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Moving beyond ACT Medicare Local

– By Dr Martin Liedvogel, ACT Medicare Local Chair

It is with pleasure that I pen this first article as Chair of ACT Medicare Local (ACTML). I would like to thank the outgoing chair, Dr Rashmi Sharma, for the 10 years she dedicated to being a Director of ACTML, with seven of those years as Chair. Her strategic leadership has left us with a vibrant organisation that is well placed to take the next step in its development. I am also grateful that my role as Chair is well supported by a dynamic Board and a skilled CEO.

I have been in Canberra for just over ten years, having moved to the area from Albury/Wodonga. Being close to the ski fields and closer to my Newcastle family made Canberra a good choice. During my first few years here I worked as a GP and the Medical Director of CALMS, before becoming the Practice Principal at Fisher Family Practice. I find Canberra to be a family-friendly place; perfect for bringing up children.

I have stepped into the role as Chair of ACTML at a time of change in the primary health care sector. As most of you are aware, the Coalition Government instituted a review of Medicare Locals. The Horvath Review was delivered in May 2014 and recommended the formation of a new network of primary health care organisations (PHCOs), called Primary Health Networks (PHNs). The role of the new PHNs are aligned with many activities we provide at ACTML, but with some distinct differences. ACTML's tender has been submitted and we expect the outcome to be known in March 2015.

We have taken this transition from ACTML to ACT PHN as an opportunity to review and enhance how the organisation is operating. As the ACT PHN, we will have a renewed focus on supporting General Practice as the cornerstone of primary health care delivery and on more services for general practice.

Dr Martin Liedvogel

There will be a strong focus on health care service integration, especially for vulnerable populations such as the indigenous population, the homeless, people with mental health issues, unemployed, disabled and people with drug addictions. PHNs will no longer deliver direct patient services unless there is market failure, but rather commission those services.

We will continue to evaluate the primary care needs of the people living in the ACT, and be actively involved in planning health improvement strategies. In order to do this, we will support our members to continue to provide quality services to their patients, and to enable them to enhance these services over time.

Support services will include the exploration of eHealth solutions, data management and analysis, presenting practice models, providing peer support/review opportunities, and building on our quality education program.

The budget that has been allocated by the Federal Government to the running of the ACT PHN is smaller than what is allocated to the ACTML at the moment. This will mean that there will be some changes to how we operate.

We will concentrate on long-term programs that will improve the health of the ACT population, rather than having a number of shorter tenure programs. We will also focus on using our expertise and relationships in the primary health care sector to effect system change.

We will further explore partnerships with private organisations, ensuring that this will always be in the interest of the health care sector in the ACT.

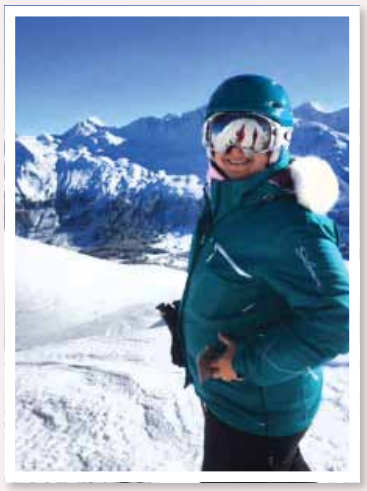
Once the ACT PHN is established, we will be in the position to invest in General Practice through release of the GP Fund carried forward from the ACT Division of General Practice (ACTDGP).

Uses for the fund include: leadership training; supporting the practice research network run by the Academic Unit of General Practice; a project exploring GP experiences and support requirements; investment into *HealthPathways*; enhanced educational programs; a practice development program; and a clinical placement program.

The ACTML Board and CEO are confident that the transition to becoming the ACT PHN will be successful and have minimal impact on members and stakeholders.

The transition will require some minor constitutional changes that we are planning to present in an Extraordinary General Meeting in May or June 2015. We will continue to actively communicate with you, our members, throughout this process.

Capital Conversations with President, Dr Elizabeth Gallagher



Welcome to the first edition of *Canberra Doctor* for 2015. I hope you have all had a good start to the year. Having just had a 5 week European winter with my young adult boys, I don't have a lot to mention in terms of AMA-ACT activities, so I thought I would put together a wish list of things we would like to achieve or see come to fruition in the next year or two.

But first, despite having my head in the sand (or snow and Christmas lights), a few things have happened that are worth a mention.

Firstly, federal AMA has been intimately involved in having the Abbott Government withdraw some of its proposed changes to Medicare- in particular the attack on rebates for GP level A and B consultations. We had a forum to canvas thoughts from our local GPs, which was attended by A/Prof Brian Owler, who has been central to all of these negotiations, and a good number of local member and non-member GPs. There are still many policies we are continuing to oppose, and that are ongoing, but a win is a win … hopefully more to come.

Secondly we have some farewells … and some welcomes. To our long standing Health Minister and Chief Minister Katy Gallagher we say farewell as she heads into federal politics. We are grateful for the positive and consultative relationship we have shared with her over the years and wish her the best as she takes on her new role and new challenges. We welcome the new Health Minister Simon Corbell and hope we can continue the same mutually respectful relationship. We are also to say goodbye to Dr Peggy Brown who has announced she will leave her role as the Director General of ACT Health later in the year when her contract expires. Again, I have always found her a fair and consultative colleague and hope that her replacement will be as approachable as she has proven to be. It would be great to see another medical clinician appointed in her place. We also welcome Karen Edwards who has been appointed as the new CEO at Calvary health Care Bruce and send her our best wishes in this challenging role.

Congratulations are in order to Dr Rob Reid AM and Dr John Smiles AM who were included in the 2015 Australia Day Honours List.

Now to that wish list.

For the profession:

2015 sees the start of negotiations for the new VMO contracts with ACT Health. It seems like we only just finished the last ones! I wish for an easy agreement and resolution. I wish for better engagement between professionals, to work collaboratively and cooperatively , to ensure our hospitals are well run and patient care is the best it can be. This should be through genuine dialogue, not via megaphones, hearsay and The Canberra Times!

For the community:

I wish for a sensible approach to medical cannabis so that those who legitimately will benefit from its use for medical conditions can access it safely. This should include Australian trial results and engagement with the TGA for a product or products with a legitimate medical and safety profile-0 and which will have limited street value or scope for abuse.

I wish for the introduction of an NSP at the Alexander Maconachie Centre after engagement and agreement of all interested parties – including the Prison Officers Union, detainees, medical profession – and addresses the public health concerns.

I also wish for a careful approach to e-cigarettes so that we are not introducing a new medium to young people and non-smokers. Further discussion is addressed later in this edition.

For the AMA:

The AMA is a membership organisation for all doctors. It advocates for individuals, the community and all members of the medical profession. It does not discriminate. It has contacts at territory/state as well as federal level, and continues to be powerful, and active.

I therefore wish for an increase in membership. From GPs who should be aware that the AMA is representing their views to government on issues such as the co-payment, rebate freeze, loss of the GPPPP and changes to GP training. From the junior doctors and doctors in training as they move from non-paying to paying members, as the AMA represents them as medical students, then junior doctors and DiTs and is very active in work force and career planning to make sure that we do not have a glut of unemployed or under employed doctors in the future. We rely on the paying membership to support this service. From salaried doctors who should be aware that the AMA-ACT can and will renegotiate on their behalf as a bargaining agent in salaried medical practitioner terms and conditions – all for the price of a membership.

So the wish list sets the board and I some challenges to deal with over the next year. If any of you have anything you think should be on that list – please let me know. I hope you enjoy this very full, and diverse edition of *Canberra Doctor*.

The ACT Children and Young People Death Review Committee

The ACT Children and Young People Death Review Committee was established in 2012 and is chaired by former Director of the Australian Institute of Health and Welfare and Chief Executive of the ACT Health and Community Care Department, Dr Penny Gregory. Local doctors on the Committee include Alison Kent, Sue Packer, Michael Rosier and Catherine Sansum.

Sue Packer

As part of its role to prevent or reduce future deaths, the Committee conducts individual death reviews. These individual case reviews are conducted by gathering information from a variety of sources – including family, friends and community members – and preparing a confidential and detailed chronology for high-level analysis by the Committee.

It is not the role of the Committee to investigate or determine the cause of death of a particular child or young person. This remains the Coroner's responsibility. The purpose of the Committee is to identify patterns and trends which may require further research, or change in practice, and to help the Committee to make recommendations as a consequence of their findings.

