AUSTRALIAN
Medicine
The national news publication of the Australian Medical Association

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AMA

ISSUE 27.04A - MAY 4 2015

AUSTRALIAN
Medicine

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Australian Medicine is the national news publication of the Australian Medical Association Limited. (ACN 008426793)

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In this issue

Climate change threatens a hotter, unhealthier world

BY AMA PRESIDENT ASSOCIATE PROFESSOR BRIAN OWLER

Climate change is a significant worldwide threat to human health that requires urgent action. There is overwhelming evidence that the global climate is warming and human factors have contributed to the warming. It is happening gradually, but there is no doubt that it is warming. The AMA supports that evidence.

As the world continues to warm, there will be significant and sometimes devastating impacts of climate change — particularly for human health.

Last week, along with the President of the highly respected Australian Academy of Science, Professor Andrew Holmes, I launched the Academy's much-anticipated report — *Climate change challenges to health: Risks and opportunities*.

The report brings together the latest comprehensive scientific evidence and knowledge on the serious risks that climate change poses to human health. It suggests a pathway for policy makers at all levels to prepare for the health impacts of climate change.

Both the AMA and the Academy of Science hope it will be a catalyst for the Federal Government to show leadership in reducing greenhouse gas emissions ahead of the United Nations Climate Change Conference in Paris later this year.

Not only does the report outline a case for policies to mitigate climate change, but it is also a call to action for all Australian governments to prepare for the health impacts of climate change. Policies and institutions must be in place now to ensure that Australia can adapt to the health consequences of climate change — these phenomena are inevitable.

As the climate warms, and we experience more extreme weather events, we will see the spread of diseases, disrupted supplies of food and water, and threats to livelihoods and security.

The health effects of climate change include increased frequency of extreme weather events such as heat waves, flooding and storms. In Australia, we are already experiencing weather extremes with prolonged drought and bushfires in some areas, and severe storms and floods in others. Not only can these cause illness and death, but there are significant social impacts as well.

Climate change will dramatically alter the patterns and rate of spread of diseases, rainfall distribution, availability of drinking water, and drought. International research shows that the incidence of conditions such as malaria, diarrhoea, and cardio-respiratory problems is likely to rise.

The Academy of Science recommends that Australia establish a National Centre of Disease Control to provide a national and coordinated approach to Australia's response to climate change.

Such a centre would prioritise research and data collection to better evaluate and anticipate where the burden of disease from climate change would have the greatest effect, and be able to respond accordingly.

Doctors and other health workers need to be informed by sound, up-to-date data. For example, we need to know when a disease that is traditionally found in tropical regions has moved south.

This will allow health authorities to plan and allocate health personnel and services to deal with changing patterns of disease.

All these events will affect the health of Australians and the health of the people in other countries in our region.

We are already seeing forced migration of people from areas, such as in the Pacific region, that are no longer habitable or productive. As forced migration increases around the world, there will be conflict and threats to food security and sustainability.

Nations must start now to plan and prepare.

We must educate and inform the population about the health impacts of climate change, and what we can do together to minimise them.

Doctors and other health professionals can and will play an active and leading role in educating the public about the health issues associated with climate change.

If we do not get policies in place now, we will be doing the next generation a great disservice.

It would be intergenerational theft of the worst kind — we would be robbing our kids of their future.

The Australian Academy of Science Report, *Climate change challenges to health: Risks and opportunities* is available at https://www.science.org.au/sites/default/files/user-content/documents/think-tank-recommendations.pdf.

Medicare review 'not a savings exercise', Ley promises

The AMA has told the Federal Government its plan to update the Medicare Benefits Schedule to eliminate inefficiencies and reflect advances in medical practise shold not be used to cut health spending and warned it could be undermined by the ongoing Medicare rebate indexation freeze.

Health Minister Sussan Ley has launched a review of the Schedule, to be led by Sydney Medical School Dean Professor Bruce Robinson, to scrutinise and assess the appropriateness of the more than 5500 services listed.

In parallel, the Minister has also appointed immediate-past AMA President Dr Steve Hambleton to head a Primary Health Care Advisory Group to recommend improvements in providing care, particularly for patients with mental health problems and chronic and complex illnesses.

AMA President Associate Professor Brian Owler said doctors supported the MBS review, but it should not be simply a cost-cutting exercise.

"There's no doubt that the Government is looking for savings, but as I've said to both the [Health] Minister and the Prime Minister, we're not going to participate in a review that simply is about saving money," A/Professor Owler told ABC radio. "What we're happy to do is participate as a profession to make sure that we get a schedule that reflects modern medical practice, but it's not going to be a hit-list of savings. It's not going to be something that just looks at trying to take money out of the system."

