AUSTRALIAN

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Health policy stagnation

BY AMA PRESIDENT ASSOCIATE PROFESSOR BRIAN OWLER

As Health Minister Sussan Ley engages in consultation with health and consumer groups about the Government's GP co-payment and other Medicare changes, work on other areas of the health system is in stagnation. There is a vacuum as far as health policy is concerned.

The co-payment has sucked the life out of health policy development, discussion, and debate. This has not only been detrimental to the Government, it is also harmful for the practice of medicine and for our patients.

Minister Ley was thrown somewhat of a hospital pass when she took on the portfolio. Her attempts to consult and develop something more akin to health policy are laudable. However, it means she has little time to devote to the many potential crises brewing in her broad portfolio – and many crises there are.

The biggest policy vacuum is public hospitals. Little has been said about public hospitals since funding was ripped out of the sector in last year's Budget, but recent media reports indicate there is trouble ahead.

There are concerns about hospital capacity in many States, with problems in NSW and South Australia in the news. The new government in Queensland has sacked the Director General of Health as investigations into its health system are underway. Targets are not being met across the country.

The vexed issue of public hospital funding and efficiency will come to a head when COAG meets in April. By then, State Treasurers will have assessed the impact that last year's Federal Budget cuts will have on their ability to keep their public hospitals running effectively to meet growing patient need – and meet targets for surgery and emergency departments.

Mental health is another neglected area.

In February last year, then Health Minister Peter Dutton tasked the National Mental Health Commission with conducting a review of mental health programs and services. That review has been completed and has been with the Government for some time, but we are still waiting on the public release.

The Personally Controlled Electronic Health Record (PCEHR) was not that long ago touted as the most important initiative in health. Today, all we hear about is the massive waste of taxpayer money in its development. The Abbott Government commissioned a review but, 14 months later, is yet to respond to the review's recommendations. The PCEHR remains in limbo, a very large white elephant.

The abolition of agencies, including the Australian National Preventive Health Agency and Health Workforce Australia, has resulted in a noticeable pause in policy development as key functions are moved to the Department of Health and bedded down. This process has been slow, which means that important planning for future medical workforce and medical training is delayed, and public health programs around alcohol, tobacco, and obesity, among others, are non-existent.

Primary Health Networks – the bodies set to replace Medicare Locals – have not yet appeared. The tender process is finished, but we are yet to know which organisations, possibly including private health funds, will be administering primary health care services across Australia.

The recent Close the Gap reports show that we are failing in Indigenous health.

Rural and remote areas of Australia continue to suffer health service inequity due to a lack of major rural health initiatives.

Aged care is under enormous stress. There needs to be a greater focus on palliative care.

The Minister is in the middle of negotiations on the new Pharmacy Agreement, which has involved discussions with many key stakeholders outside pharmacy.

The medical profession is still burdened with too much red tape.

All these pieces of the health system are linked. When one part is suffering, the effects are felt across the health system. There are many troubling ripples at work at the moment.

It is vital that the co-payment saga is dealt with as a matter of urgency. It must be off the table.

Health Minister Ley has shown she is full of energy and enthusiasm, and is consultative. She wants to get on with the job. She has to get on with the job.

The whole health system needs action – and good policy – right now. Let's get on with it

Govt set to dump co-payment

The Federal Government is set to scrap its $5 Medicare cut and instead plans to prod GPs into charging patients more by freezing rebate indexation.

As Prime Minister Tony Abbott scrambles to shore up his position by unloading damaging policies, Health Minister Sussan Ley yesterday presented a proposal to Cabinet to dump the politically poisonous $5 Medicare rebate cut due to come into effect from 1 July.

The move, which is expected to be ratified by the Liberal Party Room today, follows sustained pressure from the AMA, doctors and other health groups who have argued that the plan would deter patients from seeking timely treatment, adding to health care costs in the longer term.

It has also been reported that the Government will scale back its planned freeze of Medicare rebate indexation from four to two years, though it hopes this will be enough to send a so-called “value signal” to patients. The Government expects that as the value of the rebate is eroded, doctors will increasingly be forced to pass rising costs on to those seeking care.

AMA President Associate Professor Brian Owler, who has had a series of meetings with Health Minister Sussan Ley and other senior Government figures in recent weeks, said that it was time for the Government to move on from its failed co-payment idea.

A/Professor Owler said that, while the issue of the co-payment had tended to dominate the public health debate, the AMA has continued to push ahead on a number of policy fronts vital to shaping how the health system will meet future patient needs.

The AMA President said he was keen to advance discussions with the Government on a range of areas including health workforce training, the role of private health insurers, public hospital funding and structural reform of the health system.

“As far as the co-payment itself, we remain against a $5 cut to the Medicare rebate, and against a four-year freeze of the rebate,” he said. “But we are continuing to work closely with the Minister, as she continues her consultations, to make sure that we can continue to evolve and adapt our health system to meet the every changing needs of patients.”

Ms Ley said her consultations with the health profession had been “most valuable…they are about the whole of the system. They’re about policy generally. They’re about every aspect. And one of the clear messages is that if you stop people getting sick in the first place the Government spend becomes less and we have happier, healthier outcomes. And I’m delighted that doctors and practitioners everywhere have got so many good ideas for me.”

Health policy became a key battleground in the leadership turmoil that engulfed Prime Minister Tony Abbott and the Coalition Government early last month.

Mr Abbott’s missteps on health, particularly his drive to impose – only to subsequently dump – two major changes to funding arrangements for GP services, proved deeply politically damaging.

In early December he was forced to ditch plans for a $7 co-payment in the face of steadfast opposition in the Senate, while a subsequent plan for a $20 cut to rebates for shorter GP consultations was abandoned just days before it was to come into effect amid fierce criticism from the AMA, grassroots GPs and other health groups.

A chastened Mr Abbott said that, although he would not rule out “some kind of a patient contribution”, there would be no further change without the support of the AMA and the medical profession, adding that “it’s no secret that we have been rethinking some policies that were brought down last year”.

“What I indicated to the Party Room was that there would be no new proposals come forward without the broad backing of the medical profession,” the Prime Minister said. “As you know, I was a Health Minister for four years. I rapidly came to the conclusion as Health Minister that, in any dispute between a politician and a doctor, the doctor normally won.

“While the Health Minister can’t be a Minister for Doctors, nevertheless, it is important to maintain the support of the medical profession because, let’s face it, they have the best interests of their patients at heart. That is certainly something that governments have to take very, very seriously indeed.”

In his talks with Ms Ley, A/Professor Owler urged the Government to view the health system in its totality.

“My concern is, when we deal with one part of the health system in isolation and we pull that leaver, it has totally unintended consequences,” he said. “A co-payment or price point should not be the starting point to the discussion. I think that what we do is restrict ourselves to the options that can be put on the table, that might actually get much stronger, better and effective outcomes.”

ADRIAN ROLLINS

Consultations, not ideology, path to better policy: AMA

AMA President Associate Professor Brian Owler said the much more consultative approach adopted by Health Minster Sussan Ley has been a welcome change in the Federal Government's approach to health policy.

"I think I've had more conversations and more meetings with the current Minister in a month and a half than I had with the previous Minister over the last eight months or so," A/Professor Owler said. "It has been a good change."

Earlier, the AMA President told a Senate inquiry into health policy that the measures pursued by the Government since last May's Budget had been driven by financial concerns and ideology rather than health considerations.

"Anecdote, personal assertion and, in particular, ideology" had driven the past year of health policy, Professor Owler said. "When you [make policy] on the basis of no evidence and no data, ideology becomes the natural enemy of logic, common sense and, unfortunately, moderation.

"I think that's how we ended up with the poor proposals that would have very significant impacts, not only on general practice, but I think on the health care of Australians."

In the submission it made to the inquiry last September, the AMA warned that the changes pursued by the Government, which had included a $7 co-payment and a subsequent proposal for a $20 cut to rebates for shorter GP consultations (both of which have now been dumped), posed an "enormous and unnecessary risk" to the health system.

A/Professor Owler said the experience of the past eight months showed how important it was that governments consulted with the medical profession before embarking on changes that may have devastating consequences for patient health.

"We could have told the Prime Minister [Tony Abbott] and Treasurer [Joe Hockey], the Health Minister, well before those policies were announced, that they were going to meet, first of all, with opposition, but also that they were bad policy," he said. "They would have significant impacts on the viability of general practice, particularly in low socioeconomic areas. And they would have devastating consequences for the health care of everyday Australians."

His comments came as leadership speculation continued to swirl around the Government, with suggestions Mr Abbott could face a further challenge to his leadership after winning a party room ballot last month.,

But A/Professor Owler said the AMA's concerns about the conduct of health policy were not about the Prime Minister per se, but about how his Government has operated.

"I don't think that necessarily you need to change leaders," he said. "I think what has to happen is a change in process. I've said all along, it's not about who's delivering the message or how the message is being spun. At the end of the day the problem has been the process...how you've gotten to those policies.

"And so, what we need to see is not necessarily a change of leadership; what we need to see is a change in attitude and a change in process."

Queensland MP and former Howard Government Minister Mal Brough publicly broke ranks early last month by calling for the co-payment policy to be disowned.

"I am suggesting to the Government that we should be taking the co-payment off the table full stop," Mr Brough said. "I don't think it makes economic sense, and I don't think it makes health sense."

The Member for Fisher said the Government had made a mistake by approaching health policy from a purely economic viewpoint, and its focus on costs in primary care was misconceived.

In a speech on 3 February, he contradicted Government claims that spending on Medicare was out of control, and instead echoed A/Professor Owler in arguing that investing in primary health would save money in the long term.

"I believe very simply is that if we have a healthier community, we have less hospitalisations, we have less acute cases," Mr Brough said. "The savings we will make in hospital funding, where the big dollars are, are far greater than any savings we can make by potentially having a co-payment."

Ms Ley said that the very nature of the consultations she was undertaking meant that she was seeking feedback on a broad range of issues.

"This is a genuine consultation effort on Medicare reform, and I am going in with open eyes and ears open to ensure we get the best outcomes for patients and health professionals alike," the Minister said.

ADRIAN ROLLINS

Drugs test a hairy proposition

Doctors and other health workers whose registration has been restricted because of drug abuse will have both their hair and urine tested for alcohol and "a wide range" other substances under changes being implemented by the medical profession watchdog to strengthen national drug screening.

The Australian Health Practitioner Regulation Agency has announced that, under the new protocol, all health practitioners who have registration restrictions linked to past substance abuse will be subject to routine hair analysis in addition to the current urine testing regime.