For example, the Committee has recently promoted a fact sheet about unsafe sleeping practices, recommending against co-sleeping after analysing the deaths of 14 ACT infants in recent years.

The Committee does not contact families directly, as this could be very intrusive and the families have already been through the emotional trauma associated with the death and often other inquiries such as coronial and police. However, many families and friends wish to share their experiences, particularly to assist change that might help other families. The Committee is keen to ensure these people feel valued and heard. Family and community input could provide an insight into a child's life which isn't obtained by reviewing information provided by government and non-government organisations.

Canberra doctors are being asked to show their support for the ACT Children and Young People Death Review Committee by ensuring their patients are aware of the Committee's existence and its functions. A good way to help with this would be for Doctors to include the Committee's information brochure in existing resource displays.

For more information about the Committee please see http://www.childdeathcommittee.act.gov.au/

To order copies of the brochure, please contact the Committee Secretariat on (02) 6205 2949 or by email on childdeathcommittee@act.gov.au. An A4 size poster is also available. For queries or to discuss please feel free to contact Committee Chair, Dr Penny Gregory, through the Secretariat.

Calvary John James Hospital news

- In late November 2014 CJJH successfully underwent its ISO Accreditation. It was measured against the 10 National Safety and Quality Health Service (NSQHS) standards.
- Following the successful refurbishment of the Maternity Unit earlier this year, the hospital will be working with the John James Foundation to refurbish the patient accommodation on Curtin Ward. This work commenced late December 2014 and will be expected to be finished in March 2015. This will involve the complete renovation of all patient bathrooms, rooms, televisions and furniture. We are aiming for a more "hotel like" finish.
- CJJH is also be upgrading a second Operating Theatre to the latest Stryker iSuite digital technology. This system will give the surgeon the best possible images whilst performing surgery. All camera equipment in the Operating Suite has also been upgraded to the latest digital quality. The upgraded Theatre will be on line by the middle of January 2015.
- During Christmas/New Year period the hospital has also installed a further two Steris Reliance Vision single-chamber washer/disinfectors. This will ensure the CSSD can meet demand with a total of four Steris Reliance Vision single-chamber washer/disinfector in place. This technology eliminates the need for any manual washing of instruments and reduces turnaround time of instrumentation.

For those who like to know the numbers:

- In the 2013-2014 financial year, Calvary John James Hospital
- Welcomed 1,185 babies into the Canberra Community
- Performed 10,948 surgical procedures
- Admitted 21,218 patients
- Provided a total of 48,456 bed days of care
- Provided 8,604 occasions of service in our Day Rehabilitation Service
- Provided In-patient Rehabilitation Services to 682 patients

CJJH is proud to provide Maternity, Medical, Surgical and Rehabilitation Services to the Canberra Community and surrounding areas.

Sharing the love: A utilitarian view for individuals considering a response to international public health crises

– By Phillip Whiley

A general practitioner may average four consultations per hour, seven and a half hours a day and five days per week. If none of these consultations were to be with the same patient that would amount to over 100 patients in one week. From a utilitarian view, a GP is likely providing a significant amount of benefit for a significant number of people.

GPs might therefore, feel as though they have positioned themselves in the profession and in the society in which they serve, in a way that their skills are impacting that society commensurate with the value they place on their own time. But would a doctor offer even greater utility when there are global health crises and they can offer their skills abroad? This question might be applied to all people living in affluent nations and draws in to focus the ethical dilemma of global health equality. Doctors are uniquely placed to respond to pandemics because they can offer assistance that is fundamental to tackling health crises.

The Ebola outbreak that continues to threaten enormous numbers of people represents a public health disaster that would spread uncontrolled unless there is an international response. For many medical practitioners, it could seem a moral imperative to leave their current medical practices, risk contracting the disease themselves and assist in the response effort. In fact, most medical practitioners would be aware that there are disease outbreaks in other parts of the world that are less virulent but are imposing suffering on a scale even greater than Ebola is presently. War has displaced hundreds of thousands of people in the middle-east creating a public health disaster of massive proportions while third world health conditions can be found in Australia as a result of multifactorial determinants including a shortfall in provision medical care.

Every doctor is endowed with and acquires a set of skills and aptitudes shaping their career path and only a select group of doctors are equipped to participate immediately and be effective in an acute population level health outbreak. Doctors choose a pathway from range of possible alternatives that suit them as they develop their careers. Many also bring to their practice other skills built through life experiences and pursuits. Overall, a doctor could turn his or her skills to many specialisations and there would be a large portion who could decide that humanitarian work is a priority over local practice. What would be the impact of leaving a local practice or hospital? Perhaps the loss of one doctor would make a minor difference to health provision in our country but there may be a deeper ethical humanitarian imperative. A utilitarian doctor would move around the globe filling the needs as they arise however, it would be counter-productive for an individual to attend to a pandemic without the appropriate aptitude and skill especially if their talents are yielding (or promise to yield) far more fruitful outcomes in the local setting. So for a doctor considering how to make the greatest impact, what is the ethical decision process that needs to be embarked upon?

For each doctor this decision will depend on their ethical stance and for most it will be a process influenced by several ethical models.

A deontologist might employ moral rules derived from a religious doctrine or by consulting the Universal Declaration of Human Rights stating a right to the highest attainable state of health. This attitude runs the risk of ignoring the consequences of a course of action but it could be argued that if enough doctors act according to a charter of ethical values, the overall result would be a significantly improved level of health and happiness.

A truly virtuous doctor might feel the compulsion to act decisively out of compassion and empathy in the face of disasters that evoke emotion and a sense of injustice. This course of action also risks neglect of current responsibilities and may sacrifice local needs for the sake of a global imperative.

The utilitarian is faced with the task of weighing up the potential gains made by maintaining local responsibilities against potentially saving lives and alleviating tangible suffering in a humanitarian response.

Utilitarian economic theories provided the basis for modern utilitarian bioethics arguing that medical treatment should be aligned with the future potential for an individual's productivity and happiness. Later proponents such as philosopher, Peter Singer state that it is morally indefensible for developed nations not to aid disadvantaged nations.

Wealthy nations are not free of suffering by virtue of their wealth. Bhutan claims that its people are the happiest in the world by self-assessment and it would not be considered to be a wealthy nation in comparative economic terms. Wealthy nations have a unique brand of suffering and it is argued strongly that wealth itself has given rise to the increased rates of lifestyle diseases, mental health disorders and degenerative disorders. There is also a large disadvantaged minority whose health is compromised by a range of socioeconomic factors. Doctors are therefore required in privileged nations as much as ever.

A perceived level of health and happiness can only be measured in terms of an expected level of health and happiness. It is almost impossible to escape the "me too" mentality of modern urbanised life and health and well-being is no exception. We generally expect to retain health to a reasonable age and generally expect that we can maintain a peaceful existence interspersed with many happy moments. In an affluent society any shortfall in an achieved level of well-being from the expected level tends to be amplified and negatively affects our overall health. A modern doctor is expected to assist in bridging these shortfalls. Of course, a patient in pain has a priority and can expect care but there is a spectrum of pathology spanning acute and immediate to chronic and bearable. A doctor will administer care along this spectrum on an individual basis but a decision about where to pitch a career or at least a period in a career can be made on ethical grounds. He or she might ask, "is it best to see many patients and make small but cumulative impact or is it best to see few patients (or perhaps no patients) but have a drastic and possibly life-saving impact?"

One month into the 2014 Ebola outbreak, as the incidence rate continued to climb, locum recruitment company, Ochre Health called for rural Australian doctors to go to West Africa to contribute. Individual motives for participating or not participating in the response would need to be weighed up against the call for compassion. A judgement might also be

made about the benefits that can be expected from an intervention. Past humanitarian efforts have resulted in unwittingly spreading disease, contributing to the evolution of resistance strains, quarantining that creates social and psychological disruptions in villages and communities, improper regard for privacy, administration of mandatory testing without consent and disruption to economic stability and education. It has become clear that the presence of the medical workers in outbreak areas has caused many local people to hide or to leave, promoting transmission of infection across neighbouring regions. The lofty ideals of humanitarian efforts need be giving a measurable outcome to the beneficiaries.