Ms Ley sought to allay fears the review was solely driven by the need to pare back health spending, insisting that "this is not a savings exercise".

"I expect that savings and efficiencies may well come from it, but I'm not going to predict that because, while we start this process, we don't know exactly what our initial scoping of the MBS will determine," the Minister said, adding that no savings target had been set.

But A/Professor Owler said that while ever the Government's four-year freeze on Medicare rebate indexation remained in place, there was justifiable concern that the Government's overriding objective was to cut health spending.

"The AMA and the medical profession will work closely with the Government and the [MBS Review] Taskforce to ensure Medicare reflects best practice clinical care and provides the highest quality and easily accessible services to patients," he said. "But the ongoing freeze of Medicare rebates threatens to undermine the good intentions of these reviews."

A/Professor Owler indicated in early March that he was in discussions with Ms Ley about how restructuring aspects of the MBS could improve patient outcomes and achieve efficiencies that would obviate the need for an extended rebate freeze.

He said the freeze would threaten the viability of many GP practices, cut bulk billing rates and push up patient out-of-pocket expenses.

"Freezing Medicare rebates for four years is simply winding back the Government's contribution to patients' health care costs. The freeze will also have a knock-on effect that could ultimately lead to higher private insurance premiums and higher out-of-pocket costs for patients," he said. "If doctors absorb the freeze, their practices will become unviable."

Ms Ley told ABC radio she regretted the freeze, but added it was necessary for "fiscal responsibility".

She said the freeze would not be withdrawn in the May Budget, but expressed hope that it could be removed earlier than 1 July 2018, as currently planned.

"I would like it to be removed earlier than that. I'll be working towards removing it earlier than that, and I very much hope that it will be," the Minister said. "Yes, it's here in the up-coming Budget...but I would like to see it go. It freezes what I might call an inefficient Medicare system."

A/Professor Owler said it was reassuring that the MBS Review and the Primary Health Care Advisory Group were both being led by eminent and highly-regarded clinicians, making it likely their recommendations would be based on frontline medical evidence and experience.

"We've got some eminent people that are going to be involved in these reviews. And this has to be clinician-led. It has to be based on evidence," he said. "And if the review delivers some savings - and there will be some savings I expect that can be found - then we'd be very happy to participate in that, as long as some of those savings are actually re-invested back into health care as well."

Ms Ley said there were several examples where the MBS system did not support best clinical practice, such as creating incentives for GPs to order x-rays for patients with lower back pain, and to encourage en masse tests for vitamin D and folate deficiencies.

"I believe the biggest modernisation that needs to happen is because the clinical practices and the equipment and the technology are moving faster than the MBS updates," the Minister said. "So, where you use scopes to look down people's throats and look at cancers, they weren't done in the same way

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Medicare review 'not a savings exercise', Ley promises

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years ago. They're now much different."

The MBS Review and the Primary Health Care Advisory Group's work will also be accompanied by a crackdown on Medicare rorting.

Ms Ley said that although the "vast majority" of doctors acted appropriately and conscientiously, a "small number do not do the right thing in their use of Medicare. Their activities have a significant impact on Medicare and may adversely affect the quality of care for patients".

Shadow Health Minister Catherine King said the Opposition cautiously welcomed the MBS review, but remained "deeply suspicious" about the Government's intentions.

Ms King said Labor began an MBS review while in Government, and changes it made would save $1 billion over the next five years.

But she said it was "crucial [the review] not be used as just another excuse to rip money out of health", and called for any savings made to be reinvested in the health care system.

Ms Ley said each of the three taskforces was expected to provide recommendations by late this year.

"Basically, there's wide agreement the Medicare system in its current form is sluggish, bloated and at high risk of long-term chronic problems and continuing to patch it up with bandaids won't fix it," Ms Ley said. "Not imposing a savings target allows us to work with doctors and patients to deliver high-quality health policies that focus on delivering the best health outcomes for every dollar spent by taxpayers."

ADRIAN ROLLINS

MBS review savings must stay in health: AMA

AMA President Associate Professor Brian Owler says he has received assurances from Health Minister Sussan Ley that any savings realised from the review of the Medicare Benefits Schedule will be ploughed back in to funding new treatments.

Ms Ley provoked a surge of concern about the review last week when she told Sky News that any money freed up by the process would be diverted into the $20 billion dollar Medical Research Future Fund rather than being reinvested in new MBS items.

"If there are savings, it [sic] will go into the Medical Research Future Fund, as we promised in the last Budget," the Minister said.

But A/Professor Owler told News Corp he had sought assurances from Ms Ley that this would not be the case.

"I clarified with the Minister's office, and if there are savings identified through the review, these would be reinvested into health rather than the Medical Research Future Fund," the AMA President said.