The arrangement replaces the interim drug screening protocol introduced nationally in mid-2014.

AHPRA Chief Executive Officer Martin Fletcher said the change had been made to ensure drug screening in the National Scheme was "evidence-based, effective, and up-to-date".

The regime sets out nationally consistent testing standards and mandatory reporting thresholds for use by pathologists in conducting drug tests, as well as identifying critical events to trigger remedial and disciplinary action, such as skipping screening tests, providing diluted samples, testing positive for a drug and non-compliance with screening requirements.

National Boards will continue to make decisions about practitioners with impairment on an individual basis, but the testing protocol provides "a clear framework across professions for AHPRA's advice to National Boards about the management of registered practitioners with drug-related impairment," Mr Fletcher said.

The regulator has invited expressions of interest from pathology services to undertake the drug screening, and it has appointed an expert panel to provide ongoing advice about biological assessment, testing and monitoring of registered health professionals who have abused, or are impaired by, the abuse of alcohol and other drugs.

ADRIAN ROLLINS

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 on hand to provide practical advice and information.

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.

Dedicated national doctor health service 'soon'

The AMA is rushing to finalise details of a national health service for doctors amid calls for a culture change within the medical profession in how practitioners with mental health problems are treated and supported.

As the medical community reels from the sudden deaths of four young Victorian doctors earlier this year, AMA Vice President Dr Stephen Parnis has warned that poor mental health was a "serious and systemic" problem within the profession.

"For a profession trained to care for others, medicine has been often quite inept at recognising and understanding, accepting or supporting doctors and medical students who are suffering from anxiety, depression, substance abuse, family conflict or other issues that impact on their own health," Dr Parnis said. "We must do better."

Doctors have often been reluctant to seek help for fear that being known to have a mental health problem will harm their career.

Dr Bill Pring, who is Chair of the Australasian Doctors' Health Network, said there continued to be some who looked down on those diagnosed with a mental illness, but the stigma attached to mental health problems within the medical profession appeared to be gradually fading as attitudes changed.

Dr Pring said it was encouraging that doctors appeared to be increasingly receptive to the message that they needed to ensure their own physical and mental health in order to provide the best possible care for their patients, and growing numbers were willing to seek help for mental health conditions.

But the recent spate of deaths, coupled with the results of a beyondblue report from 2013 that found psychological distress, burnout and suicide were disturbingly common among doctors and medical students, have underlined concerns that practices within the profession are fuelling the problem and support is inadequate.

There has been a call to rigorously address the reasons some doctors find it hard to seek and obtain help, including the culture of the profession, the work environment, the training culture, and mandatory reporting.

There is concern that often doctors are deterred from seeking care for fear their treating doctor will be required under Medical Board of Australia mandatory reporting rules to notify the regulator.

But Dr Pring said this was not necessarily the case.

He said that under the interpretation of the law used by the ADHN, a treating doctor is only required to report a doctor who poses an imminent risk to their patients.

Dr Pring said often the fact that a doctor recognised they had a problem and was seeking help meant that there was no imminent threat to patients, and consequently there wasno need to report them.

But he was concerned about the number of doctors contacting his service because they did not have a regular GP, and Dr Parnis said the nature of the job as a doctor did not help: "We have highly stressful, hierarchical, and competitive work environments, with an often unforgiving culture".

Dr Pring said the pressures could be especially acute for young doctors, who not only had to deal with a highly stressful work environment, but also a highly competitive training environment.

He said the ADHN was working closely with medical colleges to do what it could to make sure doctors in training were better looked after.

While there has been a gradual increased in the number of health services specifically for doctors, Dr Parnis said current arrangements were inadequate, and the AMA had for a long time strongly advocated for a national model to support the work of the services that make up the Australasian Doctors' Health Network.

"As a result," he said, "the Medical Board of Australia has set aside funding, and the AMA is working with the MBA to establish the right model for the national delivery of doctors' health services in each State and Territory".

The AMA Vice President said the details of the new system "will be finalised soon".

ADRIAN ROLLINS

Govt report shows why co-payment a bad idea

The Federal Government's back down from implementing a $5 GP co-payment has followed confirmation that the nation's general practitioners provide timely, affordable and cost-effective access to care.

The Productivity Commission has reported that 83.6 per cent of GP patients were bulk billed in 2013-14, and two-thirds of those seeking an urgent appointment were able to see their family doctor within four hours.

Underlining the affordability of GP care for patients, just 4.9 per cent said they had deferred a visit to their doctor in 2013-14 because of cost, down from 5.8 per cent the previous financial year.

GPs are not only cheap for patients, they are also cost-effective for the Government, the report found.

The Commission's *Report on Government Services 2015* showed Government spent an average $298.60 per person on GP services last financial year, compared with an average $5204 on hospital treatment in 2011-12 (the most recent year for which this data is available).

AMA President Associate Professor Brian Owler said the report's findings showed how effective and efficient the nation's primary health care system was.

"General practice remains accessible and affordable for most Australians, and ultimately provides savings for the Government by keeping people out of more expensive hospital care," A/Professor Owler said. "It is bad health policy to create disincentives for people to go to their GP by making health care more expensive for the people less able to afford it."

The Productivity Commission report showed that Commonwealth health expenditure actually declined by $1.5 billion to $61 billion in 2012-13, and just 8.7 per cent of this went on primary health care – down from more than 9 per cent a decade earlier.

A/Professor Owler said the GP-patient relationship was the cornerstone of the health system, and should be supported by Government.

ADRIAN ROLLINS

Hospital funding squeeze intensifies

Public hospitals are being short-changed by a recalculation of the amount the Federal Government will pay for their services, increasing the strain on their finances amid signs performance gains are stalling.

The Independent Hospital Pricing Authority has announced that the National Efficient Price (NEP), used to calculate what around 260 hospitals – including all the large metropolitan hospitals - will receive under the activity-based funding arrangements, has been set at $4971 per National Weighted Activity Unit (NWAU) for 2015-16.

This represents a 3 per cent increase from this financial year's revised NEP of $4826, but a 0.7 per cent cut from the original NEP estimate for 2014-15.

The Authority said the downward revision of this financial year's NEP was due to the use of more up-to-date data showing that hospital costs were growing at a slower rate than originally anticipated.

Small rural hospitals, whose size makes the use of activity-based funding inappropriate and are instead funded according to the National Efficient Cost (NEC) formula, have also been hit by a funding cut.

The Authority said that the average NEC payment for the nation's 380 small country hospitals would be $4.784 million in 2015-16, down from $5.725 million this financial year.

The funding cuts come amid mounting evidence that public hospitals are struggling to cope with increasing patient demand and shrinking budgets.

As reported in 20 January edition of *Australian Medicine*, the nationally-agreed target to cut emergency department waiting times is under threat after New South Wales walked away from a commitment to ensure 90 per cent of all patients would be admitted, referred or discharged within four hours, and the previous Queensland Government put the standard under review.

The AMA's annual Public Hospital Report Card, due out later this month, is expected to show the performance of public hospitals is suffering as the Commonwealth scales back its contribution and pushes more of the cost burden on to the State and Territory governments.

In last year's Budget, the Federal Government disavowed hospital funding guarantees worth $1.8 billion up to 2017-18, and announced that from mid-2017 its contribution to public hospital costs would be indexed at just CPI plus population growth. The AMA warned that the two measures would rip $20 billion from the public hospital system in the next five years.

In addition, in its mid-year Budget update, the Government revealed a further cut of $941 million over four years.

Critics warn that the effect of these cuts is set to be compounded by IHPA recalculations of activity-based funding.

The Authority's practice of revising down its initial NEP estimate (it has occurred in each of the past three years) has raised concerns that the base price for hospital services is being gradually ratcheted back, and will be enshrined at a grossly inadequate level when Commonwealth funding becomes indexed from 2017-18.

ADRIAN ROLLINS

$1bn e-health record system shunned

Doctors and patients have shunned the former Labor Government's $1 billion electronic health record system, underlining the urgency of calls to heed the results of a review recommending a major overhaul to make it clinically useful.

Health Department officials have admitted that the vast majority of the 2.1 million records created since the Personally Controlled Electronic Health Record scheme was launched in mid-2012 are sitting empty because doctors have uploaded just 41,998 shared health summaries to the system.

While the creation of reliable and nationally-accessible electronic medical records containing information about medications, allergies, treatments and test results, has long been touted as a major advance in improving patient safety and continuity of care, critics have complained that the PCEHR was fatally flawed in its design and needed to be overhauled.

Soon after coming to office, the Coalition Government appointed a review panel, including immediate-past AMA President Dr Steve Hambleton, to examine the scheme and suggest changes.

In its report, the review called for PCEHR to be changed to an opt-out system, among a raft of other changes.

In its submission to the review, the AMA called for a fundamental change to the system to reduce patient control.

The AMA said the ability of patients to remove or restrict access to information in the PCEHR undermined its usefulness, because doctors could not be confident that it provided the comprehensive medical information needed to make an accurate diagnosis or properly assess the safety of proposed avenues of treatment.

The Abbott Government is yet to respond to the review's recommendations.

Health Minister Sussan Ley condemned the system as a "complex, expensive mess".

AMA President Associate Professor Brian Owler said that, "to have spent that much money and still not have anything of widespread value [out of it] is terrible".

ADRIAN ROLLINS

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

Stop stalling on Research Fund, Govt told

AMA President Associate Professor Brian Owler has called on the Federal Government to immediately act to establish the Medical Research Future Fund, amid surprise revelations that the centrepiece of its health budget is yet to be implemented.

A/Professor Owler said the fact the Government was yet to create the Fund even though $15 billion could be directed into it in the next six years, suggested it was no more than "an accounting trick" to make the Budget look better.

> The Fund has won the backing of a group of high-profile business leaders, but has split the medical research community because of the fact that it is to be created using funds diverted from other areas of health

"I think we should establish the Medical Research [Future] Fund, because we actually have about $15 billion in savings over the next six years, which has essentially already been passed," the AMA President said. "There is no reason why the fund should not be in existence as we speak. It has been held hostage over the co-payment and I think we need to get away from that."

Under the Government's plans, "every dollar" of savings from health, including a freeze of Medicare rebate indexation, almost $2 billion taken from public hospitals, and money freed up from the abolition of agencies such as Health Workforce Australia, would be channelled into the $20 billion Fund.

According to last year's Budget, the Fund would receive $1 billion from uncommitted funds in the Health and Hospitals Fund, $3.5 billion through the $5 Medicare co-payment, almost $2 billion from cuts to public hospital funding, $1.7 billion from extending the Medicare rebate freeze and the income thresholds for the Medicare Levy Surcharge and Private Health Insurance.