Making decisions about how to direct your efforts for utilitarian benefit is difficult. Even by accepting to contribute to disaster relief, there are levels of involvement from hands-on to administrative. A doctor who wants to maximise the positive outcomes of their efforts might identify an acute need in a foreign country and immediately travel to respond with primary care, they might feel compelled to conduct research into vaccines and other treatment, publicise the adverse conditions, coordinate efforts within the target country or from the home nation, lobby for a greater home government response or campaign more broadly for prevention. On the other hand, wealthy nations train practitioners in a response to the needs of that nation and there is an inherent obligation to provide a return on that investment. In addition, a doctor can impact on local health problems by maintaining the high levels of health in a wealthy nation and it is plausible that that gives the wealthy nation the strength to open itself to aiding less fortunate nations or to respond to crises.

The value placed on a medical service is governed by personal attitudes. It might be argued that if a doctor is enabling an individual to reach a standard of health that grants a primary human right, a premium should be placed on the utility of that service. Alternately, the benefit of providing a service diminishes as that service enables an individual to approach self-fulfilment which means a higher volume of these services is required to meet the same benefit as a primary human right.

Phillip Whiley is a year 2 student at the ANU Medical School

New research shows almost 2.4 million Aussie adults sunburnt on summer weekends

New research released by Cancer Council on World Cancer Day – 4 February 2015 – shows that approximately 430,000 more Australian adults are getting sunburnt on the weekend than they were four years ago, increasing their risk of skin cancer.

Findings from Cancer Council's National Sun Survey suggest the downward trend in adult sunburn since 2003/04 has hit a hurdle, with adults potentially becoming more complacent about the dangers of excessive exposure to UV rays.

The Chair of Cancer Council's National Skin Cancer Committee, Vanessa Rock, said that the latest data shows that on a summer weekend roughly 2.4 million Aussies are getting sunburnt.

"This means that compared to four years ago, approximately 430,000 more Aussie adults are getting burnt and putting themselves at risk of skin cancer."

She said the data was a wake-up call that highlighted the need for Government to reinvest in national mass market skin cancer prevention campaigns to ensure adults remained vigilant about skin cancer.

"While this latest research demonstrates the number of Australians who were getting sunburnt is still significantly lower than ten years ago, the recent increase is cause for concern.

"The survey suggests men in particular are neglecting sun protection, with 18 per cent getting sunburnt on the weekend, compared to 12 per cent of women."

Ms Rock said possible explanations for the higher rates of sunburn included an increase in the amount of time adults spend outdoors during peak UV periods.

"Our survey indicates that adults are spending more time outdoors in peak UV times than four years ago, increasing their chances of getting sunburnt.

"We also know that 18 per cent of adults didn't protect their skin from the sun when they spent more than an hour outside during summer."

"Almost all skin cancers are caused by UV exposure, so it's important organisations like Cancer Council, as well as government, continue to remind Australians that skin cancer is largely preventable and encourage them to take the simple steps to lower their skin cancer risk – slip, slop, slap, seek and slide."

Key results

Table 1. Weekend adult sunburn – prevalence and trends over time

	2003-04	2006-07	2010-11	2013-14
Sunburnt	18%	14%	13%	15%
Estimated number of people sunburnt*	2,397,521	1,958,997	1,946, 532	2,380,227

Table 2. Weekend adult sunburn by sex 2013-14

	Men	Women	All persons
Sunburnt	18%	12%	15%

Table 3. Weekend sun exposure during peak UVR times – prevalence and trends over time

	2003-04	2006-07	2010-11	2013-14
Respondents outdoors longer than 15 minutes during peak UV times	73%	67%	66%	70%
Mean Time spent outdoors in minutes	118	116	111	116

Organ and Tissue Donation Outcomes: Performance report released

Some 1,117 Australian lives were transformed by the generosity of 378 organ donors in 2014, Assistant Minister for Health Fiona Nash said recently.

Releasing the Organ and Tissue Authority 2014 Performance Report, Minister Nash thanked families of organ and tissue donors and urged Australians to discuss their decision to donate with their families.

"These families gave the gift of life at the time of their loved one's death," Minister Nash said.

"It is a truly amazing gift. The number of deceased organ donors has now increased by 53 per cent since 2009, when the DonateLife Network was established.

"However in 2014, a fall in the number of people donating in some States and Territories meant the number of deceased organ donors nationally decreased by 3 per cent – to 378 organ donors from 391 in 2013.

"Transplant recipients also decreased by a small number."

Research shows that more than 60 per cent of Australian families give consent for organ and tissue donation to proceed. However, families that have discussed and know the donation decision of their loved one allow organ donation to proceed on 80 per cent of occasions.

"I urge all Australians to discuss this important issue with their families and register their wish to donate," Minister Nash said.

"Less than 1 per cent of people die under the specific circumstances in hospital where organ donation is possible.

"Families that have had a prior family discussion find it much easier to agree to a loved one becoming a donor. For many, the donation process provides them with comfort in their loss of a loved one.

"I invite discussion on how the Australian community can continue to lift donation rates and on the appropriateness of the current donation arrangements, which place responsibility on the family to decide whether or not organ donation can go ahead.

"One organ and tissue donor can transform the lives of ten or more people. One conversation with your family today could help save the lives of many."

The challenge of continuing to increase organ donation rates will be discussed by Commonwealth, State and Territory governments in the coming months.

The number of organs transplanted in Australia has increased by 39 per cent since 2009, while the number of transplant recipients has jumped by 38 per cent, as doctors often take multiple donated organs from each donor.

"The report also showed that in 2014, we saw a 31 per cent increase in deceased tissue donation from both tissue only donors and multi organ and tissue donors.

"In the same period there was a 45 per cent increase in tissue grafts transplanted and a 50 per cent increase in the number of tissue transplant recipients," Minister Nash said.

"In 2015 we will focus on continued change in clinical practice such as increasing the number of identified potential donors, improving the donation process for loved ones and enhancing IT systems to support organ and tissue donation and transplantation."

For more information and the full Organ and Tissue Authority 2014 Performance Report visit www.donatelife.gov.au

donate life

Calvary Hospital appoints new CEO

Karen Edwards is the recently appointed Chief Executive Officer of Calvary Health Care ACT. This role embraces Calvary Health Care Bruce (Calvary Public Hospital), Clare Holland House (public hospice and specialist palliative care service), and Calvary Private Hospital Bruce.

Karen was formerly the Chief Executive Officer and Director of Nursing at Calvary Health Care Sydney, an inpatient day-only and community based palliative care, rehabilitation and aged care service provider.

Karen's earlier career included being the Assistant Director of Clinical Operations for the South Eastern Sydney Illawarra Area Health Service, Director of Clinical Business Development with the Singapore National Kidney Foundation, and senior positions in the Northern Sydney Area Health Service and NSW Health.

"I have really enjoyed settling into Calvary and appreciated the hospitality extended to me from all quarters of the health services network. I am aware of the collective desire of public and private health and hospital services, primary care providers and specialists to develop within the ACT an integrated network that offers patients timely access to services and seamless transitions from one care modality to the next.

"I have an excellent team at Calvary embracing clinical and administrative excellence, I have inherited frank and effective communications channels with the ACT Government and ACT Health, and I have also become aware that primary care providers have confidence in and support for Calvary.

"I am very keen to repay your confidence and support by having our services work closely with you so that we develop a holistic approach with you to caring for 'our' patients.

"Our Community Specialist Palliative Care program illustrates how effective, and good for patients, we can be when we work in partnership. I would welcome the opportunity to attend any forums or events that enable me to meet primary care providers and expand my knowledge of how we can best work with you and your patients."

Karen is also a survey coordinator and education provider with the Australian Council on Healthcare Standards and until moving to Canberra was the Board Chair for the Health Services Association in NSW.

GP Co-payment: Contraindicated

– By Kate Musil

In May 2014, the Abbott Government proposed a reduction in the Medicare rebate for general practitioner (GP) visits and outside-of-hospital pathology and diagnostics, asking individuals to cover the $7 gap when accessing these services.

The policy aims to deter unnecessary usage, with a 1% reduction in doctor visits expected to raise $3.5 billion over the next four years. These savings, the Government argues, are necessary to sustain Medicare against the increasing costs of an ageing population, novel medications and public hospital funding. With Medicare costs having increased from $8 billion in 2004 to $19 billion in 2014 and projected to reach $34 billion in 2024, the proposal might seem like a quick fix. However, it relies on the notion that some GP visits are unnecessary, and that a $7 fee will deter such visits.

