President A/Professor Brian Owler said hospitals have worked hard to improve emergency department waiting times and these figures showed the $7 co-payment would undermine this effort.

Radio

A/Professor Brian Owler, ABC News Radio, 26 September 2014

AMA President A/Professor Brian Owler called for Australia to make arrangements with other countries to treat any Australian volunteer health workers who may contract Ebola while working in West Africa.

Dr Stephen Parnis, 2GB Sydney, 29 September 2014

AMA Vice President Stephen Parnis talked about the privatisation of Medibank Private and the future of premiums. Dr Parnis said you don't need to be an economist to realise that privatisation poses a risk to premiums.

MORE P16

AMA IN THE NEWS

... FROM P15

Dr Stephen Parnis, 2SM Sydney, 1 October 2014

AMA Vice President Dr Stephen Parnis discussed the Ebola virus in the US and Australia's response to the outbreak.

Dr Stephen Parnis, 2UE Sydney, 1 October 2014

AMA Vice President Dr Stephen Parnis talked about Senator David Leyonhjelm's statement backing smokers. Dr Parnis said smoking is the largest single preventable cause of death in Australia

Dr Stephen Parnis, Radio National, 2 October 2014

AMA Vice President Dr Stephen Parnis discussed criticisms by the AMA and Medecins Sans Frontieres' of the Federal Government's response to the Ebola outbreak in West Africa.

Dr Stephen Parnis, 6PR Perth, 7 October 2014

AMA Vice President Dr Stephen Parnis shared his view on a proposal to have pharmacies operate in supermarkets. Dr Parnis said commercial restrictions on pharmacies were unnecessary and that there was too much red tape setting up a community pharmacy

A/Professor Brian Owler, 2GB Sydney, 8 October 2014

AMA President A/Prof Brian Owler talked about estimates the $7 Medicare co-payment could result in an extra 500,000 patients flooding public hospital emergency departments. A/Professor Owler said if the co-payment was introduced, many patients would choose to visit emergency departments rather than their GP.

Television

Dr Stephen Parnis, Sky News Sydney, 29 September 2014

AMA Vice President Dr Stephen Parnis discussed the sale of Medibank Private and its potential impacts on health outcomes. He also commented on the AMA's stance on medicinal cannabis and the Federal Government's $7 GP co-payment model.

Dr Stephen Parnis, Southern Cross Tasmania, 7 October 2014

AMA Vice President Dr Stephen Parnis commented on claims Australia paid $400 million too much each year for prescription medicine. The AMA has accused pharmacists of failing to pass on savings from dug companies.

COMMENT

INFORMATION FOR MEMBERS

Essential GP tools at the click of a button

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

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

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

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

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

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

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

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

Your AMA Federal Council at work

What AMA Federal Councillors and other AMA Members have been doing to advance your interests in the past month

Name	Position on council	Activity/Meeting	Date
Dr Chris Moy	AMA Federal Council representative for SA and NT	NeHTA (National E-Health Transition Authority) Clinical Usability Program (CUP) Steering Committee	30/07/2014
Dr Will Milford	AMA member	AMC Specialist Education Accreditation Committee	13/08/2014
Dr Sally Banfield	AMA member	GP Training Stakeholders Consultation Meeting	02/09/2014
Dr Brian Morton	AMA Chair of General Practice	GP Training Stakeholders Consultation Meeting	02/09/2014
Dr Richard Kidd	AMA Board member	Clinical Care Standards Advisory Committee (for Dr Saxon Smith)	10/09/2014
Dr Gino Pecoraro	AMA Federal Council representative for Obstetricians and Gynaecologists	MSAC (Medical Services Advisory Committee) Review Working Group for Lipectomy Services	16/09/2014
Dr Ian Pryor	AMA member	MSAC (Medical Services Advisory Committee) Review Working Group for Lipectomy Services	16/09/2014
		MSAC (Medical Services Advisory Committee) Review Working Group for Percutaneous Coronary Artery Intervention	22/09/2014
Dr Chris Clohesy	AMA member	MSAC (Medical Services Advisory Committee) Review Working Group on Imaging for Back Pain	18/09/2014

COMMENT

Doctors in danger

Red Cross official Dr Bruce Eshaya-Chauvin suspects health workers being targetted more than ever before

When doctors and paramedics respond to emergency calls for assistance, they can never know exactly what they will encounter – though few would expect to be the target of bombers or snipers when they arrive on the scene.

But this is an all-too-real risk for those working in some of the world's worst trouble spots, where the International Committee of the Red Cross (ICRC) has recorded 26 follow-up attacks where emergency workers responding to an initial bomb blast were themselves killed and injured by a secondary explosion timed to coincide with their arrival at the scene.

Unfortunately, there is nothing new about attacks on health workers.

As many emergency department doctors and ambulance paramedics can attest, being the target of vicious threats and assaults is a depressingly common aspect of their work.

In Victoria alone, police were called to major hospitals and medical centres 265 times in 2012-13, and more than 7000 "code grey" alerts were issued over aggressive and threatening behaviour, according to crime statistics obtained by the *Herald Sun*.

But, distressing and harmful as these incidents are for the individuals affected, they pale in comparison with the dangers faced on a daily basis by medical staff working in countries marred by political strife and instability, where hospitals, ambulances, doctors, nurses and patients are often the target of attacks by armies, militia, rebels, criminal gangs and violent individuals.

MORE P19

Doctors in danger

... FROM P18

More than 2000 attacks on health workers

According to figures compiled by the ICRC as part of its *Health Care in Danger* project, 168 health workers were killed in 2624 assaults documented in 21 countries in 2012 and 2013, along with 481 of their patients and dozens of ancillary staff, aid workers, relatives and by-standers.

The litany of violence during the period also included 267 health workers who were wounded or beaten and 564 who were threatened. A further 143 reported being blocked or delayed in attempting to get to injured people or taking patients to hospital, while almost 90 were robbed and 35 suffered other assaults including torture, kidnapping, being thrown out of health facilities or surviving unsuccessful attacks.

Not only individuals are hurt

In recent and current conflicts in Syria, Iraq, and Gaza combatants have been accused of deliberately targeting hospitals and other health facilities.

Of 1809 incidents documented by the ICRC, 40 per cent involved attacks on or within hospitals and clinics, more than a third of which were carried out by state troops and police, while militias, rebels and insurgents were responsible for 32 per cent of these assaults.

National armed forces and police were the most likely to bomb or fire upon such facilities, while rebels and militias were more likely to invade and loot.

For ICRC employee Dr Bruce Eshaya-Chauvin, who is medical adviser to the project, such incidents are disappointingly familiar.

With more than 20 years of experience working for the Red Cross around the world, including stints in Lebanon and parts of Africa, Dr Eshaya-Chauvin has firsthand experience of the dangers many health workers face in doing their job in conflict situations.

He said the problem was not just the threat to health workers, but the corrosive effect such threats and violence had on access to health care, often when need was greatest.