It would also gain $1.3 billion from increasing Pharmaceutical Benefits Scheme co-payments and safety net thresholds, as well as savings gleaned from shutting down a range of health programs and abolishing several agencies.

The Fund has won the backing of a group of high-profile business leaders, but has split the medical research community because of the fact that it is to be created using funds diverted from other areas of health.

Speaking at a Senate inquiry into health reform, A/Professor Owler said that although he supported the Fund, the AMA objected to the fact money was being plundered from other areas of health to help pay for it.

"We all want a Medical Research Future Fund," the AMA President said. "I have done research, [and] more money for research would be great. But it should not come at the expense of sick people going to the doctor."

A/Professor Owler said the spectacle of researchers being set against general practitioners and other sin the health system was "terrible".

"I think one of the worst things that we have had over the past eight months or so is this process of having researchers out there lobbying, ignoring where the money is actually coming from and essentially pitting researchers and GPs against each other," he said. "I think that has been a terrible episode."

The AMA President's criticism came as the National Association of Research Fellows warned delays in getting the MRFF up and running threatened the jobs of up to 2000 medical researchers.

Association President Professor Rob Ramsey told The Australian the NHMRC needed an extra $300 million a year if the nation was to sustain the "critical mass" of researchers that it had developed in recent years.

While the number of researchers supported by the NHMRC has more than doubled to 10,000 in the past decade, less than 15 per cent of grant applications are successful, making medical research an increasingly precarious career choice.

Professor Ramsay rejected comments by NHMRC head Professor Warwick Anderson that there was an over-abundance of researchers, and instead argued the country needed to lift its investment in research.

ADRIAN ROLLINS

Spiralling drug costs not driven by R&D

Drug companies are charging increasingly astronomical prices for cancer-fighting drugs according to what the market will bear rather than what they cost to develop, a US study has concluded.

As controversy swirls around the cost of hugely expensive treatments such as the anti-melanoma drug Yervoy, which costs around $150,000 for a course of therapy, an investigation by American health economists indicates prices of new medicines are being set by reference to the cost of existing drugs, resulting in an upward spiral of charges that has seen the value of the global anticancer drug market soar to $116.6 billion in 2013.

The study, based on pricing trends for 58 anticancer medicines approved for use in the US between 1995 and 2013, found that the launch price for medicines were growing by an average of 10 per cent a year, forcing patients and insurers to pay increasingly higher amounts to extend lives.

Across the sample of drugs included in the study, the average cost of each year of life gained soared from $69,000 in 1995 to $178,000 in 2005, before reaching $265,500 in 2013.

The spiralling cost of treatment has alarmed clinicians and policymakers worldwide. In 2012, three leading oncologists at New York's renowned Memorial Sloan Kettering Cancer Centre announced they would refuse to prescribe the metastatic colorectal cancer treatment Zaltrap because of its massive mark-up compared with older therapies, and a year later The Lancet medical journal warned the world had reached "the crossroads of affordable cancer care," while a group of more than 100 prominent oncologists in the US publicly criticised the high cost of new cancer treatments.

Governments, including those in Australia, the United Kingdom and Europe, are also turning an increasingly critical eye on the evidence for hugely expensive treatments, and taking more time to weigh up the cost against the likely extension to lives.

In 2013, for example, the Pharmaceutical Benefits Advisory Committee announced it would gather data on the use of Yervoy and its effects, the first such assessment for a drug approved for listing on the Pharmaceutical Benefits Scheme.

The drug was one of three cancer treatments listed on the PBS whose supply was estimated to cost $430 million over four years, for a claimed average 3.9 month extension to the lives of patients.

The pharmaceutical industry argues the high prices are justified by the high costs of research and development, and backers warn big returns are necessary to encourage further innovation.

But the authors of the US study, including Associate Professor David Howard from Emory University in Atlanta, Peter Back from the Memorial Sloan Kettering Cancer Centre, and Ernst Berndt from the Sloan School of Management at the Massachusetts Institute of Technology, said the arguments were unconvincing.

"It is unlikely that changes in development and production costs alone can explain launch pricing trends," they said, noting that the low cost of generic relative to branded drugs suggested that production costs were only a small component of price.

Furthermore, they pointed out, research and development expenses were "sunk costs" at the time a product was launched, and so "ought not to factor into the pricing decisions of a profit-maximising firm once the product has been developed".

Instead, they said, the direction of causation between prices and research and development costs was the other way around: "manufacturers are willing to spend more to discover new drugs".

Instead, they found that prices of new drugs were set based on the cost of existing therapies as a reference.

Buyers tend to accept a relatively small premium above existing prices, giving manufacturers the opportunity to slowly bump up prices as new drugs enter the market.

This, rather than intrinsic development costs, is what drives the pricing of anticancer drugs, according to the study, which is published in the Winter 2015 issue of the *Journal of Economic Perspectives.*

ADRIAN ROLLINS

Govt subsidises access to expensive drug for rare disease

The Federal Government has approved subsidised access to a hugely expensive treatment for children with a rare and life-threatening genetic disorder that causes progressive muscle weakness and breakdown.

> "Pompe disease is a rare and severe medical condition, affecting only a very small number of Australians every year,"

Children with late onset Pompe disease, caused by a genetic mutation that compromises their ability to breakdown glycogen, leading to a toxic build-up of sugar in muscles, tissues and organs, will have affordable access to the drug Myozyme following a decision by Health Minister Sussan Ley to add it to the Life Saving Drugs Programme (LSDP).

"Pompe disease is a rare and severe medical condition, affecting only a very small number of Australians every year," Ms Ley said. "However, it is a very expensive treatment – costing several hundred thousand dollars – putting it out of reach for many Australians."

Subsidised access to the drug through the LSDP has been available to infants since 2010, and the Minister's decision means it will now also be within the reach of families of children diagnosed with the condition between two and 18 years of age.

Patients will have to undergo an initial clinical assessment to determine their suitability for the treatment, and will then be examined each year to ensure the use of Myozyme remains appropriate.

The Minister said children who respond to the treatment will continue to have subsidised access to the drug throughout their life, and flagged that people who develop Pompe in adulthood may also eventually receive assistance in accessing Myozyme.

"This is only the first step," Ms Ley said. "The Government is committed to continuing to work with the company towards a future application and subsidy for Myozyme on the PBS [Pharmaceutical Benefits Scheme] for adult late onset Pompe patients.

ADRIAN ROLLINS

Warfarin safety advice update

Safety advice on the use of a commonly prescribed anticoagulant is being updated amid concerns patients could be at risk of serious haemorrhaging.

The Therapeutic Goods Administration has announced that it is working with drug companies to improve the clarity and comprehensiveness of advice on the use of medicines containing warfarin, including Coumadin and Marevan.

A TGA review found that information provided to practitioners and patients regarding potentially harmful interactions with other drugs, as well as advice on the need for regular patient monitoring, needed to be updated.

"The TGA found that the [product information] for warfarin required an update for clarity and inclusion of important clinical information," the medicines watchdog said. "Warfarin may interact with other medications, including herbal [and] complementary medicines...[that] may result in serious bleeding events."

The TGA added that, to use warfarin safely, the health of patients needed to be regularly monitored.

"The major causes of bleeding with warfarin include the concomitant use of antiplatelet agents, anticoagulants and non-steroidal anti-inflammatory drugs, and concomitant use of medicines that alter the metabolism of warfarin," the regulator said.

The TGA said more detail about the updated advice, which is being developed in consultation with manufacturers, will be provided "in a future alert".

ADRIAN ROLLINS

Govt told to change course after drop in organ donors

The national organ donation rate has slipped following four years of strong gains, sparking calls for the Federal Government to scrap plans to merge the Organ and Tissue Authority with the National Blood Authority.

Figures compiled by the Organ and Tissue Authority show there were 378 deceased donors last year, a 3 per cent decline from 2013 , pushing the ratio of donors per million down to 16.1 – a drop of almost 5 per cent from the previous year. The number of transplant recipients was also slightly lower.

But, while the number of donors and recipients fell, the number of organs transplanted was actually 1 per cent higher than in 2013, due partly to improvements in identifying and matching donors and recipients, and in harvesting multiple organs and tissue from individual donors.

In all, there has been 53 per cent increase in the number of donors since 2009, when the DonateLife program was introduced, a 38 per cent jump in recipients and 39 per cent rise in the number of organs transplanted.

Assistant Health Minister Fiona Nash said "the challenge" of increasing organ donation rates would be raised in discussions with her State and Territory counterparts in coming months.

"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," Senator Nash said.

But the Opposition has seized on the fall in the number of donors to lambast the Government and urge it to call off the Organ and Tissue Authority/National Blood Authority merger.

"While Australia has made important strides in recent years to lift our poor level of organ donation rates, the fall in 2014 is distressing news," Shadow Health Minister Catherine King said. "The slip in donation rate sin 2014...is a huge wake-up call that now is not the time for the Abbott Government to be merging the Organ and Tissue Authority with the National Blood Authority."

But the Organ and Tissue Authority said that, using the international standard measure of organs transplanted per million population, Australia's performance had barely changed since 2013.

Furthermore, it said, "reform of organ and tissue donation is an incremental process that takes time. International experience from leading organ donation countries has shown that variation in donation and transplantation outcomes has occurred annually while rates continue to trend upwards over time."

Kidneys were the most common organ donated and transplanted last year – 659 in all. There were also four combined heart/lung transplants and one intestinal transplant.

Australian doctors have also had success with a world-first procedure to transplant hearts from donors who have suffered circulatory death.

Previously, donated hearts had come solely from brain-dead patients. But the Authority said the success of the technique "has the potential to increase the number of available hearts for transplantation and, consequently, the number of heart transplant recipients".

In addition, 38 live kidney transplants occurred through the Australian Paired Kidney Exchange program.

ADRIAN ROLLINS

Poisoned berries spark food labelling overhaul

Shoppers will be able to use an easy-to-read symbol to quickly determine where the food they are buying comes from under changes to country of origin labelling standards order by Prime Minister Tony Abbott following an outbreak of hepatitis A linked to frozen berries imported from China.

Mr Abbott has assigned Industry Minister Ian Macfarlane and Agriculture Minister Barnaby Joyce to present plans for clearer food country of origin labelling to Cabinet by the end of March in response to widespread community disquiet about the safety of imported food when more than 20 people contracted hepatitis A after eating Chinese frozen berries.