The AMA has backed the creation of the Fund, but has been highly critical of plans to pay for it using money taken from patients and primary health care, such as through GP co-payments, various forms of which have been proposed and dumped by the Government.

Although several savings measures to free up money for the Fund have come into effect, including the abolition of stand-alone health agencies, the Government is yet to set up the Fund amid speculation its size and scope will be considerably reduced.

But A/Professor Owler has previously said the money was there to get the Fund going, and last week he repeated his challenge to the Government to set it up.

"If the Fund is so important, why hasn't it yet been established?" he told the *Northern Territory News*.

Earlier, the AMA President commented on rumours the health portfolio had been targeted for $7 billion of savings in the forthcoming Budget.

"That would be a very big surprise for the AMA and, I'm sure, doctors and the Australian public," he said. "The Prime Minister has said on a number of occasions that there would, first of all, [be] no cuts to health, but second of all, has said that there will be no new health initiatives without the broad support of the medical profession.

"So, I would be very surprised if those sorts of measures were introduced without talking to the AMA or other health groups.

"I heard some of those rumours...and I put those questions directly to the Minister for Health, who has reassured me that that is not going to be the case. But, obviously, we will be watching the Budget very closely."

ADRIAN ROLLINS

Wasteful, unnecessary treatments and tests face the axe

More than 200 routinely used treatments have been placed under the microscope as doctors, led by medical colleges and societies, take part in a national crackdown on unnecessary, costly and potentially harmful tests, procedures and medications.

Groups including the Royal Australian College of General Practitioners, the Australasian College for Emergency Medicine, the Royal Australian College of Physicians, the Royal College of Pathologists of Australasia and the Australasian Society of Clinical Immunology and Allergy have already joined the National Prescribing Service's Choosing Wisely initiative aimed at improving the appropriateness of care.

It has been estimated that up to $15 billion a year is spent on unnecessary and unproven treatments and therapies that inconvenience patients, tie up precious medical resources and could be harmful.

NPS Medicinewise Chief Executive Dr Lyn Weekes said patients frequently assumed that more care was better, when often the opposite was the case.

Many procedures and tests like x-rays and CT scans, carried costs and risks as well as benefits, while others, such as spinal injections of steroids to treat non-specific back pain, were not supported by evidence of their effectiveness.

Dr Weekes said the intention was to encourage "informed conversations" between and among doctors and patients about the appropriateness of proposed treatments.

Medical colleges and societies have already identified a range of tests and procedures whose use warrants much closer scrutiny, including:

- the long term use of proton pump inhibitors, which are widely used to treat reflux and peptic ulcers and cost $450 million last financial year;
- routine blood glucose self-monitoring for type 2 diabetics on oral-only medication, with test strips costing $143 million a year;
- conducting stress and ECG tests on asymptomatic, low-risk patients;
- widespread screening for vitamin D deficiency;
- PSA testing for prostate cancer in asymptomatic men;
- x-rays for non-specific lower back pain;

- routine use of CT scans for head injuries; and
- routine cervical spine imaging in trauma cases.

AMA President Associate Professor Brian Owler said Choosing Wisely was a welcome initiative, and it was important that it had the support and involvement of medical colleges and societies.

"The involvement of the medical colleges will ensure clinical stewardship and leadership in health care resources," A/Professor Owler said.

He said it was important that the criteria used in identifying tests, treatments and procedures was "reasonable and transparent", because it would help build confidence in the process.

There is likely to be considerable cross-over between the lists prepared through the Choosing Wisely initiative, and the tests, treatments and procedures that come under scrutiny the Medicare Benefits Schedule review announced by Health Minister Sussan Ley.

A/Professor Owler said both programs were an important opportunity to help ensure that the best use was being made of scarce health funding and resources.

ADRIAN ROLLINS

Haikerwal departs top World Medical Association position

The international standing of the medical profession is high, with governments around the world regularly seeking the counsel of the World Medical Association and national organisations on health matters, according to outgoing WMA Chair of Council Dr Mukesh Haikerwal.

Dr Haikerwal, who served as WMA Council Chair for four years until losing a run-off for the position last month, said many doctors and other health professionals continued to work in extremely challenging conditions, but their commitment to the welfare of patients meant that the profession was well-respected and influential.

"The profession is highly regarded and its contribution is sought after," the former AMA President said, though he warned, "a lot of work has to be done to retain that place, with on-going advocacy on the behalf of patients and doctors".

Dr Haikerwal said one of the most gratifying achievements of his four-year term was the development of the medical profession in Africa, particularly the creation of national medical associations.

He was particularly pleased by the founding of the Zambian Medical Association last year by doctors who had received WMA-sponsored training and support in organisational skills.