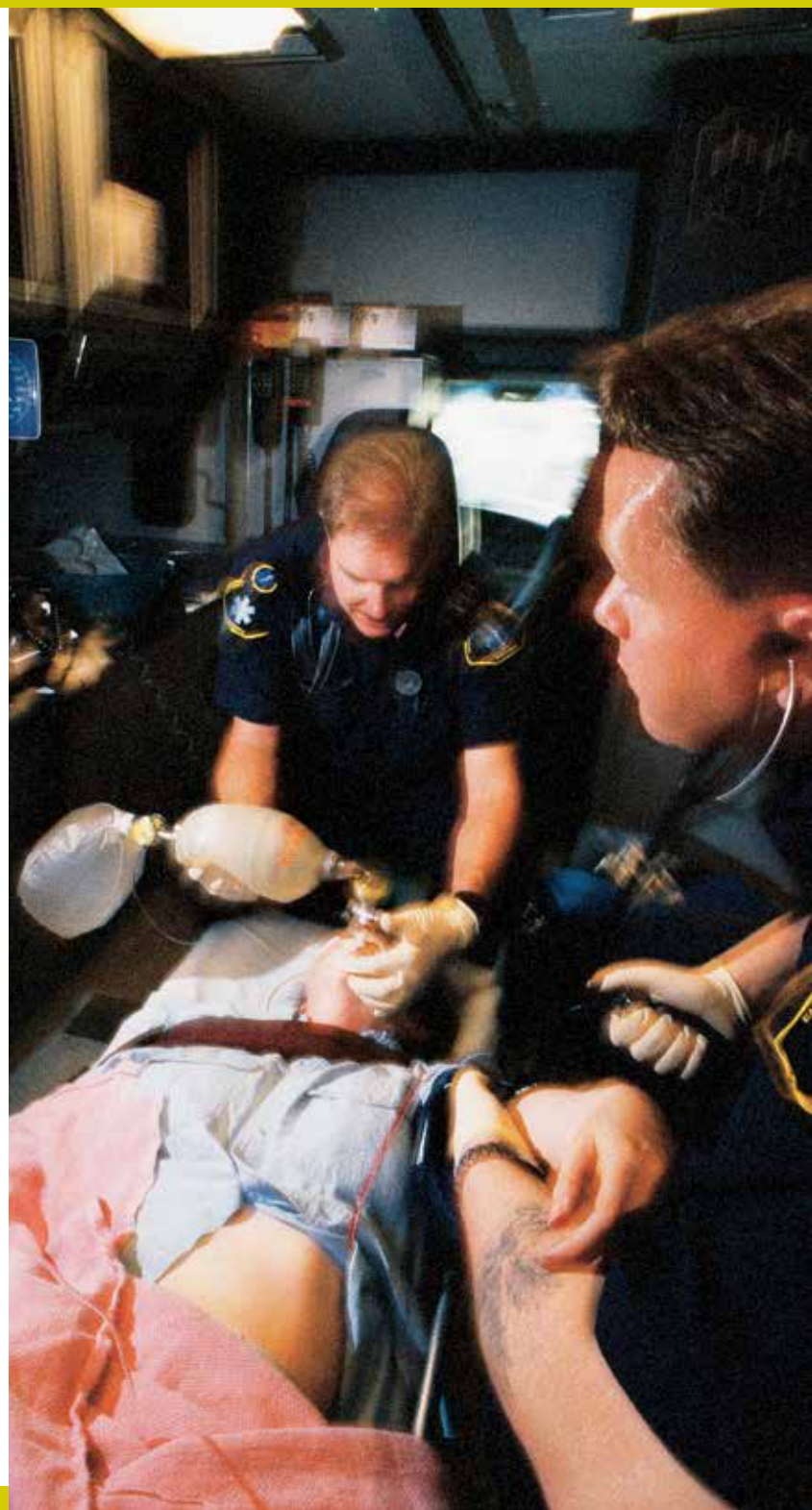
Dr Eshaya-Chauvin, who visited Australia late last month, told *Australian Medicine* attacks on hospitals and health clinics – whether intentional or not – could have far-reaching effects.

"It is very difficult to know whether it is intentional or not, but the result is unfortunately the same," he said. "The knock-on effect is that if you prevent a doctor going to hospital, it means patients have to wait longer for treatment, or not receive it at all."

It is why he is passionate about the Health Care in Danger project and what it could do to help ameliorate the risks health workers face in conflict situations, and improve their ability to provide care for those who need it.

"It has a very simple objective, with wide ambition – to make sure that patients can access proper treatment, and that health care practitioners can do their work in areas of conflict and other emergencies," Dr Eshaya-Chauvin said. "We want to not only find solutions, but implement them."

MORE P20



Doctors in danger

... FROM P19

Not one, but many solutions

There are three strands to the strategy the ICRC has developed to achieve this – working with governments to improve recognition and respect for the neutrality of health workers in conflict situations, bringing together practitioners and experts from around the world to share experiences and ideas, and engendering community understanding and regard for the care provided by health workers to all who need medical treatment, irrespective of political affiliation, gender, race or religion.

The dilemma humanitarian organisations face is that, aside from the inherent danger of working in conflict zones where need is often greatest, measures taken to improve health worker safety can put barriers in the way of people who need treatment.

Dr Eshaya-Chauvin said the complexity of the issue meant there was no simple set of recommendation or procedures for health workers to follow.

"You always have to balance security and access," he said, citing the example of possible responses to bombings and the threat of follow-up blasts targeting emergency workers.

"We don't have one response, but we have learnt the elements that need to be taken into consideration by ambulance despatchers in these situations."

The merits of some measures that might, on the face of it, seem straightforward are also debated.

At a workshop on ambulance safety organised as part of the project, the pros and cons of personal protection gear for paramedics, such as helmets and flak jackets, were hotly debated.

Some thought the case for their use was obvious, but others argued wearing such equipment put paramedics at greater risk by making them appear more like participants in the conflict rather than independent and neutral actors.

In addition to attacks by armies, police or militias, health workers can also find themselves under assault from angry families or communities.

Mobs in West Africa have attacked health teams working to help control the devastating Ebola outbreak in the mistaken belief they are actually spreading the disease, and there have been deadly assaults on vaccination workers in Pakistan from both Islamic militants and those who believe that are poisoning children.

Engaging governments, communities

"The role of communities is very important," Dr Eshaya-Chauvin said. "We need to work with communities on issues of perception and acceptance. In the case of Ebola, there is the perception of the disease, and acceptance of people coming to try and help with the problem."

He said one of the issues was often differences in the understanding of what was meant by neutrality, and the impartiality of the medical profession in the way it treated patients – something that was often not understood or appreciated.

Dr Eshaya-Chauvin said it was easy to look at places like Syria and become discouraged, but there were examples where the situation was improving, sometimes significantly.

"We cannot just look at where there is no hope – I am not saying we will not see any improvement in Syria, but it is a very difficult place to work," he said.

"We cannot just look at where there is no hope – I am not saying we will not see any improvement in Syria, but it is a very difficult place to work"

"It is very important that people keep in mind examples like Colombia [see 21], Afghanistan and Yemen, where people are able to find and implement solutions."

He said his own experience in Beirut was instructive. During the civil war that wracked Lebanon, Red Cross crews were able to move around the country and cross fiercely contested battle lines because the value of their work, and their neutrality, was universally understood and respected.

Similarly, Keysaney Hospital in the Somali capital Mogadishu provided uninterrupted care in one of the world's most dangerous environments by adhering to its priority of delivering care solely on medical grounds.

Dr Yusuf Mohamed Hassan, who has been the hospital's director for the past decade, said "the hospital serves everyone on Mogadishu, regardless of their clan affiliation or political views. I believe we have been able to function over time simply because of our impartiality and neutrality".

Broadening this understanding across other conflict-riddled countries, Dr Eshaya-Chauvin believes, could go a long way to saving more lives and make providing health care safer.

Adrian Rollins

COMMENT

Doctors under attack: recent examples

Gaza

During the recent Israeli assault on Gaza there were numerous attacks on ambulances and medical facilities in which at least five medical staff were killed in the line of duty, and dozens were injured.

The United Nations Office for the Coordination of Humanitarian Affairs reported on 2 August that a third of Gaza's hospitals, 14 primary health care clinics and 29 Red Crescent and Ministry of Health ambulances were damaged in the first three weeks of fighting alone, creating what it described as a "health disaster of widespread proportions".