"For too long people have been talking about country of origin food labelling, and nothing much has changed," Mr Abbott said. "Whenever we have a problem with imported food in particular, people want to know more about where their food's coming from. It's important that we grasp this particular nettle and actually make a difference."

Attempts in the past to tighten labelling standards have met strong resistance from food manufacturers, who complain changes will add significantly to production costs.

The Prime Minister said the Government would seek to ensure any changes were as "business-friendly" as possible, but Mr Macfarlane warned additional costs were unavoidable.

"We are in a position where we are going to have to break eggs to make an omelette," Mr Macfarlane said. "There will be costs and there will be changes, but those changes have to be made if consumers are going to have the information they need on their food products."

"We are looking at a symbol where someone can walk into a supermarket and say 'yes, that is entirely Australian', or 'that's ninety per cent Australian in produce', or 'there's no Australian produce in this'," Mr Macfarlane said on ABC Radio, adding the Government was also reviewing biosecurity arrangements.

Commonwealth authorities have placed a "holding order" on berries imported from two Chinese factories linked to the outbreak, but shipments of the fruit from 29 other Chinese suppliers are still being admitted into the country.

Senior Agriculture Department officials told a Senate estimates hearing that the hold order had been imposed after the food safety regulator, Food Standards Australia New Zealand (FSANZ), had determined that products from the two factories "pose a medium risk to public health until further information becomes available".

But the officials admitted the only tests being applied to berries

being imported from other Chinese suppliers were for pesticides, and said the Department was seeking advice on conducting tests for hepatitis.

Altogether, 30 companies import frozen berries from China.

The Department of Health reported 19 verified cases of hepatitis A across four states as at 26 February, and said that "detailed analyses of food consumption histories…confirmed a possible association with frozen berries", which were "the only common exposure".

The company at the centre of the scare, Patties Foods, has recalled all supplies of Nana's Mixed Berries and Nana's Raspberries (1 kilograms packs), as well as Creative Gourmet's Mixed Berries (500 and 300 gram packs).

Chinese authorities are investigating the possible food contamination, but the Health Department said hepatitis A was spread by food and water, "including ice that has been contaminated with faecal matter from infected people".

Patties Foods Managing Director Steven Chaur said the recall had been initiated as "a precautionary measure. There is still no detailed viral analysis from accredited laboratories that proves any firm association of hepatitis A virus with our recalled products".

Small Business Minister Bruce Billson said the new laws would require that producers disclose where food originated from and, possibly, where it was packaged and processed.

ADRIAN ROLLINS

Eddy of hope for critics as door left ajar on wind farm harm

People may find wind farms annoying, but there is no scientific evidence that they are harmful to health, the nation's peak medical research organisation has found.

A three-year investigation by the National Health and Medical Research Council involving the review of more than 4000 papers has concluded that there "is currently no consistent evidence that wind farms cause adverse effects in humans".

But the Council added that the science is not yet settled and warrants further research, provoking accusations the nation's peak research organisation has kept the issue alive so as to avoid putting itself at odds with Prime Minister Tony Abbott, who has said the possible health effects of wind farms requires investigation.

Of the more than 4000 pieces of research reviewed for the study, led by Emeritus Professor Bruce Armstrong, just 13 were found to be of sufficient scientific rigour to test the possibility of a relationship between wind farms and human health, and they came up negative.

"Overall, the body of evidence that directly examined wind farms and their potential health effects was small and of poor quality," the NHMRC reported. "There is consistent by poor quality evidence that wind farm noise is associated with annoyance, as well as less consistent, poor quality direct evidence of an association between sleep disturbance and wind farm noise."

The Council's conclusions follow an exhaustive process involving the use of independent reviewers to scrutinise the NHMRC's methodology in reviewing the scientific literature and evidence, as well as public consultations and a revised and updated literature review.

They echo the AMA's own conclusion that there is no evidence to back assertions that wind farms cause headaches, dizziness, tachycardia or other health problems.

In a Position Statement released last year, the AMA said that if wind farms did directly cause adverse health effects, there would be a much stronger correlation between reports of symptoms and proximity to wind farms than currently existed.

The *AMA Position Statement on Wind Farms and Health 2014*, which can be viewed at https://ama.com.au/position-statement/wind-farms-and-health-2014, concluded that "available Australian and international evidence does not support the view that the...sound generated by wind farms... causes adverse health effects".

But, in a win for anti-wind farm agitators, the NHMRC has not closed the book on the issue, indicating that further research into the possible health effects of wind farms on people within 1500 metres "is warranted".

Health Minister Sussan Ley and Industry Minister Ian Macfarlane seized on the finding that only one of the 13 studies assessed by the NHMRC was conducted in Australia to justify the call for further research.

Ms Ley and Mr Macfarlane said there was "a clear lack of research based around Australia's unique environmental conditions", and welcomed the Council's decision to commission further research.

"It's essential for everyone involved – includsing both residents and the renewable energy sector – that credible evidence is gathered to ensure a considered position based on hard facts, not emotion and vested interests, can be established," the ministers said.

But the Council's caution has frustrated Australian Greens Senator Richard Di Natale, who said the call for further research was "scandalous".

"There is very little justification for wasting any more time or money on this matter," the Senator told Fairfax Media. "There's real concern here that we're politicising what should be an independent science review."

ADRIAN ROLLINS

Insurers intensify push into care despite premium hike

Private health insurance will cost families about an extra $200 a year after Health Minister Sussan Ley approved an average 6.18 per cent premium hike by insurers.

The premium increase, first reported in the 16 February edition of *Australian Medicine*, is due to come into effect on 1 April, and will see some families hit with an extra $280 in annual insurance costs.

Ms Ley said that as insurance payouts increased, rising premiums was an ongoing challenge faced by successive governments.

"Over 13 million Australians now have some form of private health insurance, and it's therefore essential for the health of our nation that we continue to maintain a strong and competitive market," the Minister said. "To achieve that, we must ensure any premium increases strike the right balance between keeping them affordable for consumers without putting the financial viability of the sector at risk."

Figures compiled by the Private Health Insurance Administration Council show that insurer hospital benefit payouts increased 8.1 per cent in the 12 months to June last year, overshadowing a 7.5 per cent increase in premium revenue over the same period.

But growth in many expenses is slowing. Hospital benefits grew by just 6.9 per cent in 2012-13, a sharp drop from a 9.3 per cent increase the previous year, and the average payout per hospital episode was $2041, up just 4.6 per cent.

The average benefit paid for medical services was $58, the same as the previous year.

Despite this, insurers complain they are being squeezed by rising payouts and uninspiring membership growth.

Newly-privatised Medibank Private last month reported a half-year net profit of $151.2 million, and is on track for a full-year profit of $258 million, but intends to increase its premiums by 6.59 per cent next month to improve revenue, while rival nib, which posted a net half-year profit of $41.4 million, has announced a 6.55 per cent premium hike.

In addition to raising premiums, insurers have also flagged they intend to continue with an aggressive and controversial push to intervene in the delivery of health care.

Nib Managing Director Mark Fitzgibbon told the *Adelaide Advertiser* there were 800,000 avoidable hospital admissions last year, and said the fund was working with GPs on ways to treat patients, including those with chronic disease, in primary care settings rather than admitting them to hospital.

Medibank Private has also piloted a program to give members preferential access to GPs, intends to drive a harder bargain with hospitals to lower their charges and is seeking approval for a scheme to provide primary health care cover.

AMA President Associate Professor Brian Owler has expressed alarm about the increasing intrusion of private health funds into the provision of care, warning that they are in danger of encroaching on the doctor-patient relationship and leading the country down the path of US-style managed care.

Shadow Health Minister Catherine King accused the Government of showing a "complete lack of concern" for families by approving the premium increases – which she noted were the second-highest in a decade and well above the inflation rate.

But Ms Ley advised that, with 30 health funds to choose from, consumers should "shop around to get the best deal".

ADRIAN ROLLINS

Vale Jacqui Britton

The AMA community is mourning the passing of Jacqui Britton, a highly-regarded former colleague who died in a car accident in south-east New South Wales last month.

Messages of sorrow and condolence have flooded in to the federal AMA from members and officials from around the country shocked by the death of a popular, cheerful and capable former member of the federal secretariat.

Ms Britton, 33, died when the car she was driving ran off Tathra Road, on the outskirts of Bega, while she was returning home to Tathra with her two young daughters – a two-year-old and three-month-old - after a swim at Bega Memorial Swimming Pool on 9 February. The children were not seriously injured in the accident.

Ms Britton joined the Federal AMA in July 2008, and quickly became a popular and valued member of staff. The devoted mother and wife left the AMA last year when she and her husband Ryan Dunning decided to move their young family back to her home town of Tathra.

Close AMA colleagues were among hundreds of mourners who attended a memorial service at Tathra on 18 February, and a fund set up by her sister Emma on Facebook to raise money to help support her surviving family has so far received donations of more than $40,000.

To contribute to the fund, visit the Jacqui – Britton Dunning Memorial Fund on Facebook at: https://www.facebook.com/pages/Jacqui-Britton-Dunning-memorial-fund/1540329456239826

ADRIAN ROLLINS

Release children from detention, reinstate health watchdog: AMA

AMA President Associate Professor Brian Owler has called for children to be released from immigration detention centres and the appointment of an independent panel of medical experts to oversee the health care of detained asylum seekers.

Following the release of an Australian Human Rights Commission report showing hundreds of children held in detention have suffered violence, sexual assault and serious mental harm, A/Professor Owler told Sky News that any children currently being held should be immediately released into "a safe environment".

In a damning assessment of Australia's immigration detention system, the Commission reported that between January 2013 and March 2014, children in detention were the victim of 233 assaults, most of the 33 reported sexual assaults and 128 instances of self-harm. In addition, a third of children detained last year suffered serious mental health problems.

Among its findings, the Commission reported that, "in the first half of 2014, ¬34 per cent of children in detention were assessed as having mental health disorders at levels of seriousness that were comparable with children receiving outpatient mental health services in Australia."

Commission President Professor Gillian Triggs said the overarching conclusion of the Commission's investigation was that "prolonged, mandatory detention of asylum seeker children causes them significant mental and physical illness and developmental delays, [and] is in breach of Australia's international obligations".

A/Professor Owler said that although the Abbott Government had overseen a significant fall in the number of children being held in detention, the harm caused showed it was an inappropriate environment for any child, and those remaining in detention should be immediately released.

The confinement of children in immigration detention centres has long been a highly controversial aspect of the tough asylum seekers polices pursued by successive governments since the early 2000s.