"It has now become the go-to organisation for the Parliament of Zambia on health issues, and Zambia is preparing a bid to host the WMA Conference in 2017. They have gone from zero to hero in very quick time," Dr Haikerwal said. "This is the work that is so gratifying, bringing the medical viewpoint into national debates by building the capacity of organisations."

But he said there were also disturbing developments, particularly increased violence against doctors and other health professionals.

Dr Haikerwal said increasingly in countries as diverse and China, Turkey, the United States and in Eastern Europe, reduced health spending meant that an increasing proportion of patients were not receiving the care they expected, often resulting in violent – and sometimes fatal – attacks on doctors, nurses and other health workers.

Dr Haikerwal said it had been a great honour to serve as WMA Chair, a position which, coming from Australia, had been "a double-edged sword".

"It was fantastic, because Australia is so highly regarded across the globe as a voice of reason and creative thinking and not locked into alliances," he said. "But the negative is that it is a long way to get anywhere."

Dr Haikerwal has been succeeded by immediate-past American Medical Association President Dr Ardis Hoven, who was elected to become the WMA's first woman Chair at its 200th Council meeting in Oslo last month.

Dr Hoven is an internal medicine and infectious disease specialist and a Professor of Medicine at Kentucky University.

"We face complex and far-reaching challenges – shrinking resources, complicated and difficult practice environments, shifting government regulations and dangerous working conditions," Dr Hoven said. "However, our current work speaks to our impact".

Dr Haikerwal has joined the Board of mental health organisation *beyondblue*.

ADRIAN ROLLINS

Govts must prepare for inevitable health effects of climate change

"This is too important an issue for the Australian community when it comes to the health consequences, for politicians to argue about the science. They are not scientists"

Increasing numbers of Australians will fall victim to heatwaves and storms, be at greater risk of contracting exotic diseases and find it increasingly expensive and difficult to get safe water and quality food as global temperatures rise, a report on the health effects of climate change has warned.

The Australian Academy of Science study, backed by the AMA, predicts that, with global temperatures likely to rise by at least 2 degrees Celsius by the 2100, Australians will confront an increasingly difficult and challenging environment marked by spreading disease, stressed ecosystems, disrupted food and water supplies, increasingly wild and extreme weather, and rising international tensions and conflict.

Scientists expect that diseases like mosquito-borne dengue and chikungunya will spread south as temperatures increase, while water will be increasingly infested with algal blooms, livestock will be at greater risk of zoonotic infections, and longer and harsher heatwaves and storms will threaten the lives of many – particularly the elderly and very young. Agricultural production will become more difficult, increasing the cost and scarcity of quality food, and there is likely to be international unrest and upheaval as areas become uninhabitable and life-sustaining resources come under increasing stress.

AMA President Associate Professor Brian Owler, who helped launch the *Climate change challenges to health: Risks and opportunities* report on 30 April, said it was "inevitable" that climate change would affect human health, and that the

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Govts must prepare for inevitable health effects of climate change

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grim outlook underlined the urgent need for national and international leadership and action in mitigating climate change and preparing for its serious effects on health.

A/Professor Owler said the country had not been well served by the Government's approach to climate change policy to date.

> " ... the report should give the Government impetus to provide leadership on ways of mitigating the effects of climate change, and to help inform the plan of action it would take to the United Nations' Paris Climate Change Conference in November"

"We have been subjected to a lot of non-scientific debate," he said. "We need to get past the fact that climate change has become a political battleground and a political football.

"This is too important an issue for the Australian community when it comes to the health consequences, for politicians to argue about the science. They are not scientists."

The AMA President said he did not expect the Government to act in ways that would adversely affect people in their daily lives, but it needed to assume a leadership role on the issue and back up policies with institutions and activities that would protect the public against the effects of climate change.

The Academy's report recommended the establishment of an Australian Centre for Disease Control to unify and coordinate disease surveillance and responses to outbreaks, an idea that A/Professor Owler backed.

"We need to be well prepared as a medical community, but also to make sure the public health policies are put in place," he said. "A Centre for Disease Control is something the Government should closely look at."

One of the report's authors, Dr Allie Gallant, said the fatal consequences of extreme heatwaves and storms had already been dramatically demonstrated in recent years.

The study found that more people (374) died during a searing heatwave that struck Victoria than in the subsequent devastating bushfires (173 deaths).

Co-author Celia McMichael, daughter of recently deceased renowned climate scientist Tony McMichael, warned that climate change was also likely to have a profound effect on Pacific Island nations, with the prospect that many people would be displaced.