Who will be deterred by a $7 co-payment?

Health services already cost money in Australia. Taxpayers contribute 2% of their gross income to Medicare, and pay the difference between Medicare and specialist charges, the Pharmaceutical Benefits Scheme (PBS) and prescription medication, and gaps not covered by their private health insurance. Many GPs charge their own co-payment, and one in twenty already avoid visiting their GP because of the costs.

Whilst those with higher economic standing are able to spend more on their health, those with lower earnings spend significantly greater proportions of their income on health services. In contrast to the average 1% spent by top-income households, 17% of households in the bottom income bracket spent more than 10% of disposable earnings on healthcare. Our poor are sicker. Those with lower socioeconomic status have higher rates of health-risk behaviours (smoking, sedentary lifestyles, poor nutrition and overweight/obesity), suffer an increased burden of disease (diabetes, cardiovascular, cerebrovascular and respiratory disease, arthritis and mental illness) and have lower life expectancies than those with higher socioeconomic standing. The converse is also true, those with chronic disease slide down the socioeconomic slope. They lose their ability to work, receive insufficient financial assistance to cover medical bills, are subject to prejudice and discrimination, turned away by friends and family, lose self-confidence and their mental well-being.

An additional $7 charge is unlikely to affect those of comfortable economic standing, but will impact those already struggling with the costs of healthcare: our poorest, sickest and most vulnerable groups. The proposed policy targets those already disadvantaged, impinging on their right to health. Everyone is entitled to enjoy the highest attainable standard of physical and mental health, and services should be within physical and economic reach for all. How could we support this policy proposal which blatantly discriminates against those in most need?

Which visits are unnecessary?

There are other disincentives to consulting a GP, besides the costs. One must ring to schedule an appointment, juggle plans to fit in with doctor availability, arrange transportation, childcare and time off work, and battle long waiting times in rooms filled with contagion. It is difficult to comprehend why anyone would subject themselves to such an experience without legitimate concerns about their health, or the health of someone they care for.

Certainly, there are conditions more sinister than others. For example, a bacterial pneumonia needing antibiotic treatment and a self-limiting respiratory tract infection requiring only supportive care. But is a consult for the latter unnecessary? Diagnosis falls under the role description of a GP with the years of education and experience required to consolidate the history of symptoms, findings of physical examination, and results of investigation to determine between differentials. Suggesting that a patient can, or should, weigh-up such information (without the appropriate background) before deciding to consult their GP is absurd.

The GP's role also encompasses that of an advisor and educator. If a patient presents for something which could be managed at home, this is an opportunity to educate the patient, to equip them with the knowledge and skill required to identify and respond to subsequent occurrences independently. The GP approach should be patient-centred, working collaboratively with the patient, discussing and addressing fears and expectations to alleviate

concerns and ensure the best outcomes for each individual. Consultations which empower the patient, enabling them to take increased responsibility for their own health, cannot be considered unnecessary. They result in the highest individual outcomes and mould efficient use of healthcare services into the future.

A major role of the GP in primary healthcare is that of prevention, early identification and intervention. Barriers and restrictions to GP access may result in missed opportunities to reduce risks and prevent disease, or to diagnose early-stage illness and reduce progression. Patients will suffer. They will present later, with increasing complications, at a greater cost to the healthcare system, and with poorer outcomes. This is unethical. Doctors have a responsibility to protect and promote the health of individuals and the community. The good of their patients should be the priority, and harm should be avoided. We cannot support a policy that is likely to cause suffering.

The verdict?

A $7 co-payment will prevent the nation's poorest, sickest and most vulnerable from accessing the health services they need. The proposed policy is a blatant contradiction of human rights: the right to health, and is likely to cause harm and suffering, unethical in the medical profession. That such discriminative policy has been proposed in this day and age is a disgrace. We should be ashamed, Australia.

Kate Musil is a year 3 student at the ANU Medical School

References available from the author on request

New alliance to take on "the big two" in health insurance

Not-for-profit and mutual health funds, making up more than a third of funds in the Australian health insurance market, have joined forces to tackle the 'big two' – Medibank Private and BUPA – head-on.

Fifteen not-for-profit and mutual health funds (representing 18 brands) have come together to launch Members Own Health Funds.

The creation of Members Own Health Funds follows the sale of Medibank Private last year – removing it from ownership by the Australian public and dramatically changing the landscape for Australian health insurance.

"The private health insurance sector is now dominated by a listed company in Medibank Private and an overseas based multinational in BUPA," Mr Brad Joyce, Chairman of Members Own Health Funds said.

The facts, as independently validated by KPMG*, are:

Over the past five years, on average Members Own health funds have collectively given more back to their members than the comparative group of Medibank Private, BUPA, NIB and AHM collectively.

Over the past five years, on average Members Own health funds have collectively delivered better service than the comparative group collectively.

Over the past five years, on average Members Own health funds have collectively had higher member satisfaction and loyalty, and dramatically lower relative rates of member complaints to the Ombudsman than the comparative group collectively.

"Members Own health funds offer an attractive alternative to the 'big two' and are now a strong third pillar in the health insurance sector," Mr Joyce said.

Members Own Health Funds is launching a nationwide public awareness campaign to make sure Australians know there is a choice beyond health funds run to benefit shareholders and overseas owners.

"We have a message that we think all Australian health fund members – indeed anyone thinking of investing in their health – will want to hear," Mr Joyce said.

Members Own Health Funds include:

- ACA Health
- Australian Unity
- Defence Health
- GMHBA
- HBF
- Health Partners
- Latrobe Health Services
- Navy Health
- Peoplecare Health Insurance
- Phoenix Health Fund
- Police Health
- rt Health
- St Lukes Health
- Teachers Health Fund
- TUH

**Refer www.membersown.com.au for the detailed report supporting these facts.*

GPs @ AMA Fora say "scrap destructive Medicare changes"

Hundreds of GPs have attended AMA fora in their State or Territory over the last two weeks to have their say about the future of Medicare and Australia's health policy.

Meetings were held in Hobart, Canberra, Melbourne, Adelaide, Sydney and Brisbane, where GPs took the opportunity to express their anger and disappointment with the Government's proposed $5 cut to the Medicare rebate for most patients from 1 July, and its plan to extend the freeze on rebate indexation until mid-2018.

The meetings formed a critical part of the AMA's campaign to support general practice, and the AMA welcomed Prime Minister Tony Abbott's announcement that no new co-payment proposals will go ahead without the support of the medical profession.

AMA President, A/Prof Brian Owler said he was "available immediately to start the good health policy conversation with the Prime Minister".

Letters to the Editor

Dear Editor

The GP Co-payment: Bad for our health, bad for the economy

The December issue of *Canberra Doctor* featured an article titled "The co-payment and its forgotten goal". In it, the author restated some of the goals of the co-payment, such as shorter waiting times, while reinforcing the urgency that the government has tried to impress upon us about solving the "budget emergency". Although the author acknowledges that the co-payment is flawed, it still endorses the idea that our current system is unsustainable and too expensive, and that the introduction of a co-payment is preferable to no change at all. This is inaccurate. A co-payment will not only be bad for the health of our most vulnerable citizens, it will also hinder economic growth through undermining our healthcare system.

To begin with, Medicare is a very efficient part of Australia's health spending. It is not growing unsustainably; rather our doctors are now diagnosing patients more efficiently as our population ages. In 2013, 6% of government health expenditure went to GP services through Medicare. 85% of Australians visited their GP, while only 15% visited a hospital where far more was spent. Australian health expenditure as a percentage of GDP has increased by 1.1% over the last decade, however this was in alignment with the OECD trend and slightly below the average.

The December issue of *Canberra Doctor* contained another article, "New reports support AMA calls for greater investment in general practice" which demonstrated this, highlighting the findings of the Bettering the Evaluation and Care of Health (BEACH) reports evaluating a decade of trends in Australian general practices. The findings were very positive:

- 68 million extra problems managed (48 per cent increase), of which 24 million were chronic conditions such as diabetes and depression;
- 35 million extra GP-patient encounters (36 per cent increase), 17 million of which were with patients aged 65+ (a 67 per cent increase);
- 10 million extra hours of GP clinical time (43 per cent increase);
- 10 million extra procedural treatments (a 66 per cent increase).