"At least 40 per cent of medical staff are unable to get to their places of work, such as clinics and hospitals, due to widespread violence, and at least half of all public health primary care clinics are closed," the UN agency said.

In all, three Gaza hospitals – al-Shifa, al-Aqsa and Wafa - were destroyed or damaged by explosions during the conflict, killing and maiming patients and medical staff and reducing access to vital medical care, while a fourth, Najjar, was evacuated.

West Africa

Several health workers have been killed and injured by angry and fearful mobs in parts of Guinea as they have worked to try and contain the worst Ebola outbreak on record.

In the deadliest incident, a delegation that included health workers, three journalists and a local politician were set upon after arriving at a village to distribute information about the deadly disease. Eight were killed in the attack, and their bodies dumped in a latrine.

Other health workers battling the disease have been assaulted or shunned by their communities.

Adrian Rollins

COMMENT

Columbia: a case study in doctor protection

For many years Columbia was rightly regarded as a dangerous place to practise medicine.

Thousands of by-standers and non-combatants, including health workers, became casualties of a vicious civil war and conflict between rival drug gangs.

Those rendering medical aid to the injured often found themselves in the firing line, and doctors often came under pressure from the police and the army to refuse treatment to perceived enemies of the state, or to disclose patient details.

But, in a major turnaround in the last six years, the country has come to be regarded as the "gold standard" of what can be achieved to establish universal respect for the sanctity and neutrality of health workers.

Increasingly alarmed by threats and violent attacks on health workers, the International Committee of the Red Cross and the Columbian Red Cross in the late 1990s began a series of meetings with Health Ministry officials.

Over time, the Government came to recognise its responsibility to ensure necessary respect for, and protection of, health workers, and the Attorney-General and the Prosecutor-General became involved.

In 2008, the National Permanent Roundtable for the Respect of the Medical Mission in Colombia to ensure nationwide understanding of the need to protect health workers from harm, and to develop standards and guidelines for the behaviour of health workers, such as being correctly identified with the medical mission emblem and following safety procedures.

"One of the most significant contributions of the Roundtable has been to achiever a generalised understanding and acceptance of the fact that the protection of the medical mission goes beyond the context of health services and personnel, and does not only involve authorities strictly related to this field," the ICRC's Columbian representative, Dr Tatiana Florez, said. "Today, it is understood that its protection involves political authorities like the Government, the Ombudsman and the Attorney-General's Office, among other state entities."

Adrian Rollins

COMMENT

SPECIAL REPORT

What Australian doctors can do

The magnitude of the task to change attitudes and achieve universal recognition of the neutrality of health workers and respect for the work they do requires a concerted global effort beyond the scope of any one organisation, International Committee of the Red Cross official Dr Bruce Eshaya-Chauvin has warned.

The ICRC's *Health Care in Danger* project was originally conceived of as a four-year undertaking when it was launched in 2011, but Dr Eshaya-Chauvin the deadline was always going to be a waypoint, rather than an end point.

"We know that the project cannot end in 2015," he said, but "it's not only the responsibility of the ICRC for the project to survive".

"People are expecting the ICRC will continue to be the focal point of this issue for the future, and we will, but we hope the issue will become one that is also addressed by countries themselves."

Dr Eshaya-Chauvin said the ICRC was already working closely with transnational groups like the World Medical Association and the International Federation of Medical Students, but there were also plenty that doctors in countries like Australia could do to advance work on the issue.

The ICRC and the WMA formalised their partnership in June 2013 when they struck a Memorandum of Understanding under which the WMA committed to assist the promotion and development of the HCiD project, while the ICRC pledged to work with both the WMA and national medical associations – including the AMA – in its work on the project.

Following this agreement, the AMA last year formally adopted the WMA's *Regulations in Times of Armed Conflict and Other Situations of Violence*, outlining the duties of doctors working in strife-torn areas as well as the support they and other health workers should be accorded to fulfil their ethical duties to care for the sick and wounded.

Dr Eshaya-Chauvin said Australian doctors and nurses could "link up" with the Australian Defence Force to share knowledge and experience, and to support the work undertaken by the Australian Government as one of five international "champions" for the project.

Last year the Government sponsored a resolution at the G20 that called for a pact to protect the safety of doctors and other health workers in Syria, and last December Australia hosted an international workshop on how military operations can affect the safety of health workers and access to medical care.

Dr Eshaya-Chauvin said the AMA had a role to play in helping prepare doctors to work in strife-torn situations by providing information on rights and responsibilities, ethical considerations, and an understanding of the legal frameworks in which they may operate.

For more details on the Health Care in Danger project, visit: https://www.icrc.org/eng/what-we-do/safeguarding-health-care/solution/2013-04-26-hcid-health-care-in-danger-project.htm

Adrian Rollins

COMMENT

INFORMATION FOR MEMBERS

Vaccine safety seminar

Ideas to improve the surveillance of patients following the administration of vaccines will be the focus of a seminar bringing together national and international experts.

Health workers, researchers, immunisations providers and public health staff interested in the active surveillance for adverse events following immunisation are invited to attend the Vaccine Safety Seminar, to be held at the Harbour View Hotel in North Sydnye on 29 October.

The seminar has been organised by the National Centre for Immunisation Research and Surveillance, and speakers include Dr Jennifer Nelson of the University of Washington's Group Health Research Institute, Associate Professor Michael Gold, a member of the WHO's Global Advisory Committee on Vaccine Safety and Dr Bronwyn Harvey of the Therapeutic Goods Administration.

Topics to be covered include methods of active and enhanced surveillance such as solicited feedback via SMS, hospital-based surveillance, and the use of large health care databases.

For more information, visit: http://ncirs.edu.au/news/index.php#Seminar

Screening success as death rates fall

Breast cancer deaths have fallen by a third since the national screening program was rolled out more than 20 years ago.

While little more than half of women in the target age group of between 50 and 69 years have a mammogram in any one year, Australian Institute of Health and Welfare figures indicate the BreastScreen Australia program has been effective in the early detection of breast cancers, vastly improving the prognosis of those found to have a tumour.

Almost half of breast cancers detected in the initial round of screening in 2011 and 2012 were classified as small (less than 15 millimetres in diameter), as were 61 per cent of those found in subsequent screens.

By detecting the cancers early, the screening program gives women with breast cancer access to wider and better treatment options and greater chances of survival.

This is significant given the relative prevalence of breast cancer – it is the most common type affecting women, with around 7500 new cases diagnosed among women in the 50 to 69 years age group in 2010.

While screening is just one element in the improved survival rate of people with breast cancer, the AIHW noted that since the BreastScreen Australia program began in 1991, breast cancer deaths in the target 50 to 69 years age group had dropped from 68 per 100,000 women to 44 – a 35 per cent fall.

Participation in the breast screening program has held steady for the last seven years at around 55 per cent of women in the target age group, but is lower in remote areas (46 per cent) and among Indigenous women (38 per cent).

A separate study by Breast Cancer Network Australia found that women diagnosed with breast cancer generally felt well served by their GP but experienced financial difficulty because of the costs associated with treatment.

A survey by the Network of 580 women with advanced breast cancer (that is, one that has spread from the breast to other parts of the body) found that 70 per cent believed their GP had a good or excellent knowledge of the issues associated with the disease that were most important to them, while almost 80 per cent reported their family doctor was almost always available when they needed them.

Underlining the lasting nature of the relationship most patients form with their GPs, 77 per cent of the women in the survey reported they had a regular doctor – including almost 60 per cent who said they had been seeing the same GP for more than five years.

“This survey has highlighted that GPs play an important and on-going role in the care of women living with secondary breast cancer,” the BCNA said. “The majority of survey respondents value the role of their GP and trust his or her judgement and clinical advice when it comes to their secondary breast cancer.