The number of children being held behind wire peaked in July 2013, when, under the former Labor Government, 1992 were held in detention. Since then, a sharp slowdown in the arrival of asylum seekers by boat has seen the number of children in detention plunge, down to around 1100 when the Human Rights Commission inquiry began, and the Government claims there are just 192 now.

The AMA President added that the treatment of those being held in immigration detention should be the subject of oversight by an independent panel of experts, such as the Immigration Health Advisory Group, which was disbanded by the Abbott Government in December 2013.

A/Professor Owler said the standard of health care provided to asylum seekers, particularly in the offshore detention centres, was "well below what we would accept on the mainland", and should be subject to independent scrutiny.

But a spokeswoman for International Health and Medical Services, which has a contract to provide health services at the immigration detention centres, rejected claims of sub-standard care and invited A/Professor Owler to visit the facilities, including those at Manus Island, Nauru and Christmas Island, so that "he can make statements based on the facts".

Prime Minister Tony Abbott responded to the release of the report *Forgotten Children: National Inquiry into Children in Immigration Detention* by accusing the Human Rights Commission of engaging in a "blatantly partisan politicised exercise".

Mr Abbott rejected the Commission's call for a Royal Commission, and instead launched an extraordinary attack on the watchdog.

"There won't be a Royal Commission into children in detention, because if there were a Royal Commission into children in detention, it would condemn them," Mr Abbott told Parliament.

He continued his attack on Macquarie Radio, claiming "this is a blatantly partisan, politicised exercise and the Human Rights Commission ought to be ashamed of itself."

The issue has since become mired in legal controversy amid allegations the Government attempted to induce Professor Triggs to resign before the publication of the report.

It was revealed in Senate estimates that that the Secretary of the Attorney-General's Department, Chris Moraitis, acting on instruction from Attorney-General George Brandis, approached Professor Triggs just before the report was released to inform her she had lost the confidence of the Minister and to discuss a possible alternate "specific senior role" for her, though the Government has denied it sought her resignation.

Professor Triggs strongly rejected the Prime Minister's accusation of bias.

"I can assure you and the Australian public that this is not a politicised exercise," she told *The Australian*. "It is a fair minded report and I ask all Australians to read the report and you will see that the evidence on which we rely is evidence that covers the period of the former government as well as the nearly 18 months of the current government."

ADRIAN ROLLINS

New approach to international criminal history checks

The Australian Health Practitioner Regulation Agency (AHPRA) and the Medical Board have introduced a new process for checking practitioners' international criminal history to strengthen public protection.

The new process aims to strike a balance between public safety and regulatory burden for practitioners. It aligns our international criminal history checks with our domestic history checks and aims to be fair and reasonable for practitioners.

Under the Health Practitioner Regulation National Law, as in force in each state and territory (the National Law), the Medical Board must consider the criminal history of all applicants for registration, including any overseas criminal history.

The new approach requires certain applicants and practitioners to apply for an international criminal history check from an AHPRA-approved supplier.

Checks will be required for all new applicants who:

- declare a criminal history outside Australia and/or
- have lived or been primarily based in one or more countries other than Australia for six consecutive months or more since the age of 18.

Currently registered practitioners will require a check if they:

- are seeking to renew their registration or applying for a change in registration type, and:
- there has been a change to their criminal history in one or more countries other than Australia since their last declaration to AHPRA
- at any time of the year, inform the relevant National Board that they have been:
- charged with an offence outside Australia that is punishable by a sentence of 12 months' imprisonment or more, or
- convicted of, have pleaded guilty to or are the subject of a finding of guilt by a court for an offence, outside Australia, that is punishable by imprisonment.

Existing requirements for checking domestic criminal history will continue.

More information is available on the International criminal history checks page on the AHPRA website.

ADRIAN ROLLINS

Damula, 5, Uganda

Don't let her drink dirty water

World Vision

malaria, cholera, diarrhoea, intestinal worm infection,

... dirty water can kill.

6,000 children are dying every day – and it's because they don't have clean water. So they're forced to drink water that could make them sick with diarrhoea, cholera and typhoid.

The good news is, problems like dirty water can be solved. You can help children access clean water through World Vision's Water Health Life program by providing practical and effective solutions.

From $39 a month your support will help drill boreholes, protect water sources and provide health and hygiene training. You'll be helping communities to make long-term changes that ensure a clean water supply and basic sanitation.

Stop dirty water killing children, support Water Health Life:
visit **worldvision.com.au** or call **13 32 40.**

Water Health Life
Basic Needs. Permanent Solutions

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

Back to the waiting room for reforms, *Sydney Morning Herald*, 17 January 2014

Recently appointed Health Minister Sussan Ley plans to dump contentious cuts to GP rebates for short visits. AMA President A/ Professor Brian Owler said no issue in recent memory has provoked the anger among doctors and patients that this rebate cut has.

Co-payment in some form still on agenda, *Australian Financial Review*, 17 January 2014

Health Minister Sussan Ley says some form of GP co-payment is still on the government's agenda despite an embarrassing backdown on GP rebates. The AMA has welcomed the Government's backflip as a victory for grassroots GPs and patients.

Libs speak out over GP 'affront', *The Australian*, 19 January 2014

Anger is welling within Liberal ranks over the failed push to cut GP rebates, with MPs urging caution on the introduction of a co-payment. AMA President A/Professor Brian Owler was sceptical of extending a co-payment to specialists, but was open to consultations with the Government.

Knives still out over GP rebates, *The Daily Telegraph*, 21 January 2014 2014

A planned $5 cut to GP Medicare rebates could be reconstructed as the Federal Government gears up for crunch talks with the Australian Medical Association. Health Minister Sussan Ley is scheduled to meet AMA bosses for a fresh round of consultations on the Government's vexed Medicare reforms.

Lib MPs fear rebate backdown, *The Australian*, 20 January 2014

Tony Abbott is being urged to abandon plans to cut the Medicare rebate by $5, as Government MPs warn against fighting an unwinnable political battle that plays into Labor's hands. The AMA also remains opposed to the $5 rebate cut.

Doctors groups expect deal on $5 co-payment, *The Australian*, 23 January 2014

Doctors groups are hopeful a fresh approach by new Health Minister Sussan Ley will see the Government strike a compromise on its proposed $5 cut to the Medicare rebate. AMA President A/Professor Brian Owler says the minister is open to looking at alternative proposals.

Calls to reform 'racket' by adding to nurse duties, *Weekend Australian,* 24 December 2014

Experts are advocating that health savings can be found by allowing nurses, pharmacists and paramedics taking on more responsibilities. But AMA President A/Professor Brian Owler rejects the suggestions that devolving GP responsibilities to other health professionals will result in savings.

RADIO

A/Professor Brian Owler, ABC NewsRadio, 19 January 2014

AMA President A/Prof Brian Owler discusses comments by former GP Andrew Lamming, who believes that doctors seeing more than 10 patients per hour cannot be delivering quality medicine. AMA President A/Professor Brian Owler says it depends what the doctor is doing for those 10 patients in the hour.

TELEVISION

A/Professor Brian Owler, SKY News, 19 January 2014

AMA President A/Professor Brian Owler talks about the Government's backdown on a $20 cut to the Medicare rebate. A/Professor Owler says there needs to be a considered and well-informed discussion of health policy to improve health care.

A/Professor Brian Owler, ABC News 24, 22 January 2014

AMA President A/Professor Brian Owler holds a press conference to discuss the outcomes of his meeting with new Health Minister Sussan Ley, including regarding the Government's planned $5 Medicare rebate cut.

Forget 'no jab, no pay' schemes, there are better ways to boost vaccination

BY ASSOCIATE PROFESSOR KRISTINE MACARTNEY, DISCIPLINE OF PAEDIATRICS AND CHILD HEALTH, UNIVERSITY OF SYDNEY

This article was first published by The Conversation on 27 February 2015, and can be viewed at: http://theconversation.com/forget-no-jab-no-pay-schemes-there-are-better-ways-to-boost-vaccination-37921

Removing the childcare rebate for parents who do not fully immunise their children is unnecessarily punitive and could have repercussions.

Immunisation in Australia isn't compulsory – and doesn't need to be controversial. Most Australians recognise the incredible benefits that vaccination provides to prevent serious disease; we have high and stable coverage rates of around 93 per cent.

Most parents whose children are un- or under-vaccinated need more support to help protect their child: a carrot rather than stick approach

Getting childhood immunisation to the 95 per cent target rate would be even better, providing more individual protection and "community immunity".

However, the McClure Review recommendation that child and youth welfare payments be conditional on having up-to-date immunisation is not the answer to maintaining or improving vaccine uptake.

Nor is the Productivity Commission's recent suggestion that parents who have not had their child fully vaccinated should not receive the childcare benefit tax rebate the right way forward.

Most parents whose children are un- or under-vaccinated need more support to help protect their child: a carrot rather than stick approach.

Why aren't all children vaccinated?

Financial incentives are in place to encourage parents get their child to the clinic multiple times early in life to get their shots on time. We all know this can be challenging.

Research tells us that parents of the 7 per cent of incompletely vaccinated children fall into two distinct groups.

The first group, more than half of the 7 per cent, face practical, economic, social or geographic impediments to full and timely vaccination. They are more likely to experience poverty or social exclusion.

A smaller proportion, estimated at 2 to 3 per cent of the population, have beliefs, attitudes and concerns that cause them to reject or delay some or all vaccines.

In addition, some parents who are up-to-date with their child's routine immunisation can be hesitant or uncertain about vaccines. Who can blame anyone for having questions about vaccines when misinformation abounds, promulgated by small fringe groups.

Reminding and supporting parents

Recent changes to childcare legislation in New South Wales require parents to provide documentation about their child's immunisation when they enrol into childcare. Other states are examining the legislation and Victoria plans to follow suit in 2015.

This is a great initiative for a number of reasons. First, it provides another "reminder point" to check on a child's immunisation status and gives an opportunity to enrol the child in a "catch up" program.

Second, it requires that parents who actively decline vaccination have visited an immunisation professional or GP to discuss their decision. If those parents continue to choose not to vaccinate, they need to produce a signed objection form.

Parents who follow any of these options are currently eligible for the childcare rebate.

Continued on p22 ...

Forget 'no jab, no pay' schemes, there are better ways to boost vaccination

... from p21

Unfortunately, these system improvements have been characterised by the media as "no jab, no play": that unimmunised children don't have the right to attend childcare. This is blatantly untrue; "no form, no play" is more accurate but not as sensational.

To protect both themselves and others, unimmunised children are required to stay at home from childcare for weeks in the case of a vaccine-preventable disease outbreak, such as measles or whooping cough. This is a financial and practical disincentive for parents who don't vaccinate their children.