So, the health expenditure as a percentage of GDP increased incrementally by 1.1% over this period while the health outcomes achieved were far more significant. These trends are extremely positive as we want individuals to visit their GPs when they are ill as primary care has consistently proven to be the most cost effective form of health care.

Despite these positive trends, the author would have us forego this progress for a simpler solution to our health needs:

"the disincentive provided by the co-payment against going to the GP will mean consumers would have a new incentive to think twice about going to the GP with a minor complaint. They would look after their own health and, to avoid the co-payment, move to more healthy lifestyles."

This attitude is the opposite of what we should be encouraging. GPs help their patients to adopt healthier lifestyles – being healthy is not a form of ingrained knowledge. It is also important to remember that sometimes you need to see a doctor to tell you if you need to see a doctor. How is the patient expected to diagnose what is or is not a "minor complaint"? This backwards logic needs to be removed from the debate on the merits of a co-payment as it is not based on facts or even common sense.

There is also strong evidence to suggest that government spending on health benefits the economy, while cutting back on health and social spending inhibits economic growth. A 2013 study on government spending on health in the European Union found that, on average, for each $1 spent on health, $4.30 was returned to the economy. Basu and Stucklers' larger study of government spending during economic downturns globally and historically found that governments that invested in health and social support recovered much faster than those that cut support, which often faltered on the path to economic growth. Spending wisely on health is the right economic policy, and the wise choice is strengthening primary health care, not cutting funding for it.

The concern that the author has for future generations is sincere, but we need to ask ourselves what legacy we want to leave future generations: a small budget deficit (which Australia's is by OECD standards), or a fundamentally broken healthcare system? A co-payment is not policy based on research, public demand, or economic necessity, it is based on ideology and we should continue to resist it.

Nicholas Elmitt is a research officer at the Academic Unit of General Practice, ANU Medical School. References available on request from the author.

Choosing Wisely Australia launching in 2015

Australia's medical community will unite in 2015 for a new initiative – Choosing Wisely Australia®.

Peak medical colleges and consumer groups will collaborate in this national initiative to improve the quality of healthcare and facilitate better conversations between clinicians and consumers.

The initiative identifies tests, treatments and procedures that are commonly used but can often provide no or limited benefit to the patient and in some cases, lead to harm. Improving conversations about medical tests and other procedures will help support quality healthcare through appropriate use and improved patient safety.

Lists of tests, treatments and procedures that should be considered or questioned will be developed by participating medical colleges and societies. These will help facilitate optimal healthcare.

Choosing Wisely Australia is facilitated by NPS Medicine Wise, an independent, not-for-profit, evidence-based organisation that promotes quality use of medicines and medical tests. Importantly, the Choosing Wisely initiative is health profession-led.

Choosing Wisely Australia is modelled on the successful Choosing Wisely campaign in the United States launched in April 2012 by the American Board of Internal Medicine's ABIM Foundation, and Choosing Wisely Canada, launched in April 2014. Many countries around the world are currently adopting the campaign.

The full list of participating medical organisations and further information will be provided ahead of the launch of Choosing Wisely Australia in the first half of 2015.

The official twitter handle for the initiative @Choose WiselyAu is now active and will provide updates as the launch approaches.

Congratulations to the graduating class of 2014 ...











AMA and BOQSpecialist Bank host the graduating class to breakfast

Qantas Club membership rates for AMA members

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

(all rates are inclusive of GST)

To renew your Qantas Club Corporate Membership contact the secretariat to obtain the AMA corporate scheme number.

For new memberships download the application from the Members' Only section of the AMA ACT website: **www.ama-act.com.au**

For further information or an application form please contact the ACT AMA secretariat on **6270 5410** or download the application from the Members' Only section of the AMA ACT website: **www.ama-act.com.au**

AMA (NSW) welcomes Government move to ban sale of e-cigarettes to under 18s

AMA (NSW) President, Dr Saxon Smith, is congratulating the State Government on producing a bill that would ban the sale of e-cigarettes to under 18s.

"With the great work that's been done in reducing smoking levels in Australia, now is not the time to start a new fad that leads to poor health outcomes, including addiction.

"Removing the smoke from cigarettes does not suddenly make them safe for human consumption," Dr Smith said.

"Liquids for e-cigarettes can contain nicotine, just like regular tobacco products, even if it doesn't say so on the package.

"Nicotine is a highly addictive substance which also increases your blood pressure, among other negative health effects.

"It doesn't matter if it gets into your system through smoke or vapour, it's still going to affect you the same way.

"So, even if e-cigarettes are better for your lungs, they're still no good for your heart," Dr Smith said.

"Great strides have been made in the last few decades in encouraging people not to smoke.

"We've reached a point where we have historical low levels of consumption of tobacco products in Australia.

"It would be a shame for this fantastic public health success to be wasted, if take up of e-cigarettes manages to reverse this trend," Dr Smith said.

Dr Gallagher, President of AMA (ACT) stated the issue of e-cigarettes is currently under consideration by ACT Government and AMA (ACT) supports a ban for under 18's.

E-cigarettes should be subjected to the same restrictions as tobacco cigarettes

– By Monica Lamberton

Electronic cigarettes (e-cigarettes) entered the market as an aid for the cessation of tobacco smoking and as a substitute for nicotine replacement products.

However, uncertainties still remain on the harms and benefits of these products. Their aggressive marketing campaigns which resemble those used to popularise tobacco cigarettes in the 50's and 60's, are a growing cause for concern. e-cigarettes are proving to be more than just a nicotine substitute in some circles and are potentially normalising the act of smoking. These products should be subject to the same restrictions as tobacco cigarettes to minimise any potential negative impacts on smoking cessation and undermining of existing tobacco control measures.

e-cigarettes simulate tobacco smoking by delivering a nicotine-containing vapour resembling smoke. Heating of a solution containing usually propylene glycol or glycerol, nicotine and flavouring agents, produces a vapour that does not contain some of the harmful chemicals found in tobacco smoke. Marketing via television, the internet, and print advertisements portrays e-cigarettes as a healthier alternative to tobacco smoking. However, popular claims have also included that they are cheaper, modern, do not produce second-hand smoke, and can be smoked anywhere because they circumvent the smoke-free policies. There is also a strong presence in social media to reinforce these marketing messages with celebrity endorsement from the likes of Katherine Heigl and UK musical group Girls Aloud, "puffing on e-cigarettes to cope with the stress of their 10th anniversary tour".

The World Health Organisation (WHO) recently released a report on electronic nicotine delivery systems, calling for their regulation in the interest of public health. The WHO report notes that is it the entry of the tobacco industry into the market which appears to be the greatest threat to public health. Leading cigarette manufacturers have been aggressively promoting electronic cigarettes designed to look remarkably like traditional cigarettes. This is the first time since the 1970's that tobacco companies have been able to market their products on television and radio. It's also the first time new generations are being exposed to mass marketing of an addictive nicotine product for use in a recreational manner.

It is the opinion of the WHO that there is insufficient evidence to determine any benefits of e-cigarettes on quitting smoking. Furthermore, the risks of e-cigarette use is also uncertain due to the variability of products and their ingredients. The second-hand smoke has not been found to be a significant health concern. However, this was the conclusion of studies funded by the e-cigarette industry. Therefore there needs to be some form of marketing regulation to prevent false information penetrating societal views.

The majority of e-cigarette users are dual users, that is, they also continue to smoke conventional cigarettes. Quite often users of e-cigarettes have the intention to reduce the harms from smoking and to cut back from conventional cigarettes but not to quit smoking overall. Therefore e-cigarettes may reinforce delaying or deterring a desire to quit smoking.

Although most users of e-cigarettes have a history of smoking tobacco cigarettes, some young people who are non-smokers have also tried e-cigarettes and these numbers are rising. In the US, among grade 6-12 students, the use of e-cigarettes increased from 3.3% in 2011, to 6.8% in 2012.

A subculture has emerged, calling itself the 'vaping community' which views electronic cigarettes as a safer alternative to smoking but also as a hobby. There is concern that the new image of smoking created by e-cigarettes has the potential to normalise smoking to new generations that would have otherwise perceived smoking as dangerous.

The ultimate consequence of e-cigarettes on public health will depend on what policies are implemented. Regulation should at least include the same restrictions that apply for tobacco cigarettes. That includes; prohibiting the use and sale of e-cigarettes to anyone who cannot legally do this with conventional cigarettes, prohibiting television and radio marketing of e-cigarettes, prohibiting any health claims of these products unless approved by regulatory agencies, and establishing standards for the regulation of e-cigarette ingredients and functioning.