But the study also found that many such women were missing out opportunities for extra assistance in managing the effects of their disease.

It showed that only about one in five of women with advanced breast cancer did not have a current GP Management Plan, which would entitle them for up to five

subsidised visits to allied health professionals each year, and less than 15 per cent had a GP Mental Health Care Plan, which provides for up to 10 subsidised visits to a counsellor, psychologist or specially trained social worker.

Network Chief Executive Officer Maxine Morand said GP Management Plans should be offered to women with advanced breast cancer as a matter of course.

“We know GP Management Plans really help women living with advanced disease to manage the ongoing side-effects of their treatment and care, and could also help with the significant financial challenges reported by survey respondents,” she said.

Ms Morand said almost two-thirds of those diagnosed with advanced breast cancer reported being in financial difficulty, with out-of-pocket expenses reaching an average of $687 a month

Adrian Rollins

COMMENT

When it comes to cancer, most receive timely care

When a patient gets diagnosed with cancer and told they need to have surgery, they are understandably anxious to have the operation as quickly as possible.

Happily, in Australia virtually every cancer patient booked in for potentially life-saving surgery undergoes the operation within 45 days.

Of almost 33,000 patients scheduled for surgery for malignant bowel, breast or lung cancer in Australia in 2012-13, 92 per cent were treated within 30 days and 97 per cent were operated on within 45 days, figures compiled by the National Health Performance Authority show.

But, while the vast majority got timely treatment, the NHPA report found that 1028 patients had to wait more than 45 days – including some whose surgery was delayed for than 75 days.

In findings intended to give clinicians and hospital administrators a guide to how they are performing relative to their peers, the NHPA examined how long patients had to wait for surgery on three different types of malignant cancer – of the bowel, the breast and the lung.

The importance of such treatment is underlined by the fact that, "without timely surgery, cancers may progress and patients with early-stage disease may face a reduced opportunity for care".

Of the three disease types examined, those with breast cancer faced the shortest delay, with a median waiting time of 12 days at major metropolitan hospitals, and 14 days at regional facilities. By comparison, those with lung cancer faced a median waiting time of 13 days and those with bowel cancer had the longest median wait - 15 days at major metro hospitals and 16 days at their regional counterparts.

The longest delays for breast cancer surgery in the country were faced by patients Joondalup Health Campus, where it took longer than 45 days to complete 90 per cent of breast cancer surgeries.

When it came to lung cancer surgery, the NHPA report found patients in western Sydney faced the longest average wait. It took Liverpool Hospital more than 45 days to complete 90 per cent of scheduled lung cancer surgeries, and the hospital at Blacktown took more than 75 days to reach the same benchmark.

But bowel cancer patients faced the longest average delays. In all, seven hospitals nationwide took more than 45 days to complete at least 90 per cent of planned bowel cancer operations, and two – the Royal Hobart and Brisbane's Princess Alexandra – took more than 75 days to reach this benchmark.

Interestingly, the study found no significant difference in performance between hospitals in metropolitan and regional areas, and a marginal improvement in performance from when the first report was conducted 2011-12.

The Authority said its report was not intended to pass judgement on how well or poorly individual hospitals performed.

"There is no agreed definition of poor performance in relation to waiting times for cancer surgery," the NHPA said. "Therefore, the Authority makes no determination that any hospital is performing either well or poorly. Instead, the information…is intended to help clinicians, hospital managers and system managers see what I possible at similar hospitals and support sharing of successful strategies to manage surgery waiting lists."

Adrian Rollins

COMMENT

Chemist coeliac test is a false positive

Doctors have warned lives could be put at risk by a test for coeliac disease being heavily promoted by two nationwide chemist shop chains.

Amcal and Guardian branded chemists are offering a $45 blood test they claim is 93 per cent accurate in diagnosing the serious illness, which affects up to 2 per cent of Australians.

But AMA New South Wales President Dr Saxon Smith, said he was alarmed by the move, which he warned would fragment care and may give rise to missed or false diagnoses that could put lives at risk.

Writing in the *Sydney Morning Herald*, Dr Smith said the test being offered by the chemist chains had serious limitations.

He said research by the company that made the test showed that, while it was quite effective at identifying those who did not have coeliac disease, "it falls down significantly when it comes to those who do".

"It is only 49 per cent accurate when it comes to positive results, which means more than half the people the test says have coeliac disease actually don't," Dr Smith said.

He said this was particularly a concern because of evidence that people without coeliac disease who followed a gluten-free diet suffered poorer health.

Dr Smith said the screening questions presented before taking the test were "exceptionally vague", and some of the symptoms described could actually indicate other serious conditions such as stomach cancer, inflammatory bowel disease or a thyroid condition.

He said diagnosing coeliac disease was not a simple task and it was inappropriate that it be done "between the toothpaste and the toilet paper in a chemist".

"Diagnosis is not straight forward, as there needs to be a level of clinical suspicion about the diseases," Dr Smith said, adding that unexplained iron deficiency or osteoporosis could be indicators.'

"There are questions about your health and your family's health that need to be asked to evaluate your risk," he said. "There are blood samples tests as, ultimately, a biopsy of the bowel via endoscopy for a definitive diagnosis."

He said coeliac disease was an important medical condition that could lead to serious complications such as lymphoma and osteoporosis, and its detection and on-going management required the skills of a doctor, not a pharmacist.

"Doctors' highest duty of care is to look after you and your loved ones," he said. "This is what the law demands. I wonder if the pharmacists who choose to sell this test truly understand this expectation and what it entails."

Adrian Rollins

COMMENT

INFORMATION FOR MEMBERS

Medical tourism summit

Virtually unheard of a decade ago, medical tourism is becoming an increasingly common aspect of modern medical practise.

Cheap air travel and the spread of medical knowledge and technology has meant more people than ever before are willing to seek treatment overseas, lured by lower costs or cutting edge expertise and techniques.

The Medical Tourism 2014 Summit is being held next month to explore rapid growth in medical tourism and its impact on the Australian health system.

It will look at factors driving Australians to seek treatment offshore, as well as the flow of patients coming to Australia.

Speakers will include NIB Health Fund CEO Mark Fitzgibbon, Melbourne IVF medical director Lyndon Hale, Epworth Group medical director Professor John Catford and Global Health Travel, Thailand managing director Cassandra Italia.

The Summit is to be held on 20 and 21 November at Rendezvous Grand Hotel, Melbourne.

For details, visit: http://www.informa.com.au/conferences/health-care-conference/medical-tourism-summit

Meningococcal vaccine recalled

Australia is part of a worldwide recall of a meningococcal vaccine following reports batches have been contaminated with rust and stainless steel.

Drug company Emerge Health is working with the Therapeutic Goods Administration to retrieve all unexpired doses of its Meningitec meningococcal serogroup C conjugate vaccine suspension, sold as a single dose syringe.

The global recall was initiated after a small number of syringes in Europe were found to have been contaminated with particles of iron oxide and oxidised stainless steel from manufacturing equipment.

The TGA said the risk that anyone in Australia had received a contaminated dose was “very low” because the number of syringes affected was small, and the rust particles would be readily seen in any pre-vaccination inspection of the vials of the vaccine.

It said the incident underlined the importance of Health Department advice to “inspect before you inject”.

Patients injected with the contaminated serum might experience some pain, redness or swelling around the vaccination site, while there is a potential risk of iron toxicity in babies weighing less than seven kilograms.

But the watchdog said it had not received any reports that vials of vaccine in Australia had been contaminated, and there had not been any increase in adverse event reports that could stem from this issue.