Punishment can backfire

Removing welfare payments or childcare rebates for parents who do not fully immunise their children is unnecessarily punitive and could have a number of negative repercussions.

On the one hand, these measures are unlikely to influence the completely committed vaccine objectors. But not all parents who haven't vaccinated are completely committed to that position.

On the other hand, removing incentives could paradoxically push very hesitant parents who have some willingness to immunise their children further against doing so.

Removing childcare subsidies carries the risk that children of low-income non-vaccinating families may not attend childcare or access much needed financial support to visit the doctor at all – a terrible outcome.

Removing welfare payments would obviously have a devastating effect on these children and their families.

History tells us that coercive policies can galvanise and further radicalise fringe movements. These proposals, together with a steady flow of adversarial public discussions, may actually increase exposure of everyone to anti-vaccination arguments and "normalise" vaccine objection.

Increasing vaccination rates

Strategies that increase the opportunity to vaccinate are most effective. Improving access, awareness and affordability could potentially boost coverage rates by as much as 3 to 4 per cent.

Research shows that maintaining openness and trust is key to guiding parents to feel comfortable to immunise. This is also my experience as an immunisation professional who sees parents with low-vaccine acceptance.

Parents can change their position over time. A proportion of registered vaccine objectors have at least one vaccine recorded for their child: some have started the vaccine schedule but then ceased vaccinating or continue to selectively vaccinate.

Some registered objectors go on to fully vaccinate their children. The example of the mum who said "I never realised whooping cough could be so bad" and who went on to fully immunise her daughter after a prolonged hospitalisation for that preventable disease, springs to mind.

Having vaccine-hesitant parents engage with well-qualified health professionals who can take the time to address immunisation concerns is pivotal to helping them wade through the challenges that misinformation can create.

Another strategy that can work is grassroots campaigning for immunisation.

In the Northern Rivers district of New South Wales, which is notorious for low immunisation rates, a community movement called the Northern Rivers Vaccination Supporter Group is seeking not to demonise neighbours who don't vaccinate, but to promote immunisation as part of a healthy lifestyle.

Their message of "love, protect, vaccinate" might not persuade the most ardent sceptics in their region, but it is going a long way to promote positive messages in their community and tell the real story of serious preventable illnesses.

A similar group in Western Australia, Immunisation Alliance WA, is supporting parents to get the best information about vaccines.

Finally, it's important to remember the child in this debate. Good policy and practice should afford young children every opportunity to be both healthy through immunisation, educated through childcare, and supported in their family environment.

Let's focus on improving opportunities for our kids, not punishing parents.

Health on the hill

POLITICAL NEWS FROM THE NATION'S CAPITAL

Plain packaging under review as global fight lights up

The Federal Government has launched a review of the nation's breakthrough tobacco plain packaging laws amid continued local and international efforts to have the anti-smoking measure overturned.

The Government has engaged consultants Siggins Miller to examine the effect plain packaging has had on the tobacco industry and consumers and, "where possible, quantify the costs and benefits of the measure", with the information to be used as part of a post implementation review.

The review is a requirement of the Australian Government Office of Best Practice Regulation, and is intended to determine whether the law "remains appropriate", and how effective and efficient it has been in reducing the appeal of tobacco products and discouraging smoking.

But the review comes against the backdrop of a concerted international campaign by the tobacco industry to have the Australian legislation overturned and prevent other countries from introducing similar laws.

Philip Morris Asia has launched a legal challenge against the legislation, claiming it breaches the terms of a 1993 investment agreement with Hong Kong.

The case represents the first time Australia has been subject to an investor-state proceeding.

The tobacco industry has also sought to undermine support for the laws by claiming they are driving an increase in the black market trade in cigarettes.

British American Tobacco Australia told *The Australian* newspaper last month it had discovered several counterfeit packets of cigarettes for commercial sale, and a KPMG study commissioned by the tobacco industry estimated illegal products comprised almost 14 per cent of the local market.

Several countries, including the Dominican Republic, Indonesia, Cuba and Ukraine, have also launched action against Australia at the World Trade Organisation, claiming the plain packaging laws breach international trade obligations regarding intellectual property rights, in particular trademarks, and geographical indications.

Despite the multi-pronged assault, other countries are moving to introduce similar laws.

The British Government has said it wants to introduce plain packaging laws before the general election, meaning that could come into force as early as May 2016, while the Irish Government has so far resisted enormous pressure from the tobacco industry to dump planned plain packaging legislation.

Industry giants Imperial Tobacco and Japan Tobacco have both threatened to launch legal action against the governments if they introduce plain packaging legislation, and the United States Chamber of Commerce wrote to Irish Prime Minister Enda Kenny warning the bill will "expose the Irish State to higher costs from compensation" and "potentially violate important aspects of Ireland's international commitments".

But Big Tobacco may be fighting an uphill battle, with other countries already considering introducing similar laws, including New Zealand, France and India, while many European countries are watching the developments closely.

Evidence suggests plain packaging is working to help reduce the incidence of smoking, particularly in deterring young people from taking up the deadly habit.

The National Drugs Strategy Household Survey released last year found a dramatic decline in smoking rates had coincided with the introduction of plain packaging laws.

The daily smoking rate plunged from 15.1 per cent to 12.8 per cent between 2010 and 2013, according to the nation's largest and longest-running survey on drug use. It found most people are now 16 years old before they smoke their first full cigarette, up from 14 years in 2010, and 95 per cent of 12 to 17-year-olds have never smoked.

The results have been claimed by public health experts as vindication for the effectiveness of the measure, and have undermined tobacco industry claims that they have had little effect on smoking rates.

ADRIAN ROLLINS

Mental health future cloudy despite short-term funds relief

The Federal Government has announced a one-year extension of funding for services supporting people suffering mental illness and their carers, allaying fears tens of thousands would be left stranded without help.

Assistant Minister for Social Services Mitch Fifield has said contracts for organisations currently receiving funding to provide services under the Personal Helpers and Mentors program and the Mental Health Respite: Carer Support program would be extended to 30 June 2016, taking them through to the full implementation of the National Disability Insurance Scheme on 1 July next year.

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The decision is a relief for the operators of around 150 federally-funded programs that were struggling to hold on to staff and plan ahead because of funding uncertainty.

Up to 4000 mental health workers were at risk of losing their jobs before the Government announced its decision.

"The extension of these contracts will ensure people living with mental illness, and those who care for them, can still access these support services," Senator Fifield said. "This one-year funding extension will help ensure a smooth transition to the NDIS for these services."

While the decision has provided short-term reassurance to many, the sector is still gripped by uncertainty as the Government sits on the results of a major review of the nation's mental health system.

It is understood that the National Mental Health Commission delivered the results of its Government-commissioned inquiry into mental health services to the Minister in November last year, but the Government has so far withheld the findings, causing consternation among service providers, practitioners and patients.

The Australian Medical Students' Association is among those calling on the Government to release the results of the review and use the forthcoming Budget to announce greater investments in mental health services.

AMSA President James Lawler said the Budget was the "ideal time" to act on the review's findings and invest in severely underfunded mental health services, particularly for young people.

Shadow Mental Health Minister Jan McLucas, who has been pushing hard for the Government to release the Commission's report, said that although she had misgivings about the competency of the Commission to undertake an inquiry focused on the finances of mental health services, now that the report had been completed, the fact that it would be used to steer Government mental health policy decisions meant it should be released immediately.

"It is absolutely essential that this [policy making] be done transparently, that the conversation is held in a way that each and every participant has an understanding of the direction of the Government," Senator McLucas said. "We need an informed discussion about the future of mental health programs in the country."

Senator McLucas has moved a motion in the Senate calling on the Government to the final report, as well as two interim reports provided to the Government in February and June.

The Government has so far resisted these calls.

ADRIAN ROLLINS

In brief

New research head appointed

Renowned immunologist Professor Anne Kelso has been appointed to succeed Professor Warwick Anderson as head of the National Health and Medical Research Council. Professor Kelso is former Director of the WHO Collaborating Centre on Influenza, and Health Minister Sussan Ley said her distinguished career in medical research made her an ideal choice for the job. Professor Kelso will take up the position in April.

Changes at medicines watchdog

Dr Suzanne Hill is stepping down as Chair of the Pharmaceutical Benefits Advisory Committee to take up a role with the World Health Organisation. In other changes announced by Health Minister Sussan Ley, long-standing committee members Professor Robyn Ward and Professor Andrew Roberts have been re-appointed for further four years, and will be joined by former RACGP President Dr Liz Marles and infectious diseases expert Dr Thomas Snelling. They replace Professor Jim Buttery and Professor David Isaacs, who are stepping down after eight years of service.

Pfizer beats anti-competition charge

Drug giant Pfizer has been cleared of charges it misused its market power by trying to get pharmacies to stock its supply of atorvastatin in early 2012. In a blow to the competition regulator, Federal Court judge Justice Flick has dismissed accusations that, by offering incentives to pharmacies to stock its brand product Lipitor as well as its generic version of atorvastatin, the company had engaged in anti-competitive conduct. Justice Flick found that, while Pfizer had taken advantage of its position in the market, its market power was no longer "substantial" at the time it made the offers. Australian Competition and Consumer Commission ACCC Chairman Rod Sims said the regulator would "carefully consider" the judgement.

Chief Scientist stays on

Chief Scientist Professor Ian Chubb has had his appointment extended to the end of 2015. Professor Chubb was due to step down in May, but has agreed to stay on while the Government conducts an international search for his replacement. Professor Chubb has held the position for almost four years.

Research

Turn the pedals to hold back the years

Every year billions of dollars are spent on potions and creams, as well as the odd nip and tuck, in the pursuit of youthful looks.

But the key to appearing and, more importantly, feeling young in the face of advancing years can be found in the garages and backyard sheds of homes across the country.

A British study has found that the humble bicycle, used regularly, can enable people to stave off many of the physical and mental aspects of ageing, leaving those in their fifties, sixties and even seventies, with minds and physiques equivalent to people half their age.

Researchers at King's College, London wanted to explore how ageing affects the body, and whether there were specific physiological markers that could be used to determine age.

For the study, they recruited 84 men and 41 women aged between 55 and 79 years who were keen cyclists, and subjected them to tests measuring a wide variety of characteristics from cardiovascular, metabolic, endocrine and cognitive functions through to assessments of muscular and bone strength, reflexes and oxygen uptake.

The test subjects were fit individuals. To qualify for the study, the men needed to be able to cycle 100 kilometres in less than six-and-a-half hours, while the women had to cycle 60 kilometres in less than five-and-a-half hours. Smokers, heavy drinkers and those with high blood pressure and other health conditions were excluded.