A landmark legal case in Western Australia saw the banning of electronic cigarette sales. The Supreme Court ruled that the sale of a product designed to resemble a cigarette was in breach of the Tobacco Products Control Act 2006 (WA). Other mainland states including NSW, Queensland and South Australia have similar provisions to create offence for the sale of products which resemble tobacco products. However in the ACT the only prohibition is on the sale of toys or confectionary which resemble a tobacco product.

Some people find it counterintuitive to ban the sale of a product which has the potential to help people quit smoking. However, the simple solution to this is having e-cigarettes available on prescription as a quitting smoking tool, but not something readily available to young people.

It is crucial that the ACT follow suit in banning the sale of e-cigarettes but also implement other policy to protect public health. These are; restrictions to marketing of e-cigarettes on television and radio, prohibition of unapproved health claims, and regulation of e-cigarette ingredients and functioning. It is through implementation of this policy that we can prevent potential harm caused by rising levels of e-cigarette use in young people, delayed or deferred quitting among adults and young people, and renormalisation of smoking behaviour.

Monica Lamberton is a year 3 student at the ANU Medical School

References are available on request from the author

New open access public health journal focuses on policy and practice

A new online-only open access journal focussed on high-quality peer reviewed research meaningful to those working in public health, has recently been launched by The Sax Institute.

Public Health Research & Practice is targeted at public health decision makers and practitioners, as well as those whose work encompasses aspects of public health.

"Our point of difference is our strong commitment to connecting public health decision makers and practitioners with research that has direct relevance to their work," said journal Editor Ms Anne Messenger. "Our journal aims to make a real-world impact on public health policy and practice."

The journal aims to publish high-quality papers with a special focus on innovations, data and perspectives from policy and practice. It represents a new direction for the *NSW Public Health Bulletin*, published for nearly a quarter of a century by the NSW Ministry of Health. The journal remains supported by the Ministry and will build on the *Bulletin's* strong history with sharpened focus on papers that describe cutting-edge research and public health programs. A full archive of *Public Health Bulletin* articles is available on the journal's new website.

In its first issue *Public Health Research & Practice* looks at systems thinking in chronic disease prevention and how we can look systemically at environmental and societal problems that harm our health and cause lifestyle-related diseases such as heart disease and diabetes.

One of the papers in the first issue outlines a national research project about to get under way that will allow us to measure for the first time how "liveable" Australian cities are in terms of the impact they have on our health.

The National Liveability Study will develop Australia's first set of national "health liveability indicators" and the results will be an important tool for federal, state and local governments, developers, public health planners and other groups working to create healthy neighbourhoods.

Led by Professor Billie Giles-Corti, of the University of Melbourne, the study team is made up of researchers from across the country, including University of Canberra's Centre for Research and Action in Public Health.

The project has buy-in from state and federal governments and nongovernment organisations, who will sit on a national advisory group. State-based technical working groups in the ACT, Victoria, NSW, Queensland and WA will provide advice during the project, which will run over two years.

"We hope this project will leave a legacy to the nation," Professor Giles Corti said.

"By developing a standard set of indicators that can be used across the country, we will be able to measure which environments work best for our health – and which don't. And we'll also be able to use them to measure differences within and between cities, and the progress being made towards improvements."

While there are existing measures used across the globe of how "liveable" cities are, no-one has yet measured "liveability" from a health perspective.

Evidence already shows that making neighbourhoods more liveable benefits health and wellbeing. A liveable neighbourhood is one that is "walkable", has access to public transport, public open space, local amenities, and social and community facilities.

The study's research team will kick-start the measurement process by using a Geographic Information System (GIS) to examine five domains of liveability:

- Alcohol – access to licensed and off-licence premises
- Food – access to local food outlets such as grocery stores, supermarkets and takeaway outlets
- Public open space – access to parks, open spaces and vegetation
- Transport – access to public transport and private vehicles, and household travel patterns
- Walkability – access to street connectivity, land-use mix and residential density.

The team will review relevant urban planning policies of Australian states and territories for each domain, map this against health information, and create and compare a set of indicators based on the policies.

The research is a project of The Australian Prevention Partnership Centre, a collaboration of more than 20 organisations that is investigating how to build a national system to prevent chronic disease. The Liveability Study team is made up of researchers from institutions across Victoria, NSW, WA, ACT and Queensland.

Sally Redman

Public Health Research & Practice is guided by an expert editorial board, chaired by Editor-in-Chief and Sax Institute CEO Professor Sally Redman.

Readers can subscribe to receive free quarterly e-alerts when the journal is published, make suggestions about themes or topics for future issues, submit manuscripts and follow the journal on Twitter @ phrpjournal.

AMA ACT welcomes the new class of 2015 medical students

2015 Directory of Medical Specialists, Directory of Allied Health Professionals and Directory of GPs with Special Interests

… a publication of the AMA ACT

AMA (ACT) LIMITED

The second edition of the directory of **Allied Health Professionals** and **GPs with Special Interests** will be published as a service to ACT general practitioners and distributed with the 10th edition of the **Directory of Medical Specialists** during Family Doctor Week in July 2015.

Entries must be on the form below and returned to the address below no later than 30 April 2015.

Mail: AMA ACT, PO Box 560, CURTIN ACT 2605
Fax: 6273 0455

☐ **Directory of Medical Specialists** ☐ **Directory of Allied Health Professionals** ☐ **Directory of GPs with Special Interests**
(Select which Directory/s you would like to go in)

Name:

Services offered:
(Please keep this brief and use only accepted abbreviations – eg: DCH, Diploma in Child Health)

Practice Details (1)	**Practice Details (2)**
Phone:	Phone:
Address:	Address:
Fax:	Fax:
Email:	Email:
Website:	Website:

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

Signed: _____ Date: _____

AHPRA registration number: _____

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

NOT FOR PUBLICATION

Contact Phone: _____

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

☐ Fax number:_____ ☐ Email address:_____

Divesting from general practice – addressing some of the myths around primary care and heatlhcare spending

The current Federal Government has suggested that divestment from general practice is the way to improve the "budget bottom line".

As recent Fellows of the RACGP, we have been dismayed at the myths and legends that seem to be informing government policy. We are equally troubled by the lack of consultation with general practitioners who actually know how things work on the front line of primary care. We would like to address some of these myths for the Canberra medical community, whom we hope will be behind supporting quality primary care.

There a healthcare budget emergency

Often quoted is the rise in total healthcare spending, from $68.7 billion in 2002-03, to $147.4 billion in 2012-13. However no one mentions that as a percentage of GDP, this spending has remained relatively stable rising only 1.1% over this time. During this period, Australian health expenditure as a percentage of GDP has grown at the same rate as the OECD average to 2012, so it would seem that this talk of an emergency might be slightly premature.

We agree that with an ageing population, healthcare costs are going to rise, but is divesting from primary care the best way to control this spending? Reviewing the healthcare system as a whole, rather than targeting general practice, would seem a more holistic way to do things.

Current bulk billing rates are enough to cover general practice care

For years governments have been reporting "bulk billing" rates of GPs as some kind of marker of quality . They have been proposing that general practice can be provided at Medicare item rates.

In reality, Medicare items do not cover the cost of quality general practice. MBS items have not been increased to keep in line with inflation costs alone, and a consultation up to 20 minutes is rebated at $37.10. At these low levels, GPs are forced to work in one of two ways – see more patients more quickly and be creative with billing codes, or get the patient to pay the gap. Despite these difficulties, GPs have managed to bulkbill more than 50% of consultations in the ACT .

A common misrepresentation is that Medicare billings equal a GPs wage. However Medicare billings have to cover rent, rates, electricity, water, reception staff, nursing staff, medical equipment, consumables, computer systems and stationery.

In a general practice that offers 15 minute appointments, with nursing support and reception staff, a complex, in-depth bulk billed appointment is really not much more than pro bono work. The average contracted GP will earn (before tax) $19 for a bulk billed 15 minute appointment, and like any other contractor, will need to make their own arrangements for leave and superannuation.

It's OK, the government will always protect those most vulnerable to healthcare costs

The initial Federal Government policy suggested charging a co-payment for HCC holders for up to ten visits per annum, with the more recent policy removing this clause. However, any GP will tell you that we have many Canberrans who do not meet eligibility criteria for the HCC, who earn just over the income threshold and they will suffer.