Health professionals who find they have stocks of Meningitec, sponsored by Pfizer in Australia, are asked to place them in quarantine and contact Emerge Health to arrange their return.

The TGA said no other meningococcal serogroup C conjugate vaccines are affected by the recall.

Adrian Rollins

COMMENT

INFORMATION FOR MEMBERS

AMA LIST OF MEDICAL SERVICES AND FEES

The 1 November 2014 edition of the AMA List of Medical Services and Fees will soon be available, both in hard copy or electronic format.

A hard copy of the fees book will be sent to AMA members listed as being in private practice or with rights of private practice, as well as salaried members who have requested a copy. Dispath will commence from 15 October.

The AMA Fees List Online **(http://feeslist.ama.com.au)** will be updated on 1 November. To access this part of the website, simply enter your username and password in the box provided on the screen. Members can view, print or download individual items or groups of items to suit their needs.

Electronic versions (PDF or CSV) of the AMA List will also be available for free download from the Members Only area of the AMA Website (www.ama.com.au/feeslist) [https://ama.com.au/node/4597] from 22 October 2014.

A Fees Indexation Calculator is also available for members to calculate their own fee increase based on their individual cost profile.

To access this part of the website simply enter your username and password in the box on the top right hand side of the screen and follow these steps:

1) once you have entered your login details, from the home page hover over **Resources** at the top of the page;
2) a drop down box will appear. Under this, select **AMA Fees List**;
3) select the first option, **AMA List of Medical Services and Fees - 1 November 2014**;
4) download either or both the **CSV** (for importing into practice software) and PDF (for viewing) versions of the AMA List;
5) for the Fees Indexation Calculator, select option **15. AMA Fees Indexation Calculator**.

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

If you do not receive your hard copy of the 1 November 2014 AMA List of Medical Services and Fees or would like one, please contact the AMA on 02 6270 5400 or email feeslist@ama.com.au

Lost talent the brutal legacy of a beleaguered training system

BY KUNAL LUTHRA, VICE PRESIDENT (EXTERNAL), AUSTRALIAN MEDICAL STUDENTS' ASSOCIATION. KUNAL IS A 5TH YEAR MEDICINE STUDENT AT MONASH UNIVERSITY.

> "Australia sorely needs all levels of Government to work together in providing more than last minute band aid solutions"

Imagine you are a Canadian student studying medicine at the University of Sydney.

Since making the significant decision to cross hemispheres in pursuit of your medical dreams, you have met the same competencies, and passed the same assessments, as all of your peers.

But there are some differences in your medical school experience. One is that you are paying more than $66,000 a year for your studies. Just as strikingly, your chance of achieving full registration as a doctor in Australia may be little more than a coin toss.

The National Medical Intern Data Management Working Group has indicated that 240 applicants for a medical internship in 2014 were not offered a place from the states and territories, out of approximately 480 international full-fee paying graduates of Australian universities.

This year, the abolition of the Prevocational General Practice Placements Program (PGPPP) in the Federal Budget has been a blow to graduate internship hopes.

PGPPP provided rotations to prevocational trainees, including interns, in community general practice. Its axing has meant, in those areas without the funding or capacity to make up for their disappearance, these rotations have been lost. South Australia, for example, announced a reduction of 23 internships in the immediate aftermath of PGPPP's removal.

This story is familiar to those who have watched this issue in recent years.

The Commonwealth initially increased medical student numbers, but the states and territories were expected to train these students when they graduated. After supporting initial increases, the states have tried to pass the buck back to the Commonwealth, which has been resolute in its insistence that it is not its responsibility.

Australia sorely needs all levels of Government to work together in providing more than last minute band aid solutions when managing workforce issues. The problem does not end with internships. Bottlenecks are appearing throughout the medical training pipeline.

But, while AMSA and the AMA have long foreseen these bottlenecks, a myopic approach by Government has stymied any hope of correcting them. As if to highlight this, in September the Senate passed the Health Workforce Australia (Abolition) Bill 2014 in the name of cutting excess bureaucracy, thereby abolishing the body directly tasked with leading the nation's health workforce planning.

We know how many medical graduates are coming through. We know that this number is set to plateau after 2016. We know that it will likely stay that way unless the government lifts the cap on medical student numbers, or approves new medical schools, after this date.

Access to an endless stash of funding for training is not practical, but it is also not necessary. We simply require enough initiative to incrementally match the number of internships with the number of graduates until that plateau is reached.

There is capacity in the private hospital system to train more interns.

The Commonwealth Medical Internships (CMI) initiative, introduced by the Coalition as an election commitment, provided 76 accredited internships in the private sector last year. These internships were mostly in rural and regional areas, and included a one year return-of-service obligation. They were oversubscribed. Expanding the CMI initiative will not only ensure interns stay in Australia, but will provide more junior doctors with experience in rural settings.

We cannot afford to ship out doctors when many rural and remote regions in Australia face a doctor drought.

We should not ship out doctors when those doctors are willing to work in areas of need.

And it makes no sense to ship out doctors on one end of a bottleneck, and then import overseas-trained doctors at the other end to fill workforce gaps.

Failure to respond would be a triumph for political blame-shifting at the expense of community health and the careers of young, Australian-trained medical graduates.

RURAL HEALTH

A phoenix arises in Brisbane?

BY DR DAVID RIVETT

I have recently had the somewhat sorry privilege of attending the final General Practice Education and Training (GPET) convention.

It was held at the Royal International Convention Centre at the Brisbane Showground, a site which certainly reinforces the impression that Brisbane is a supersized country town as one gazes out from the forum's foyer over the cattle sheds.

The presentations and discussion groups were of a high standard, and a good learning experience for an ageing but L-plated dinosaur of a GP supervisor like me.

It was heartening to see the Australian College of Rural and Remote Medicine and Royal Australian College of General Practitioners leadership expressing a determination to work together, and with General Practice Registrars Australia, to find a solid solution to present to the Health Department about how to fill the void when GPET is wound up.

Common themes from the presentations of both RACGP President Dr Liz Marles and ACRRM President Associate Professor David Campbell were that the current apprenticeship system of GP training must continue, and that registrars must be given certainty of training pathways, while also maintaining a rural training scheme.

Large corporates were not seen as part of the solution.

I somewhat uncertainly dragged myself along to the workshops on social media in medical education, and was hugely impressed by what is taking hold.

FOAMed (Free Open Access Medical Education) and many other sites may be in their infancy but they are the future and, in due time, will largely replace textbooks and didactic lectures.

The ability to learn in short bites from peers, whether by sound grabs in podcasts or via videos demonstrating procedures on You Tube is so user friendly it is a no-brainer. Toss in the ability to partake in online discussion groups and you have a great formula. This will help end feelings of isolation for many rural and remote doctors.

Social media is playing a large role in informing today's medical students, and our patients likewise will rely on it increasingly for health information. We can ignore it at our peril or become informed, so we can guide patients and students to reliable sites.

A large thank you to my local training organisation for inviting me, and to GPET for the excellent quality of their educational sessions.

For Government to wipe GPET, which for 14 years has put so many runs on the board, seems idiotic. However, if something better can arise from the ashes with the profession taking ownership of GP training, it could be a change for the better.

> "It was heartening to see the Australian College of Rural and Remote Medicine and Royal Australian College of General Practitioners leadership expressing a determination to work together"

Maybe we are witnessing the conception and birth of a phoenix, with the two GP Colleges as doting parents.

But let us give credit where it is due - GPET has done a great job and will be a hard act to follow.

COMMENT

Health on the hill

Political news from the nation's capital

Co-payment shelved… for now

The Federal Government has shelved controversial legislation to introduce a $7 GP co-payment amid dire predictions hospital emergency departments and ambulance crews would be swamped by patients seeking to avoid the fee.