A/Professor Owler said the report should give the Government impetus to provide leadership on ways of mitigating the effects of climate change, and to help inform the plan of action it will take to the United Nations' Paris Climate Change Conference in November.

"The Report's recommendations will assist all our governments prepare for the inevitable health and social effects of climate change and extreme weather events, and must be a key reference for the Federal Government in the development of the action plan it takes to the Paris Climate Change Conference," he said.

"The Paris Conference objective is to achieve a legally binding and universal agreement on climate from all nations of the world, and the AMA believes Australia should be showing leadership in addressing climate change and the effects it is having, and will have, on human health."

The Australian Academy of Science Report- Climate change challenges to health: Risks and opportunities can be viewed at: https://www.science.org.au/sites/default/files/user-content/documents/think-tank-recommendations.pdf

The AMA released a Position Statement on Climate Change and Health in 2004, which was updated in 2008, and can be found at https://ama.com.au/position-statement/climate-change-and-human-health-2004-revised-2008

The AMA is currently updating this Position Statement.

The World Medical Association's 2011 Declaration on Climate and Health can be viewed at: http://www.wma.net/en/20activities/30publichealth/30healthenvironment/Durban Declaration on Climate and Health Final.pdf

A video message on climate change and health from A/Professor Owler can be viewed at: https://docs.google.com/a/ama.com.aulfile/d/0B2MDuYDSoCyJM0VMZDcyTUJ2clk/edit

ADRIAN ROLLINS

Doctors get carrot, anti-vax parents the stick, in immunisation boost

Doctors will be paid a $6 incentive to chase up the parents of children who have fallen behind on their vaccinations as part of Federal Government measures aimed at boosting immunisation rates.

Health Minister Sussan Ley said an extra $26 million will be allocated in the Federal Budget to the national immunisation program to encourage doctors to identify children more than two months behind on their vaccinations, as well as to develop an Australian School Vaccination Register and upgrade efforts to educate parents.

It has been revealed last year 166,000 children were more than two months behind on their vaccinations, in addition to 39,000 whose parents had expressed a conscientious objection to immunisation, and Ms Ley said the $6 incentive, which would be in addition to the $6 paid to doctors to deliver vaccinations, was part of a "carrot and stick" approach to deepening the country's immunity to serious diseases.

"I believe most parents have genuine concerns about those who deliberately choose not to vaccinate their children and put the wider community at risk," the Minister said. "However, it's important parents also understand complacency presents as a much of a threat to immunisation rates and the safety of our children as conscientious objections do. Immunisations don't just protect your child, but others as well."

The announcement came as the Government intensified its crackdown on anti-vaccination parents claiming childcare subsidies and other benefits.

Social Services Minister Scott Morrison has declared parents can no longer claim an exemption from welfare payment vaccination requirements on religious grounds, adding to the scrapping of exemptions for parents who make a conscientious objection.

It means that the only authorised exemption for the vaccination requirements of the Child Care and Family Tax Benefit Part A schemes, which provide childcare subsidies worth up to $205 a week, a $7500 annual childcare rebate and a tax supplement worth up to $726 a year, is on medical grounds.

Mr Morrison said only one religious group, the Church of Christ, Scientist, had a vaccination exemption, and it was not exercising it.

"The Government has...formed the view that this exemption, in place since 1998, is no longer current or necessary, and will therefore be removed," the Minister said, adding that it will not be accepting or authorising any further applications for exemption from religious groups.

"The only authorised exemption from being required to have children immunised in order to receive benefits, is on medical grounds," Mr Morrison said. "This will remain the sole ground for exemption."

The Government's tough stand has been backed by the AMA, though President Associate Professor Brian Owler said children should not be "punished" for the decisions of their parents and urged greater efforts to educate parents on the benefits of vaccination.

A/Professor Owler said a recent sharp increase in the number of parents lodging conscientious objections to immunisation meant it was "not unreasonable" for the Government to look at new ways to lift the nation's vaccination rate.

"The number of conscientious objectors has been rising, so that's why I think it's not unreasonable for the Government to come up with another measure," A/Professor Owler said. "I think it should be seen in that light, that it is really another mechanism, another lever to pull, to try and get the vaccination rates up. It's not going to solve all of the problems, but I think it's probably a step in the right direction."

"The overwhelming advice and position of those in the health profession is it's the smart thing and it's the right thing to do to immunise your children," Mr Morrison said.

"While parents have the right to decide not to vaccinate their children, if they are doing so as a vaccination objector, they are no longer eligible for assistance from the Australian Government."

Child vaccination rates, particularly among pre-schoolers, are

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Doctors get carrot, anti-vax parents the stick, in immunisation boost

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above 90 per cent in most of the country, but figures show significant pockets of much lower coverage, including affluent inner-Sydney suburbs such as Manly and Annandale, where the vaccination rate is as low as 80 per cent, as well as northern New South Wales coastal areas.