What they found suggests there is nothing inevitable about physical decline with ageing.

In their examinations, the researchers found that the effects of ageing were far from obvious, and people of different ages could have similar levels of function, such as muscular strength, lung power and exercise capacity.

Maximum rate of oxygen consumption appeared to have the closest correlation with advancing years, but even this characteristic could not provide an accurate guide to the age of any individual.

In many aspects, the participants had the physical and mental characteristics and agility of people much younger. For example, even the oldest participants were able to complete a simple test for falling risk – involving the time taken to rise from a chair, walk three metres, return to the char and sit down – at levels well within the norm for a young, healthy adult.

Lead author Dr Ross Pollock said the research suggested the effects of ageing were likely to be highly variable according to the characteristics of the individual.

Dr Pollock said one of the challenges facing researchers is to try and separate the physical effects of ageing from those of a sedentary lifestyle, given the prevalence of sedentary lifestyles in modern society.

"In many models of ageing, lifespan is the primary measure. But in human being this is arguably less important than the consequences of deterioration in health [such as from sedentary behaviour]," he said.

Co-author Professor Stephen Harridge said that "because most of the population is largely sedentary, the tendency is to assume that inactivity is the inevitable condition for humans. However, given that our genetic inheritance stems from a period when high levels of physical activity were likely the norm, being physically active should be considered to play an essential role in maintaining health and wellbeing throughout life."

Emeritus Professor Norman Lazarus, another member of the research team, said it was inevitable that there be some physical decline with age, "but staying physically active can buy you extra years of function compared to sedentary people".

Professor Lazarus, who is a cyclist, said cycling was a good activity because it "not only keeps you mentally alert, but requires the vigorous use of many of the body's key systems, such as your muscles, heart and lungs".

The study has been published in *The Journal of Physiology*.

ADRIAN ROLLINS

Catheter coating reverses a common hospital-acquired infection

BY JACQUIE VAN SANTEN, SOUTHERN HEALTH NEWS*

Up to 25 per cent of patients have a urinary catheter inserted during their hospital stay, with many of them going on to develop urinary tract infections associated with the use of the catheter.

"It's not surprising really, because as soon as you insert foreign material into the body bacteria will grow," explained Dr Ingo Koeper, lecturer in the School of Chemical and Physical Sciences and researcher in the Flinders Centre for NanoScale Science and Technology, based at Flinders University.

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Research

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Current medical practice is to regularly change catheters in an effort to prevent infection. However, this is uncomfortable for patients and is expensive for the health system.

In the United States, it is estimated that replacing catheters costs the health system $400 to $500 million a year.

Dr Koeper and his team, in conjunction with Flinders Medical Centre's Head ofMicrobiology and Infectious Diseases, Professor David Gordon, believe the incidence of catheter-associated bacterial infection can be dramatically reduced with a simple modification – coating the catheter with a non-toxic bacteria-resistant chemical compound.

He said the research project – boosted with a recent $30,000 grant from The Repat Foundation – came about after he learnt a colleague in the water desalination field was using a similar technique on desalination membranes.

"We are using a similar polymer and a similar method, and early laboratory results have been promising, suggesting that we can cut bacterial growth by 95 per cent," Dr Koeper said. "But now we need to determine that the product we are using to coat the catheter is safe for human use."

As part of the research, the team is working closely with urology doctors and nurses based at the Repatriation General Hospital.

"We are currently analysing the data of urology patients at the hospital, and are interviewing medical staff about current catheter practice," he said. "We also want to determine why existing catheters with non-bacterial properties aren't used very often."

Once the team has developed a suitable chemical compound, the polymer will need to undergo comprehensive clinical trials to ensure its safety and efficacy.

"It's hard to put a timeline on it, but we're hoping that within five years we may have a new bacteria-resistant catheter on the market.

** This story was first published by The Lead on 17 February, 2015, and can be viewed at: http://www.theleadsouthaustralia.com.au/innovators/catheter-coating-reverses-a-common-hospitalacquired-infection/*

Life-saving treatment can resurrect dormant killer

Patients undergoing life-saving organ transplants and cancer therapy are at risk of a potentially fatal flare-up of pre-existing hepatitis B infections, researchers from the Saint Louis University in Missouri have found.

Patients previously infected with the hepatitis B virus (HBV) who undergo treatments that suppress the immune system, including those for cancer, auto-immune disease and transplantation, may be at risk of reactivating the disease, with possibly deadly consequences, the researchers warned.

HBV is transmitted by contact with body fluids, such as blood from an infected individual, causing acute or chronic disease that attacks the liver. While vaccination helps slow the spread of the virus, it is estimated as much as 10 per cent of the global population is infected with chronic HBV.

The American Food and Drug Administration (FDA) issued a boxed warning in September 2013 for two medications that target protein CD20, which is found on immune system B cells, which may reactivate HBV. The regulator urged doctors to screen patients for HBV before using the drugs.

But Saint Louis University researchers have warned the FDA warning might just be the tip of the iceberg.

"Reactivation of HBV is a potentially lethal condition and yet is preventable," Dr Adrian Di Bisceglie said. "Our research suggests that the issue of HBV reactivation may be an under-appreciated clinical challenge that extends well beyond the use of just two anti-CD20 medications."

Dr Di Bisceglie said all patients undergoing chemotherapy, immunosuppressive therapy, hematopoietic stem cell transplantation, or solid organ transplantation should be screened for active or prior HBV infection.

"While further study will be necessary to completely define the risks, benefits and costs of universal screening, we feel that the evidence as it stands now is sufficiently compelling to make routine screening for hepatitis B a standard practice," he said.

KIRSTY WATERFORD

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Cancer rate high among transplant patients

Life-saving organ transplants can nevertheless leave recipients at far greater risk of developing cancer because of the effects of immune suppression medications, University of Adelaide researchers have found.

A study of kidney transplant patients has found that a third will eventually die of cancer many years after their surgery, most commonly skin cancer.

Lead researcher Dr Robert Carroll said that although there was no doubt that transplants were needed to save lives, many recipients were having their lives cut short because of the much greater risk of developing cancer.

"With as many as 800 kidney transplants being performed in Australia each year, that represents a significant cancer burden for those patients to come in the years ahead," Dr Carroll said.

It has been established that drugs used to prevent a recipient's body from rejecting a donated organ by suppressing the immune system also make a patient more susceptible to developing cancer.

The University of Adelaide researchers have been researching the immune systems in kidney transplant recipients to better understand the problem, and have found that a number of markers, including immune cells such as B cells and regulatory T-cells in the blood, help indicate whether a transplant patient is more likely to develop cancer.

"[Our research] may give us a method for understanding which patients are at higher risk of developing cancer, but unfortunately at this stage we have no real way of preventing those cancers from occurring," Dr Carroll said.

The research team are now conducting further studies to see what impact reductions in the immunosuppressant drugs will have on patients.

"It's about striking a fine balance between ensuring the new organ is not rejected, and helping to prevent cancer from developing in patients in the future," Dr Carroll said.

The research team is supported by the Jacquot Research Establishment Award from the Royal Australasian College of Physicians and a Team Life Australia grant.

KIRSTY WATERFORD

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.

Second Australian nurse evacuated from Ebola clinic

A second Australian nurse has been evacuated to the United Kingdom in as many months following a "low-risk clinical incident" at the Australian-operated Ebola treatment centre in Sierra Leone.

Foreign Minister Julie Bishop said the nurse, who has not been identified, is not exhibiting any symptoms of the deadly disease and is not considered to be at significant risk.

The nurse is the second to have been airlifted to Britain following an incident at the centre, which is being operated under a $20 million contract by Canberra-based Aspen Medical, following the evacuation of a nurse in similar circumstances in mid-January.

Commonwealth Chief Medical Officer Professor Chris Baggoley told a Senate estimates hearing last week that the woman's health was "not of concern", and she would return to Australia as soon as the precautionary 21-day observation period was completed.

Ms Bishop said the evacuations were conducted under the terms of an agreement struck between the Australian Government and its British counterpart prior to the deployment of Australian health workers to the Ebola-hit country.

The Government last year blamed difficulties in putting such evacuation arrangements in place to justify its tardy response to the world's worst-ever Ebola outbreak.

The AMA was a leading voice in calls from the middle of last year for the Government to join international efforts to combat the spread of the deadly virus, which has so far infected almost 24,000 people and claimed more than 9600 lives (including 490 health workers).

But for months the Abbott Government resisted, initially arguing the country should focus its response on making sure the region was prepared to deal with any local outbreak of the infection, and then stating it would not authorise any deployment of Australian medical staff until robust evacuation arrangements were put in place.

Australia's official involvement has coincided with a sharp slowdown in the rate of infections.

From a peak of up to 800 new cases being reported each week at the height of the outbreak in the second half of last year, the number of confirmed new infections has dropped below 100 in the countries at the centre of the epidemic, Liberia, Guinea and Sierra Leone.

In Liberia, where there were 9238 infections and more than 4000 deaths as at 22 February, there were just one confirmed new case in the preceding week, while in Guinea (3155 cases and 2091 deaths) there were 35 confirmed infections. In Sierra Leone, which has been hit hardest by the outbreak (11,301 cases and 3461 deaths), there were 63 new confirmed cases.

In recent weeks the World Health Organisation has become increasingly confident that the worst of the outbreak is over.

But it warned that that a spike in cases in Guinea early last month, and continued widespread transmission in Sierra Leone, "underline the considerable challenges that must still be overcome to get to zero cases".

The WHO said the infrastructure, systems and personnel needed to end the epidemic "are now in place; responses measures must now be fully implemented".

ADRIAN ROLLINS

World needs to heed Ebola lessons: WHO

The world was caught tragically short in it response to the deadly Ebola epidemic by a failure to absorb the lessons of the 2009 swine flu pandemic.

In a critical assessment of the response to the globe's worst-ever Ebola outbreak, the World Health Organisation said the international community had failed to learn from the shortcomings laid bare by the H1N1 influenza pandemic, including the need for a ready global reserve of public health workers who can drawn upon in an emergency, the creation of a contingency fund and the development of a comprehensive research and evaluation program.

A WHO review of the swine flu pandemic, conducted in 2010, recommended the measures to address limitations in the world's preparedness to cope with similar outbreaks in future.

"[But], as the Ebola outbreak has revealed, the world did not respond to these recommendations, with none of these measures fully in place to support a response that could last for many more months to come," the WHO said, adding that only 64 of its 194 member countries had the surveillance, laboratory, data management and other capabilities considered necessary.