With no sign that opposition to the proposal among key cross-bench senators is softening, Health Minister Peter Dutton early this month pulled plans to introduce the co-payment Bill, raising doubts that it will go before Parliament this year.

In a statement, a spokesman for Mr Dutton told *The Australian Financial Review* that the Government already had a number of important pieces of legislation to pass, and "there is plenty of time for this legislation to be debated before its commencement".

The Government's plan, under which a $7 co-payment would be levied on all GP, pathology and diagnostic imaging services from 1 July next year, has been vigorously opposed by Labor, the Greens, the Palmer United Party and several independent senators, and has failed to garner public support.

An Essential poll conducted earlier this month found that voter attitudes to the idea have hardened since the Budget – opposition to the idea swelled to 66 per cent, up from 50 per cent in May.

Adding to the Government's tough sell, documents obtained by NSW Labor show the NSW Health Department anticipated that hospital emergency departments would have to treat an extra 500,000 patients if a $6 GP co-payment were introduced, and in Victoria paramedics told a Senate inquiry they expected an increase in serious cases if there was a co-payment because patients put off seeing their doctor to dodge the charge.

AMA President Associate Professor Brian Owler told Fairfax Media the NSW Health analysis showed the co-payment would undo recent hard-won improvements in emergency department waiting times.

"Putting another 500,000 people into that system is going to mean all of those gains are going to be lost, and we are probably going to end up in a worse position than when we started," A/Professor Owler said.

NSW Opposition leader John Robertson said the NSW Health estimates showed the co-payment would "smash" the health system.

Despite the setbacks, Mr Dutton remains publicly upbeat about striking a deal with independent Senators to have the co-payment passed by Parliament.

While refusing to disclose details of his discussions with key cross-bench Senators, Mr Dutton said that "there is going to be the ability for us to do a deal on the co-payment".

"If we want to make our health system sustainable we have to make tough decisions," the Minister said. "We have to get this right, and I'm confident that we can negotiate a situation which makes Medicare more sustainable."

The ambiguous statement leaves open the possibility the Government might accept changes to its co-payment model to secure the support it needs to have the measure become law.

But the discussions may also involve trade-offs that could lead to even deeper cuts to spending on primary care and dumping more health costs onto individuals and families.

Mr Dutton told reporters that the AMA, like the Government, "want[s] to see a sustainable Medicare".

But the AMA has repeatedly said that although it does not oppose co-payments in principle, it rejects the Government's model.

And AMA President Associate Professor Brian Owler said figures produced by the Australian Institute of Health and Welfare showed there was no basis to Mr Dutton's claims the co-payment was needed because Government spending on health was growing unsustainably.

The AIHW reported that total health expenditure grew by a record low 1.5 per cent in real terms in 2012-13, underpinned by a 2.4 per cent slump in Commonwealth Government spending.

A/Professor Olwer said the figures "really make a mockery of the fact that the Government's been claiming that health care expenditure is out of control".

"The Government's used this as a narrative in the lead-up to its Federal Budget, saying that health care expenditure is out of control, and it's used that to justify the introduction of the GP co-payment. Now, there is no justification for a GP co-payment, let alone the $5 [cut] for the patient's Medicare rebate."

There is mounting concern about the sort of deals the Government might strike with independent Senators to achieve health savings.

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A/Professor Owler warned that even if the Government's plan for a $7 co-payment for GP, pathology and diagnostic imaging services was knocked back by the Senate, it might still receive backing for its $5 cut to Medicare rebates, leaving both patients and doctors worse off.

"What we are concerned about is the potential trade-offs and deals that might be done that might mean that we do not have a co-payment, but are still stuck with a cut to the Medicare rebate," A/Professor Owler said. "That would mean patients are worse off [and] that there is no support for GPs or investment in general practice."

Mr Dutton said he was "working behind the scenes with the independent Senators".

Adrian Rollins

COMMENT

Health fund profit margins take a hit

Private health funds have suffered a hit to their profit margin as a surge in payouts outstrip a jump in premium revenue.

Health insurers collectively made an after-tax profit of $1.057 billion in 2013-14, down from $1.11 billion the previous financial year in a result that make take some of the lustre off the forthcoming Medibank Private float.

Figures compiled by the Private Health Insurance Administration Council show health fund membership inched 0.2 per cent higher in the 12 months to June – 11 million (47.2 per cent of the population) held hospital cover, and 12.9 million (55 per cent) had cover for general treatment.

The lift in membership and a Government-approved premium increase drove health fund revenue up by 7.5 per cent to $19.4 billion, but these gains were eaten into by an even heftier 8.1 per cent jump in benefit payouts to $16.6 billion, meaning profits before tax fell 2.2 per cent.

According to the Council, health funds are becoming more efficient – expenses as a percentage of revenue fell 0.3 of a percentage point to 8.5 per cent – but this was not enough to offset the increase in other expenses.

Though Medibank Private may not share in this improvement. Grattan Institute health program director Professor Stephen Duckett told *The Australian Financial Review* the insurer – which is set to be sold off by the Government in December – had a management expense ratio of 9.2 per cent in 2012-13, one of the highest in the sector.

The rise in total payouts reflected "the increasing cost of health services and growing utilisation rates that has not been fully offset by higher premiums", the Council said.

The average payout for hospital care rose from $1044 to $1114 per patient last financial year, with the lion's share ($780) going on hospital accommodation and nursing, while $176 went on medical treatment and $156 on prostheses.

Overall, patients paid an average gap of $292.92 for their hospital stay in the June quarter 2014 – a 1.8 per cent drop from the same period the previous year.

Adrian Rollins

COMMENT

Smokers' rights speech clouded by ideology

Liberal Democratic Party Senator David Leyonhjelm has drawn the ire of the AMA and public health groups after portraying the tobacco excise and passive smoking laws as attacks on individual choice.

In an inflammatory speech in Parliament, Senator Leyonhjelm condemned the tobacco excise as "flagrant theft" and lambasted "health mandarins" who, not content with banning advertising of cigarettes and the commercial cultivation of tobacco, now sought to ban smoking in prisons and "insane asylums".

"That's right, people in cages who have lost most or all of their rights are denied even this small thing," the Senator said. "The same people worry and worry about Aboriginal and Torres Strait Islander smoking rates…Aborigines on income management, like prisoners, are also denied this small consolation. Racial paternalism lives on."

Senator Leyonhjelm said smokers paid far more in taxes than their habit cost in terms of health expenditure. He said the tobacco excise raised about $8 billion a year, while treating patients with smoking-related health problems cost the country a net $318.4 million a year and bushfire control measures cost a further $150 million.

"Smokers of Australia, despite your generosity, I need to apologise on behalf of the short-sighted pickers of your pockets in this place," he told the Senate, and likened current tobacco taxation and regulation arrangements to the Prohibition.

His comment drew swift condemnation from AMA Vice President Dr Stephen Parnis, who labelled them "misguided" and "utterly inappropriate".

"It's an unfortunate case that an elected member of the Parliament has allowed ideology to get in the way of reality," Dr

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Parnis told the *Herald Sun*. "That reality is that smoking kills. It causes long, drawn out painful deaths for thousands of Australian every year.

"Senator Leyonhjelm's comments are misguided, utterly inappropriate and quite disappointing."

Senator Leyonhjelm drew his estimate of the health costs of smoking from a report prepared for the Federal Health Department by David Collins of Macquarie University and Helen Lapsley of the University of Queensland in 2008.

They reported that in 2004-05 there were 14,901 deaths attributable to tobacco use, as well as 753,618 days of hospitalisation. In total, they estimated smoking- related illnesses cost the health system $1.836 billion that year, which was offset by a $1.517 billion saving from the reduced demand for health care from smokers who died prematurely, leaving a net cost of $318.4 million for the year.