High rates of immunisation, above 90 per cent, are considered important in providing community protection against potentially deadly communicable diseases such as measles, diphtheria and whooping cough (pertussis).

Objectors regularly claim vaccination is linked to autism. But this has been scientifically disproved, most recently in a *Journal of the American Medical Association* study which found that the measles-mumps-rubella vaccine did not affect autism rates among children with autistic older siblings.

A/Professor Owler said there were occasional instances of adverse reactions to vaccination in some individuals, "but they are by far a minority compared to the overall benefits of vaccination. Vaccination is probably the most effective public health measure that we have."

While he said the Government's latest measure might help increase the immunisation rate, it was important to continue with efforts to educate parents about the importance of vaccination and encourage them to ensure their children were covered.

"The anti-vaccination lobby has been very successful in putting lots of rubbish out there on the internet in particular. Often it's notions that have been completely discredited," he said. "One of the things we've got to keep going with [is] education - encouraging parents, giving them the right messages, and getting them to go to the credible source of information, which should be their family doctor or GP."

A/Professor Owler said often children were not vaccinated simply because it was overlooked by busy parents, and it was important to ensure people were given timely reminders.

The Government's changes have bipartisan support and are due to come into effect from 1 January next year.

ADRIAN ROLLINS

OBITUARY: Doctor Rowley Richards, 1916 – 2015

Dr Charles Rowland Bromley Richards, better known as Dr Rowley Richards, will be remembered by many for his extraordinary work as an Australian Army medical officer whose tireless work and devotion saved the lives of hundreds of servicemen who were taken prisoner by the Japanese and forced to work in brutal conditions on the infamous Burma-Siam Railway.

Held as a prisoner of war for more than two years, Dr Richards devoted himself to protecting the health and lives of his fellow captives. He drilled into the men and their officers the importance of hygiene, prevention of illness and first aid. According to the Sydney Morning Herald, his strict adherence to these principles saved many lives and ensured that no man under his care ever lost a limb to tropical disease.

Throughout his captivity, Dr Richards diligently kept secret and detailed diaries recording statistical information and medical details in hope it might be used in war crimes proceedings. His hope was fulfilled after the war, when his work was used in the prosecution of several Japanese war criminals. His diaries formed the basis for his two books, The Survival Factor, published in 1998, A Doctor's War, published in 2005. The original diaries are now in the Australian War Museum.

While his war service deservedly won Dr Richards widespread praise, he will also be remembered as a valuable community member and revered doctor.

Following the war, Dr Richards focused on preserving and honouring veterans, and encouraged the recognition of volunteer medical orderlies who served alongside him.

He practiced privately as a GP-obstetrician in Seaforth and was an active member of the community. He served as Chairman of the St John's Ambulance Association, was a medical adviser to the Australian Olympic Rowing teams at the 1968 and 1972 Games, and was honorary medical director of the City to Surf fun run from 1977 to 1998.

Dr Richards is survived by his son David.

KIRSTY WATERFORD

Hep C cure comes with $3 billion price tag

Thousands of Australians living with hepatitis C are a step closer to a cure after the Commonwealth's chief medicines adviser recommended they be given subsidised access to a hugely expensive but effective drug credited with eliminating the disease in the majority of patients.

But the Pharmaceutical Benefits Advisory Committee (PBAC) has warned that, at its current price tag of around $110,000 for a 12-week course, subsidising the drug for around 62,000 chronic hepatitis C patients would cost the country more than $3 billion over five years.

Nonetheless, in recommending that sofosbuvir (marketed under the name Sovaldi) be listed on the Pharmaceutical Benefits Scheme for the treatment of chronic hepatitis C, the PBAC said there was a "high clinical need" for such a treatment to be available on the PBS.

The Therapeutic Goods Administration approved the use of Sovaldi as part of a combination antiviral treatment for chronic hepatitis C last year, raising hopes of improved outcomes for the estimated 233,000 people living with the disease.

But the medicine's huge price tag means it will have to be subsidised through the Pharmaceutical Benefits Scheme if it is to be put within financial reach for many patients.

In its initial assessment of the drug in late 2014, the PBAC recommended against listing on the PBS, cautioning that doing so would have "a high financial impact on the health budget", warning that estimates of its cost to taxpayers were probably understated given the likelihood of a jump in demand.

But in its latest assessment, the PBAC took a more expansive view.

It said, "it was appropriate for the new all-oral treatment to be listed in the General Schedule, rather than Section 100 Highly Specialised Drug Program, to facilitate the longer term objectives for access to treatment, increase treatment rates and better outcomes with a view to treat all patients with CHC [chronic hepatitis C] over time".