There are many occasions when people who are not on any welfare, cannot afford to pay anything to the GP for care – having multiple review appointments for a child with acute illness; having just lost their job; ongoing care for chronic illnesses.

If GPs received $5 less for every patient that was in hardship, they would have to make up the difference from other patients that could afford to pay. This would likely mean that the gap charged by many practices would increase.

Australians have had a free ride for so long, isn't it time we sent a "price signal"?

Australians already pay more per capita for healthcare (consultations, medications, pathology, radiology) than any other nation except the USA . So they already have a "price signal" when it comes to looking after their health.

Increasing the cost for a patient to access general practice care will likely mean patients will delay their presentation, or they will re-route themselves to Emergency Departments. Worryingly, an Adelaide team showed that four extra patients arriving per hour in ED would increase time to be admitted by 3 hours from 7.7 to 10.7 hours .

We cannot expect patients to determine if their presentation is "appropriate" and deter them from seeking advice – in addition lower health literacy is likely to affect vulnerable populations disproportionately . They may avoid necessary care to the detriment of their longer term health, leading to more expensive health outcomes in tertiary care.

There are so many GPs practicing six minute medicine, we need to stop the "sausage factory" medical clinics

BEACH data from 2012-2013 found of all timed Medicare/DVA claimable encounters:

- the range was 1 to 165 minutes
- the average length was 14 minutes
- the median was 12 minutes
- the mode was 10 minutes
- 10% were timed as 6 minutes or less .

So it would seem that 90% of GP consultations take longer than 6 minutes, and most are well more than 10 minutes.

There are, without a doubt, GPs in our community who are not practicing quality medicine, but they seem to receive a disproportionate amount of media and professional attention.

The majority of general practitioners are passionate, caring and motivated individuals who pride themselves on rising to the challenge of caring for their patients from cradle to the grave, head to toe and everything in between with evidence for high levels of patient satisfaction.

They juggle the roles of being a patient advocate as well as gatekeeper to health services within the confines of a sociopolitical climate that is threatening to further destroy primary health care. It is our greatest fear that in the current context of devaluing general practice, these champions within the field will, indeed, burn out.

A strong primary health care system is the most cost effective way to improve the health of an entire community

This one is not a myth. This one is true and has been found to hold true in countries across the globe. In addition, the Productivity Commission has suggested that 600 000 – 750 000 public hospital admissions could have been avoided annually if effective primary care was provided in the 3 weeks before admission, a cost saving of $4000 per patient, or over $2.4 billion .

Divesting from general practice care does not make economic sense for trying to reduce healthcare expenditure. Instead of investing enormous amounts into late stage illness, we should have greater investment in upstream prevention to stop people from falling ill in the first place. And THAT is what quality primary health care does.

Review of healthcare spending is wise. Targeting one part of the healthcare system, without considering the impact of cuts on the system as a whole, is not. We welcome the Federal Government's commitment to consultation and we hope that they will look beyond MBS general practice item numbers.

The authors for the article are: Dr Elizabeth Sturgiss, Dr Janine Rowse, Dr Rebecca Kathage, Mr Nicholas Elmitt, Dr Alex Stevenson, Assoc Prof Katrina Anderson and Prof Kirsty Douglas.

Primary health care key to closing the gap

The AMA has welcomed the new Close the Gap Campaign Report and the Prime Minister's Closing the Gap Report as important reminders of how much more needs to be done to genuinely close the life expectancy and health quality gaps experienced by Indigenous Australians.

AMA President, A/Prof Brian Owler said that, despite best efforts across the political spectrum over many years, targets for life expectancy, reduced mortality rates, and other key performance indicators are not being met or are not on track.

A/Prof Owler said that health, especially access to primary health care, is key to addressing Indigenous disadvantage.

"It is vital that the Close the Gap strategy addresses all the social determinants, but without good health and access to quality health services, it is so much harder for Indigenous Australians to get to school, stay in school, get an education, get training, and get a job," A/Prof Owler said.

"Today's reports emphasise the need for a concerted effort to fund and resource primary health care service providers to detect, treat, and manage chronic health conditions in Aboriginal and Torres Strait Islander communities.

"There are significant numbers of Aboriginal and Torres Strait Islander people with undetected treatable and preventable chronic conditions, which impact on life expectancy.

"Community controlled health organisations and Aboriginal Medical Services need greater support to be able provide Indigenous Australians with access to the comprehensive primary care services that other Australians enjoy.

"These bodies also need greater support in ensuring Indigenous Australians have a healthy start to life, with early intervention programs to ensure better health outcomes for children and teenagers.

"Achieving equality in health and life expectancy for Aboriginal and Torres Strait Islander peoples is a national priority, but today's reports show that there is still a way to go before we see meaningful and lasting improvements."

A/Prof Owler said that the Government's proposed Medicare changes – the unfair co-payment model, the cut to the Medicare rebate, and the freeze on Medicare patient rebates until 2018 – will hit community controlled health services and Aboriginal Medical Services hard, and place enormous pressure on efforts to close the gap.

"These changes will also have a devastating impact on mainstream general practice, which plays a vital role in providing quality primary health care to Indigenous patients," A/Prof Owler said.

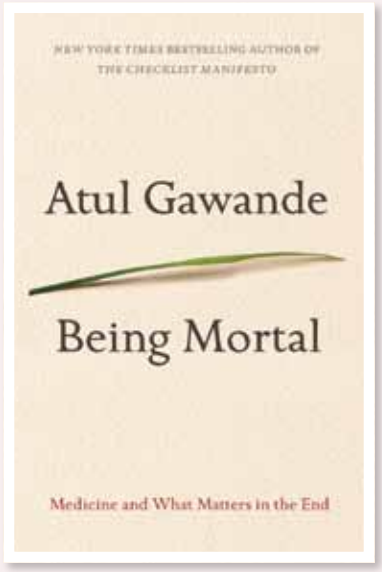
"Good policy to close the gap must start today."

The AMA is seeking talks with the Prime Minister to discuss health policy and health reform, including measures to close the gap and end Indigenous disadvantage.

BOOK REVIEW: "Being Mortal" – by Atul Gawande

Published by Profile Books, UK, GBP 12.99
Publication 2014
ISBN 978-1781253946

Ignorance, fear and avoidance of the adumbrations of mortality are part of the human lot. Atul Gawande's "Being Mortal" is a disquisition from a polymathic surgeon on these themes and more. As physicians, we are entrusted with and witness to the courage and resilience of humanity as well as the fragile impermanence of our lives.



Gawande traverses the valleys of shadow comprising ageing, aged care, the limits of critical care, and the experience of dying. Ultimately, all medicine is palliative in the context of the finitude of our lives, and medical care must encompass collaborative discussion and planning for quality of life in this context.

Gawande interweaves the personal experience of his father's terminal cancer and the ageing of his grandmother-in-law in his explorations. He tackles the relative insulation from and hence ignorance of ageing and death that is part of modern technological medicine, but also his experience as a sub-specialised general surgeon. Through the story of his grandmother-in-law and an ageing physician, he explores the vagaries and vicissitudes of residential aged care, including the shibboleths of autonomy and dignity.

In the notional second half of the book, Gawande focuses upon terminal illness. He reflects on the story of a young mother with terminal cancer, juxtaposing with snippets of his own clinical experience in surgery and against the backdrop of his urologist father's terminal spinal cord cancer. The relative reticence and discomfort of physicians and patients in discussing mortality and the ultimate aims of treatment, as well as the roles of palliative care and the hospice are writ large here.

The process of advanced care planning is arguably part of the challenge facing the finitude of life, on the background of an atavistic fear as old as recorded human experience. Considered at 3700 years ago the oldest human tale, the epic of the Uruk King Gilgamesh describes his ultimately futile quest for immortality and his anguish at his mortal doom.

Similarly, Japanese death poems capture the bittersweetness of imminent death (see poem quoted below).