But, in his speech, Senator Leyonhjelm made only passing reference to others costs attributed to smoking by Collins and Lapsley.

The researchers estimated the habit resulted in tangible social costs amounting to more than $12 billion in 2004-05, including lost productivity in the workplace and at home because of premature death and illness, the diversion of more than $3.5 billion from household budgets into buying cigarettes, and other community costs such as fire prevention measures.

The Cancer Council said Collins and Lapsley's estimates of the social costs of tobacco abuse were "extremely conservative" and the actual costs were likely to be much higher.

The Council said a lack of data prevented Collins and Lapsley assigning values to many of the social costs known to be attributable to smoking, such as the purchase of over-the-counter medicines, domiciliary care and allied health services. In addition, reduced on-the-job productivity was not costed, despite estimates that smokers take out eight to 30 minutes each work day to indulge their habit.

In earlier research, Collins and Lapsley estimated that tobacco accounted for about 80 per cent of total health care costs resulting from drug abuse in 1998-99.

In 2004, Ministerial Council on Drug Strategy reported reduced smoking rates were likely to have saved the country $8.6 billion in the previous 30 years.

Dr Parnis said the costs of smoking were all too apparent in his daily work in public hospitals.

"No one complains about life-saving care when I'm in my resuscitation bay treating someone who cannot breathe because of the effect of lung cancer," he said. "I'm an emergency physician, and I see these patients on a very regular basis."

COMMENT

Adrian Rollins

Managed care? We just want to look after members, cry insurers

Private health insurers are intensifying their push for a bigger role in the provision of care as preparations for the Medibank Private sell-off advance.

While the major funds are quick to disavow any suggestion of move toward US-style managed care, the industry's peak body, Private Healthcare Australia, has demanded that insurers be freed from current restrictions on their involvement in the provision of primary care, including visits to GPs, pathology tests and diagnostic imaging.

Chief Executive Michael Armitage told *The Australian Financial Review* said the ban on private funds covering procedures provided for by Medicare was nonsensical.

"Not only is it nuts from the financial side of things, it's nuts from the patient's perspective," Mr Armitage told the *AFR*. "Because if there are ways in which GPs can be paid to do more preventive care to keep people out of hospital and hence the GPs be the integral part of the health equation, everyone in Australia would think that's a good thing."

His comments underline warnings made by AMA President Associate Professor Brian Owler earlier this year that the industry was intent on introducing managed care, where health funds – not doctors – would determine what treatment patients received.

"Despite the protests of innocence, I fear a concerted effort on behalf of private health insurers to undermine and control the medical profession," the AMA President told the National Press Club earlier this year. ""The stage is being set for a US-style managed care system in both the primary care and hospital settings, [and] I am concerned that the Government is also looking towards such a system."

A/Professor Owler's warnings have come as major health funds Medibank Private and Bupa have made increasing forays into the provision of health care.

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Medibank, which is in the throes of being sold-off by the Federal Government, is already involved in a controversial trial in Queensland where it covers the 'administrative costs' of general practices in return for a guarantee that its members are given an appointment within 24 hours and do not face gap fees.

Through its Medibank Health Solutions arms, the insurer has also secured a $1.3 billion contract to provide on-base health services for Australian Defence Force personnel. Under the arrangement, it has sought to prescribe to which specialists patients can be referred.

And last week Medibank managing director George Savvides told the *AFR* the insurer was planning to drive a harder bargain with private hospitals: "We only want to contract with the best providers who have the lowest infection rate, the lowest revision rate, the best scores around customer care".

Bupa is making a foray into the direct provision of primary care, opening a series of 12 branded GP clinics beginning this month.

The insurer insists the operation will be kept separate from its insurance activities, and that the clinics will treat Bupa members and non-policyholders alike.

But Bupa Health Services managing director Hisham El-Ansary admitted to the *AFR* that the insurance arm could become more involved in the clinic operation in future.

The Government itself has sent out mixed messages on the issue.

In a major speech earlier this year, Health Minister Peter Dutton spoke encouragingly of that fact that health insurers were "looking at innovative options in the area of primary health care".

But his office has denied any plans to overhaul laws to end the ban on private cover for Medicare-provided services.

And private funds themselves claim they have no interest in intervening in the doctor-patient relationship, and that their sole motivation is to improve the long-term health of policyholders in order to reduce expenses for both themselves and the health system.

All this activity is occurring against the backdrop of the looming public float, with estimates it could raise around $4 billion.

Medibank Private policyholders, called members by the insurer, have until tomorrow to pre-register interest in receiving the float prospectus.

But, in a controversial decision, the Government has ruled that Medibank members will not be given preferential access to shares when the sell-off goes ahead in December.

The AMA has warned the privatisation could lead to higher premiums, but Finance Minister Mathias Cormann insists competition and Government regulations will ensure any increases are limited.

"The truth is that Medibank Private operates as a commercial business in a competitive market now. It will do so in the future," Senator Cormann told the ABC. "Its capacity to increase premiums will continue to be tempered by competitive forces in the market place, and of course by regulatory arrangements."

The Minister claimed the funds of policyholders will be much safer once the fund is privatised because governments will not be able to raid its capital reserves as has happened in the past.

Adrian Rollins

COMMENT

INFORMATION FOR MEMBERS

Qantas Club – AMA member rates – fee rise

Qantas has increased its Qantas Club membership fees for AMA members.

The new rates are listed below.

AMA Member Rates (GST inclusive)

- Joining Fee: $240 - save $140
- 1 Year Membership: $390.60 - save $119.30
- 2 Year Membership: $697.50 - save $227.50

Partner Rates(GST inclusive)

- Partner Joining Fee: $200
- Partner 1 Year Membership Fee: $340
- Partner 2 Year Membership Fee: $600

These are special rates provided for AMA members and their partners.

If you have any questions about this offer, please do not hesitate to contact AMA Member Services at memberservice@ama.com.au or phone 1300 133 655.

OPINION

Caring for those on the mental health front line

BY DR RICHARD NEWTON, MEDICAL DIRECTOR, MENTAL HEALTH CSU, AUSTIN HEALTH

Given October is mental health month, it is timely to remind ourselves of the importance of supporting family and friends who care for people with a serious mental illness.

We have known for many years supporting carers can improve outcomes for patients with illnesses such as schizophrenia.

Good quality family and carer support can help people understand and accept the effects of the illness on their loved ones, and help them support that person in a non-critical way.

Such support can reduce relapse rates and re-hospitalisation, improve quality of life and adherence to medication for the person with schizophrenia, and markedly improve the quality of life and reduce the stress of the carer.

We were taught this as far back as the 1980s, yet even today there are still significant gaps in the provision of these services to families and carers of people with schizophrenia.

In my service, we now ask families and carers to complete a burden-of-care scale, so we can understand what they are experiencing in terms of the stresses of looking after someone.

We have been able to see the enormous work done, and the emotional stress people experience, as part of caring for someone with psychosis. We also see the enormous impact of the illness on the carers and family members.

Caring for someone with schizophrenia is a long journey.

Often you can see carers pass through the five stages of grief, as set out in the Elisabeth Kubler-Ross model – denial, anger, bargaining, depression and acceptance – as they struggle to understand what is happening to someone they love who has this illness.

At different stages of their journey, carers have different needs and characteristics, but there are few services that are active and effective in flexibly and responsively meeting those differing needs.

All mental health services in Australia and New Zealand place a focus on engaging with families. In Victoria, for example, some years ago the Government passed the Carer Recognition Act, and the new Mental Health Act in that State also contains specific sections around working with families and carers.