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World needs to heed Ebola lessons: WHO

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"As a result, the WHO went into battle against this virus with no army of reinforcements to support a sustained response, no war chest to fund a surge, and weapons that date back to the Middle Ages," it said.

The WHO has been criticised for its response to the Ebola outbreak, and Director-General Dr Margaret Chan has admitted her organisation had been too slow to pick up on the seriousness of the event and recruit the staff it needed on the ground.

"Ebola is a tragedy that has taught the world, including the WHO, many lessons," Dr Chan said. "The world, including the WHO, was too slow to see what was unfolding before us."

She has announced changes to the WHO, including consistency in the way it operates in different regions and greater efforts to identify and recruit the experts it needs.

But the WHO said the global community could not rely on its alone to tackle such outbreaks, and emphasised the importance of robust national health systems.

"Countries with weak health systems and few basic public health infrastructures in place cannot withstand sudden shocks," it warned, observing that the health systems of Guinea, Liberia and Sierra Leone collapsed under the pressure of the Ebola outbreak, leaving thousands vulnerable to other diseases, such as malaria, as well.

"Fair and inclusive health systems are a bedrock of social stability, resilience and economic health," the WHO said. "Failure to invest in these fundamental infrastructures leaves countries with no backbone to stand up under the weight of the shocks that this century is delivering with unprecedented frequency."

It said the Ebola outbreak also underlined the importance of strong community engagement to any successful response, including to change behaviours that increased the risk of transmission, as well as greater cross-border coordination, accelerated research effort, better support for health workers and sustained national and international commitment.

The WHO report *One year into the Ebola epidemic: a deadly, tenacious and unforgiving virus* can be viewed at http://www.who.int/csr/disease/ebola/one-year-report/introduction/en/

ADRIAN ROLLINS

INFORMATION FOR MEMBERS

Medical Women's Society of NSW

The Medical Women's Society (MWS) of NSW promotes friendship and understanding between medical women throughout the world, while working against gender inequalities in the medical profession and advocating for and supporting the health and welfare of the local and international community.

In 2014, the MWS was involved in the successful campaign against the $7 GP co-payment, supported efforts to tackle the Ebola crisis and drew public attention to the closure of several women's refuges.

The MWS strives to:

- improve the health and welfare of all persons, especially women and children, in the Australian community;
- promote the professional development of medical women locally, nationally and internationally;
- work collaboratively to advance the status of women; and
- participate in conventions, seminars and conferences, locally, nationally and internationally.

Current and forthcoming activities include a biannual networking dinner, a mentoring program and a regular newsletter.

If you would like more information about the Society, including how to join, please visit https://mwsnsw.wordpress.com/ or email nsw@afmw.org.au

Canada gives assisted suicide go-ahead

Canada appears set to join a growing group of nations where doctor-assisted suicide is legal following a landmark ruling by its top court.

In a unanimous ruling, the Supreme Court of Canada found that laws prohibiting physician-assisted suicide “infringe the right to life, liberty and security of the person in a manner that is not in accordance with the principles of fundamental justice”.

It said mentally competent adults suffering intolerable physical or psychological distress as a result of a severe and incurable – but not necessarily terminal – medical condition, have the right to a physician’s help to die.

The judgement means that federal laws passed last year allowing doctors to help patients to kill themselves, due to come into effect from the end of 2015, will not face any further legal challenge.

Instead, anti-euthanasia campaigners are turning their attention to ensuring the laws are re-drafted to be framed as narrowly as possible.

Canada’s move toward doctor-assisted suicide comes amid mounting attention to the issue both in Australia and abroad.

A Senate committee late last year reported on Dying with Dignity legislation proposed by Greens Senator Richard Di Natale, and the Tasmanian parliament narrowly defeated voluntary euthanasia legislation in 2013.

In its submission to the Senate committee inquiry into Senator Di Natale’s *Exposure Draft of the Medical Services (Dying with Dignity) Bill 2014*, the AMA said it opposed making it legal for doctors to prescribe and administer an end of life substance.

“We believe that doctors should not be involved in interventions that have as their primary intention the ending of a person’s life,” the AMA submission said, adding that activities like euthanasia and assisted suicide breached the fundamental ethical principles underpinning medical practice.

The AMA said it was consistent with good medical practice for doctors not to initiate or continue life-prolonging measures, or to provide treatments that had as their primary purpose the alleviation of symptoms, but which may have the secondary consequence of hastening death.

“Withholding and/or withdrawing life-sustaining treatment allows the course of the person’s illness to progress naturally, which may result in death,” it said. “In addition, the administration of treatment to relieve symptoms which may have the secondary consequence of hastening death is undertaken with the primary intent to relieve the patient of distressing symptoms.

“It is important that these practices, which are ethically acceptable…are not confused with activities that constitute euthanasia or physician-assisted suicide.”

AMA Vice President and emergency physician Dr Stephen Parnis said caring for people approaching the end of their life was at once one of the most difficult and yet rewarding aspects of being a doctor.

But Dr Parnis said effective, on-going communication between doctors, patients, families and carers was key to making a patient’s final days as comfortable, calm and stress-free as possible.

“As doctors, we understand and acknowledge that most of us will eventually succumb to the effects of chronic disease, and that medical care is as much about disease control and symptom relief as it is about prevention and cure,” he said. “How we care for our patients as they approach their death can be among the most difficult yet rewarding aspects of our professional lives.”

Dr Parnis said it was important that patients prepare advance care plans to inform doctors, families, and carers about their preferences in the event they lose decision-making capacity.

He said patients with limited or impaired capacity should be encouraged and supported to participate in treatment decisions, consistent with their level of capacity at the time.

Among the most frequently voiced concerns are that people with diminished mental or physical capacity may be railroaded into agreeing to assisted dying.

But Canada’s Supreme Court this was not an overriding concern.

“We agree…that the risks associated with physician-assisted death can be limited through a carefully designed and monitored system of safeguards,” the court said in its judgement. “A theoretical or speculative fear cannot justify an absolute prohibition.”

ADRIAN ROLLINS

ISIS organ trafficking claims must be investigated: WMA

The World Medical Association has backed calls for the United Nations to investigate horrific claims that the ISIS terrorist group is harvesting human organs to raise funds.

In a statement issued late last month, the WMA said reports that the violent organisation was removing organs from hostages and dead fighters for sale on the lucrative global black market must be examined, including the possible participation of doctors.

> "the terror organisation had established a specialist organ-smuggling division whose sole responsibility was to sell human hearts, livers and kidneys on the lucrative international black market"

"If these reports are correct, it means there is a horrifying trade in human organs on an almost industrial scale being carried out by these terrorists," WMA President Dr Xavier Deau said. "The reported involvement of doctors in this activity must be investigated, as well as claims that those doctors who refuse to take part are being executed."

The possibility that ISIS was trading in human organs first appeared late last year when al-Monitor news website published claims by an Iraqi ear, nose and throat doctor, Siruwan al-Mosuli, that ISIS commanders had hired foreign doctors to run an extensive organ trafficking system from a hospital in the captured city of Mosul, northern Iraq, that is already beginning to generate huge profits.

According to the website's report, cited by the *Daily Mail* newspaper, the terror organisation had established a specialist organ-smuggling division whose sole responsibility was to sell human hearts, livers and kidneys on the lucrative international black market.

"[Al-Mosuli] said that lately he noticed unusual movement within medical facilities in Mosul. Arab and foreign surgeons were hired, but prohibited from mixing with local doctors," the report's author wrote. "Information then leaked about organ selling."

The claims gained credence late last month when Iraq's Ambassador to the UN, Mohamed Alhakim, urged the Security Council to investigate the deaths of 12 doctors in Mosul, Iraq. He said they were killed after refusing to remove organs from bodies.

"Some of the bodies we found are mutilated ... that means some parts are missing," Mr Alhakim told reporters later, adding that there were openings in the back of the bodies where the kidneys would be located. "This is clearly something bigger than we think."

Nickolay Mladenov, the UN special envoy for Iraq, told CNN the organ theft claim would be investigated.

"We have seen these reports as well," he said. "However, I do not want to hasten to confirm anything before we study them in greater detail."

Mr Mladenov said reports that the group "is using a human trafficking as part of its sources of income" have circulated for months.

"I cannot speak to the extent of that issue until we finalize our analysis of the problem, but if one looks at the broader picture, it is very clear that the brutality and the tactics that [ISIS] is using expand by the day."

Dr Deau said the UN should launch an official investigation into the matter, including any involvement by transplant surgeons in the trade, "as soon as possible", and warned action would be taken against any practitioners voluntarily taking part.

ADRIAN ROLLINS

AMA Member Benefits

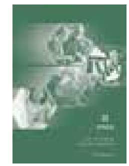
AMA members can access a range of free and discounted products and services through their AMA membership. To access these benefits, log in at **www.ama.com.au/member-benefits**

AMA members requiring assistance can call AMA member services on

1300 133 655 or **memberservices@ama.com.au**

UpToDate®

UpToDate: NEW offer for AMA members! UpToDate is the clinical decision support resource medical practitioners trust for reliable clinical answers. AMA members are entitled to discounts on the full and trainee subscription rates.

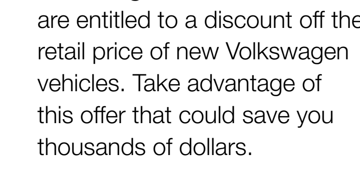


Fees & Services List: A free resource for AMA members. The AMA list of Medical Services and Fees assists professionals in determining their fees and provides an important reference for those in medical practice.

Careers Advisory Service: Your one-stop shop for information and resources to help you navigate through your medical career.

CPD Tracker: Record your continuing professional development (CPD) online with the AMA's CPD Tracker, a free service for members.

Amex: American Express is a major partner of the AMA and offers members special discounts and extra rewards on a range of credit cards, merchant services and offers for existing AMA cardholders.



Volkswagen: AMA members are entitled to a discount off the retail price of new Volkswagen vehicles. Take advantage of this offer that could save you thousands of dollars.

AMP: AMA members are entitled to discounts on home loans with AMP.

Hertz: AMA members have access to discounted rates both in Australia and throughout international locations.

OnePath: OnePath offers a range of exclusive insurance products for AMA members.

Qantas Club: AMA members are entitled to significantly reduced joining and annual fees for the Qantas Club.

Virgin Lounge: AMA members are entitled to significantly reduced joining and annual fees for the Virgin Lounge.

Not a member?

Join now to discover the representation, services, resources and benefits available to members:

www.join.ama.com.au/join