> "However, the Committee said the drug was not cost-effective at the price proposed by the manufacturer, and warned that the expense of providing subsidised access through the PBS would come at 'a large opportunity cost to the health care system'"

However, the Committee said the drug was not cost-effective at the price proposed by the manufacturer, and warned that the expense of providing subsidised access through the PBS would come at "a large opportunity cost to the health care system".

While viral hepatitis has become increasingly common – the Kirby Institute estimates more than half a million Australians now live with either hepatitis B or C – treatment rates are low.

Fewer than 5 per cent of those with hepatitis B receive treatment, and only around 1 per cent of those with chronic hepatitis C.

Unsurprisingly, in this environment, Sovaldi is regarded as something of a wonder drug.

Manufacturer Gilead Sciences said hepatitis C patients can be cured of the disease in as little as 12 weeks, eliminating the lifetime burden of an otherwise chronic infection.

Director of gastroenterology at Melbourne's St Vincent's Hospital, Professor Alex Thompson, told the *Herald Sun* last year that Sovaldi was a major advance on current hepatitis C treatments.

"This is a game-changing medicine," Professor Thompson said.

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Hep C cure comes with $3 billion price tag

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"This disease could become rare or non-existent, you could be talking about eradication."

Hepatitis Australia has warned that hepatitis C could become a major health burden for the country unless urgent action is taken.

Viral hepatitis damages the liver and, without effective treatment, it can lead to liver cirrhosis, cancer and failure – currently around 1000 a year die from hepatitis-related liver cancer, according to the Institute.

"Without urgent investment in rigorous treatment programs, Australia will continue to fail in its efforts to halt escalating rates of serious liver disease due to chronic hepatitis B or C," Hepatitis Australia said.

It said hepatitis B and C infections had continued to spiral despite national strategies aimed at curbing their growth, showing that "Australia needs to redouble its efforts and investment in prevention".

"We know what works – educating the community on the risks of infection and improving access to hepatitis B vaccinations and needle and syringe programs for vulnerable populations," the group said. "It's now time for the investment to make it happen."

Clinical trials of Sovaldi evaluated by the TGA demonstrated that the hepatitis C virus was undetectable in up to 90 per cent of patients 12 weeks after completing therapy.

Professor Gregory Dore, Head of the Kirby Institute's Viral Hepatitis Clinical Research Program, hailed the drug as "a major advance" in the treatment of hepatitis C because it was able to achieve results more quickly than existing treatments, and with fewer side effects.

But humanitarian organisation Medicins Sans Frontieres has complained that the high cost of the medicine puts it out of the reach of most of the world's poor.

The medical charity said drugs such as Sovaldi had the potential to revolutionise treatment of hepatitis C, but not at current prices.

Sovaldi, is Gilead's trade name for sofosbuvir, which in the United States costs $US84,000 ($A90,000) for a 12-week course of treatment – roughly $US1000 a pill. Even in Thailand, its costs $US5000 for a course.

"The price Gilead says it will charge for sofosbuvir in developing countries is still far too high for people to afford," said MSF Director of Policy and Advocacy Rohit Malpani. "When you're starting from such an exorbitant price in the US, the price Gilead will offer middle-income countries like Thailand and Indonesia may seem like a good discount, but it will still be too expensive for many of these countries to scale up treatment."

ADRIAN ROLLINS

Infected jails on Sovaldi frontline

Some of the nation's most dangerous criminals will be among the first to test Sovaldi's effectiveness in curing hepatitis C and preventing its transmission.

Hepatitis C is rife in the nation's prisons, with estimates as many as 50 per cent of inmates are infected – including about two-thirds of female prisoners.

Researchers are recruiting inmates at two New South Wales high-security prisons, Goulburn and Lithgow, to assess the drug's performance.

Prisoners taking part in the trial will be given one pill a day during a 12-week course of the medicine, which manufacturers claim has a cure rate above 90 per cent.

Prison authorities are grappling with the problem of how to curb the spread of hepatitis C among inmates, who are most commonly infected while injecting illicit drugs using shared contaminated needles.