The National Standards for mental health services also include clear requirements for services to work collaboratively with families and carers. To support this there are a books and web-based services aimed specifically at families or carers.

However, in most cases, this could be improved by more personal support. Indeed, one of the stresses that families report is a sense of isolation, and this is best alleviated by interacting with other people in the same predicament as themselves.

There have been some positive developments.

One of the benefits of the 'first episode psychosis service' that has been pioneered in Australia is the strong focus on working with family and carers, and supporting them.

Many services now have a carer with experience of helping someone with serious mental illness working in the unit, connecting with families who come in, and helping to put them into contact with an appropriate resource that can help support them in their journey.

Some of the work these peer workers do has transformed the care experience for families under great stress.

We know there is a whole range of positive outcomes that come from working effectively with those who care for people with psychosis.

There has been some progress but we need to do better. The gap between unmet need and service provision is still wide.

COMMENT

Research

Treating COPD with antibiotics

This story first appeared on the South Australian Government's The Lead news site on 7 October and can be viewed at http://www.theleadsouthaustralia.com.au/industries/health/treating-copd-with-antibiotics/

South Australian researchers claim to have found a better way of treating chronic obstructive pulmonary disease.

Dr Sandra Hodge from the Lung Research Laboratory at the Hanson Institute in Adelaide, South Australia said that treating chronic obstructive pulmonary disease (COPD) with the antibiotic azithromycin may be more effective than the currently prescribed steroid treatment.

Dr Hodge and a team from the Department of Thoracic Medicine at the Royal Adelaide Hospital administered the antibiotic treatment over three months and found it allows for better control of damage, death and repair in the cells that line the airways.

COPD is predicted to become the third most common cause of death in the world by 2020.

Dr Hodge said that COPD patients have an increased risk of bacterial colonization of the airway and infective exacerbations.

"Treatment with glucocorticosteroids is often ineffective," she said. "Understanding the basis of ongoing inflammation is critical to the development of new treatments."

According to the study, published in the journal *Respirology* this month, treatment with a low dose of azithromycin provides an alternative to address the issues of persistent airway epithelial injury and inadequate repair in COPD-patients.

The study confirmed the desired anti-inflammatory effect of azithromycin on epithelial cells derived from airway lavage and brushing samples of COPD-patient.

Repeated administration of azithromycin to COPD-patients over a three-month period suppressed the production of a specific T-cell toxin, granzyme B, in the airway epithelium.

Jim Plouffe

COMMENT

Planning a family? Pass on the chips…

Devouring a bucket of chips at lunchtime or scoffing fried chicken wings is not only bad for the waistline, but can increase the risk of gestational diabetes in pregnant women.

Women who regularly eat fried food before conceiving have a greater chance of developing gestational diabetes during pregnancy, according to a study published in the journal *Diabetologia*.

While it is well established that frequent consumption of fried food increases the likelihood of becoming overweight or obese, researchers are only now beginning to investigate many other possible health effects.

Researchers at the *Eunice Kennedy Shriver* National Institute of Child Health and Human Development used data tracking the health and behaviour of 15,027 women who had 21,079 pregnancies, including diet information such as the consumption of fried food.

They found that, after adjusting for age, body mass index, and other dietary and non-dietary factors, women who at fried foods four or more times a week were at noticeably greater risk of gestational diabetes (GDM) while pregnant. The risk was particularly acute for those who tucked into fried food seven or more times a week – they were 88 per cent more likely to develop gestational diabetes than those who at fired food less than once a week.

"The potential detrimental effects of fried food consumption on GDM risk may result from the modification of foods and frying medium and generation of harmful by-products during the frying process," the

authors of the study, Dr Cuilin Zhang and Dr Wei Bao, wrote. "Frying deteriorates oils through the processes of oxidation and hydrogenation, leading to an increase in the absorption of oil degradation products by the foods being fried, and also a loss of unsaturated fatty acids…and an increase in the corresponding trans fatty acids."

They added that frying also dramatically increased the presence of advanced glycation end products, which have been implicated in insulin resistance, pancreatic beta-cell damage and diabetes.

In a significant discovery, the researchers found that the increased risk of developing GDM was associated with eating fried foods cooked commercially, rather than at home.

They speculated that this was likely due to the fact that commercial kitchens commonly re-used cooking oil for frying their food.

Overall, the researchers said, "we observed that frequent fried food consumption was significantly and positively associated with the risk of incident GDM. Our study indicates potential benefits of limiting fried food consumption in the prevention of GDM in women of reproductive age".

Adrian Rollins

COMMENT

Gain on disposal? The costs of selling your car

BY **DR CLIVE FRASER**

With years of low inflation, strong competition and a high Aussie dollar it's never been cheaper to buy a new car.

And, after getting a great deal on the purchase price, the cost of acquisition is further reduced by claiming back the GST and the very generous depreciation allowances provided for business users by the Australian Taxation Office.

Until 31December last year, the accelerated depreciation meant business owners could claim $5000 plus 15 per cent of the cost-base balance in the first year, and 30 per cent of the diminishing value every year thereafter.

This arrangement was due to end with the passage of the Minerals Resource Rent Tax Repeal and Other Measures Bill 2013.

As that Bill is not proceeding, it looks like the generous motor vehicle tax deductions are still available.

Those deductions have been so generous over the years that it was possible that your trade-in was still worth more than its depreciated written-down value.

When a car is sold for more than its depreciated written-down value there is said to be a "gain on disposal".

That is, some of the tax previously refunded will need to be re-paid.

For taxation purposes, this amount can also be off-set against un-deducted funds in the capital pool.

Those un-deducted funds might relate to the purchase of a previous vehicle that cost more than the Luxury Car Limit, which is currently $57,466.

For a full explanation of this, seek professional financial advice.

Low prices, long warranties and new technology really do make the arguments for trading up irresistible.

But those of us who already have wheels will have to decide what to do with our current vehicle.

Of course, trading your car in will always be the easiest and most convenient option.

There are none of the hassles of advertising, finding a buyer, test drives, haggling and the annoyance of dealing with those who are just looking.

But dealerships make a living from what they do, and there are times when that trade-in figure will be painful.

All of those cheap new cars mean that used car values are also very depressed, and there are really some great bargains out there for those with the time to shop around.

A case in point is a colleague's recent purchase of a new C class Mercedes.

He found that special smell that new cars have irresistible, and the new C class model is a significant upgrade from his "old" 2012 version.

Anxious not to lose a sale on the new car, the dealer warned my colleague that there would be no good news on the trade-in price, given that his current car had depreciated by 50 per cent in just two years (that is, a rate of depreciation much faster than the tax write-off).

It's all a reflection of the laws of supply and demand.

The new C class has gone up marginally in price, but it's loaded with more airbags, automated braking and is 100 kg lighter, making the superseded model yesterday's technology.

To sweeten the deal, the salesman offered to help my colleague sell his car privately.

After all, a quick check on the Redbook pricing website suggested he'd be able to ask about $9000 more than the dealer would offer, and his old car was in pristine condition, still under the manufacturer's warranty and had only 14,000 kilometres on the dial.

My colleague left his car at the dealership for the morning and took a demonstrator vehicle for the day.

The dealer, at their expense did a safety inspection and roadworthy check ($77), detailed his vehicle, photographed it and uploaded the details ($115) to one of those internet sites that's sending printed newspapers broke.

All was done, and now he just had to wait for the phone to ring off the hook.

Two weeks later, and there has been barely a nibble.

Perhaps the market for second-hand Mercs collapsed the moment his vehicle's details were uploaded, but as this column is being written it is still for sale.

It's such a good car he might just change his mind and keep it after all.

Safe motoring,

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