Farewell –
I pass as all things do
dew on the grass
Death poem of Banzan

[p.143, Hoffman, Y. (1986) Japanese Death Poems. Tuttle Publishing: Tokyo, 341 pp]

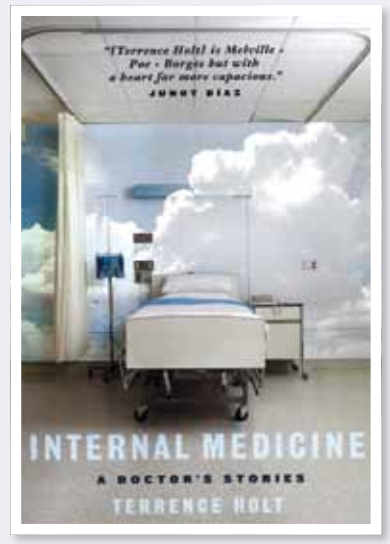
Living and dying are both parts of life, and medicine quests to compassionately preserve our mortal impermanence, however fleeting.

Reviewed by Associate Professor Jeffrey Looi, Academic Unit of Psychiatry and Addiction Medicine, ANU Medical School

BOOK REVIEW: "Internal Medicine – *A Doctor's Stories*" – by Terrence Holt

Published by Black Inc
Publication date: September 2014
ISBN: 9781863956901

Written as an attempt to "make sense of the process of becoming a doctor", *Internal Medicine* was suggested to me by a mentor just as I was beginning that process myself.



The stories within aren't case histories of any one patient, but rather amalgams of people – parables of a sort – which share a common thread of "new doctor" experiences. Good lives, good deaths, making a mess and atonement are all dealt with, as well as a hefty chunk of being a naïve young doctor, and the fact that that's okay. (Terribly comforting for a naïve young doctor!)

Terrence Holt was a Professor of Literature before he entered medicine and writes with simplicity and charm. His stories deal primarily with the "mortal condition" and the varied possible responses of doctors and patients when forced to confront mortality. Some are particularly challenging when revealing our own weaknesses – most harrowing for me the story of an intern's first night on call, read of course before my own first night! By writing from behind parables, Professor Holt is free to reveal weakness without fear of judgement, yet many of the foibles within are easily recognisable. Burnout is a real but hopefully decreasing part of being a junior doctor, and the lack of empathy involved can be shocking from an outside point of view. Some exaggerations of characters and events add layers of meaning to a tale (or may yet be true, see: *The Surgical Mask*) and only rarely does artistic licence veer into caricature (see: *Iron Maiden*). Far more often the characters inside are real and serve as warning, comfort, and hope.

Did *Internal Medicine* help me to "make sense" of this doctor thing? A little, I think, I hope. It's certainly worth a read, is skilfully written, and is curiously uplifting in the face of death (and internship).

Reviewed by Dr Fiona Wilkes, Junior Medical Officer at Calvary Hospital

Leading medical researcher to head the NHMRC

Distinguished medical researcher, Professor Anne Kelso AO, has been appointed the new Chief Executive Officer of the National Health and Medical Research Council (NHMRC).

The Minister for Health, Sussan Ley, said Professor Kelso would take up her new position with the NHMRC in April.

"Professor Kelso's distinguished career in medical research and her track record in internationally competitive research in immunology and influenza make her an ideal choice to head up the NMHRC," Ms Ley said.

"Professor Kelso's experience and expertise will be a great asset to Australia's leading expert body for health and medical research and help Australia build on its reputation as a world leader in medical innovation."

Professor Kelso obtained a Bachelor of Science (Honours) and PhD from the University of Melbourne and has developed significant global health experience and networks through her work with the World Health Organisation (WHO).

Professor Kelso, through her previous role as Director of the WHO Collaborating Centre on Influenza, worked on surveillance and vaccine policy relating to pandemic viruses and provided technical advice to ministers of health throughout the Asia-Pacific region.

She was also the Director of the Co-operative Research Centre for Vaccine Technology from 2000 to 2006.

Professor Kelso will succeed Professor Warwick Anderson AO as the NHMRC's Chief Executive Officer.

CONGRATULATIONS!

CANBERRA DOCTORS RECOGNISED WITH AUSTRALIAN HONOURS

The President, Board, members and staff of AMA (ACT) Limited extend congratulations to:

Dr Robert Andrew Reid AM. Dr Reid has been recognised for "significant service to sports medicine through executive roles with professional organisations, and as a voluntary medical officer"

Dr John Julian Smiles AM. Dr Smiles has been recognised for "significant service to medicine as an ophthalmologists, and to international relations through eye health programs in Samoa"

AMA (ACT) LIMITED

Time to 'end the uncertainty' of government's bad health policies

AMA President, A/Prof Brian Owler, congratulated Prime Minister Tony Abbott on seeing off a leadership spill vote, and called for an urgent meeting to discuss the Government's unpopular health policies.

A/Prof Owler said it was significant that one of the major messages coming from the Prime Minister's media conference and the Coalition party room was the need for the Government to consult closely with the medical profession on the controversial Medicare reforms that are hurting the Government.

"The Prime Minister said that 'good government starts today'. Good health policy must also start today," A/Prof Owler said after the vote.

"It is time to end the uncertainty about the Government's Medicare plans.

"The Prime Minister must ditch the disastrous Medicare co-payment model, the $5 cut to the Medicare patient rebate, and the freeze on Medicare rebate indexation until 2018.

"Coalition members know that these policies are hurting the Government at the local level across the country.

"Voters want health policies that improve access to health care, not policies that make it harder and more expensive to see a doctor.

"Doctors want to provide quality care to their patients and communities, and do not want the viability of their practices threatened.

"The AMA held doctor forums in several States and the message from grassroots GPs was clear – the Government must scrap its potentially destructive Medicare changes. All of them."

A/Prof Owler said it is clear from reports coming out of this morning's party room meeting that poor health policy was a significant factor in bringing on the leadership spill ballot.

"Good health policy will restore confidence in the Government's leadership and in the Government's public standing," A/Prof Owler said.

"The AMA is ready to engage with the Government to develop health policies that will ensure quality health service provision to the Australian community for the long term.

"As AMA President, I am available immediately to start the good health policy conversation with the Prime Minister," A/Prof Owler said.

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Survey demonstrates the need for complaints reform

Avant, Australia's leading medical defence organisation, is calling for significant improvements to the complaints system to reduce the adverse health impacts that doctors may face after receiving a complaint.

The call comes after a large study of UK doctors found those who experienced professional complaints had a higher risk of depression and anxiety.

The study of 8,000 UK doctors also found that the majority of doctors surveyed practiced defensively; which the study noted could impact patient care and work against the primary aim of the complaints process to protect the public.

Published in BMJ Open, the study found the health effects complaints can have on doctors mirrored an earlier investigation into such impacts on doctors in NSW.

"Avant sees many doctors who are placed under significant stress when dealing with the complaints processes in Australia," Dr Penny Browne, Avant Senior Medical Officer said

"Ensuring that complaints are managed in a timely, fair and transparent manner could reduce the subsequent health impacts that doctors may face."

In its recent submission to the current Independent Review of the National Registration and Accreditation Scheme, Avant has identified practical steps to improve the complaints system in Australia. These include:

- One point of entry for consumers and an early triage system to provide quicker resolution for the majority of notifications
- More support for the health and wellbeing of the practitioner during the complaints process
- National standards needed for timeliness in handling notifications
- Parity in timeframes so that practitioners are able to have sufficient and equivalent time to respond to regulators' requests.
- Support for the WA exemption on mandatory reporting to reflect the exemptions included which cover health practitioners under treatment.

Avant's submission can be found here.
Kirrilly Burton
Phone: 02 9260 9929
Email: Kirrilly.burton@avant.org.au

Reed Exhibitions Announces Acquisition of ThinkGP from Genesis Ed

Reed Exhibitions has announced it has completed the acquisition of ThinkGP from Genesis Ed Pty Ltd. The acquisition strengthens Reed Exhibitions' participation and expertise in the important area of delivering accredited medical education to the primary healthcare market in Australia.

Reed Medical Education states it will now be able to deliver GPs and other healthcare professionals throughout Australia the unparalleled choice of the face-to-face, experiential opportunities available at the GPCE events or the convenience and immediacy of online learning opportunities via ThinkGP.

"We believe that this strategic acquisition is the right move for Reed Exhibitions and for ThinkGP. It will enable healthcare educators and suppliers to engage with the primary healthcare sector through a multi-channel approach, which is what our customers have been asking us to provide. It will help to enhance their businesses and also deliver them a superior product offering to support GPs, nurses, practice staff and other primary healthcare professionals." said Brian Thomas, Managing Director, Reed Exhibitions Australia.

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