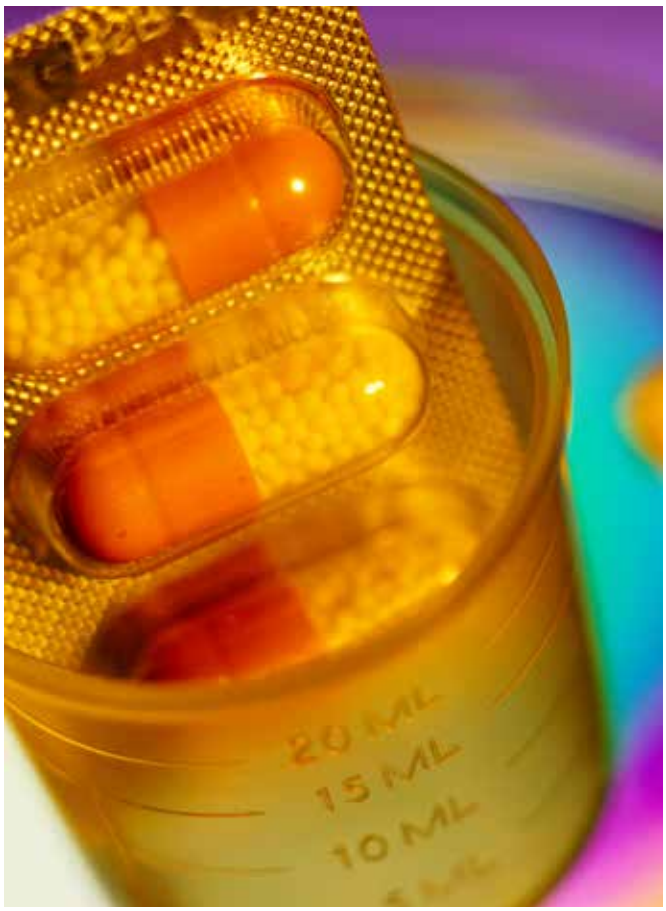
Public health groups have argued the need for needle and syringe exchange programs within prisons to help slow the spread of hepatitis C, a suggestion vehemently opposed by unions representing prison staff, who claim such measures would make prisons more dangerous.

Liberal MP Steve Irons, who is chairing a House of Representatives committee inquiring into the prevalence of hepatitis C in prisons, said it was an important issue because of the threat of infection in the broader community posed by prisoners as they moved in and out of custody.

Advocates hope Sovaldi could provide an alternative path to breaking the cycle of infection in the nation's jails.

ADRIAN ROLLINS

Painkillers to go off-script in the hunt for savings



The AMA has warned vulnerable patients must not be hurt in the Federal Government's drive to achieve huge savings from the Pharmaceutical Benefits Scheme.

The Federal Government is considering an option to save up to $3 billion from the PBS by axing prescriptions for over-the-counter painkillers and other medicines and allowing pharmacists to offer discounts on the patient co-payment.

In a major shake-up to the PBS as negotiations over the multi-billion dollar Community Pharmacy Agreement intensify, Health Minister Sussan Ley has revealed the Government is looking at removing from the scheme Panadol, aspirin, antacids and other medicines that can be bought without a prescription.

While such medicines can be cheaply and readily bought from supermarkets and other outlets, many patients are currently purchasing them through the PBS to help them to cheaply and quickly reach the safety net threshold - $1453.90 for general patients and $366 for concession card holders – after which all medications are free.

But the Australian Medical Association has cautioned of the risk of harm to patients if the Government's principle focus is cost-cutting.

AMA Vice President Dr Stephen Parnis said doctors wanted to be sure that, in any changes, "the most vulnerable groups are protected".

Ms Ley told the *Australian Financial Review* the PBS contained a number of "perverse disincentives and some perverse incentives" that were costly for both the Government and patients.

"The Government is paying a lot of money for people to access Panadol and other over-the-counter medications at their chemist on script," the Minister said. "There's a really strong argument why, under the supervision of the Pharmaceutical Benefits Advisory [Committee], we look to taking over-the-counter medications off the Pharmaceutical Benefits Scheme, and in the process get a better deal for consumers."

In addition, the Government is considering allowing pharmacies to offer a co-payment discount of up to $1 per prescription for patients who opt for cheaper generic versions of their medicines.

The measure would serve two purposes – to encourage greater use of generic medicines and so save money for the PBS, and to slow down the speed with which patients reach the safety net threshold.

Ms Ley told the *AFR* that "allowing pharmacies to reduce what patients pay is one of the key ingredients that I want to see come out of this [Community Pharmacy] Agreement: that medicines remain affordable".

But the *AFR* said, both proposed changes sit at "extreme odds" with measures adopted in last year's Budget to increase the PBS co-payment and the safety net thresholds, for a claimed saving of around $1.3 billion over four years. Legislation enshrining the changes is yet to be passed by Parliament.

They also come as the Therapeutic Goods Administration's Advisory Committee on Medicines Scheduling considers whether to make many common painkillers sold by pharmacists available by prescription only.

It has been proposed that about 150 codeine medications

Continued on p15 ...

Painkillers to go off-script in the hunt for savings

... from p14

including Mersyndol, Codral Cold and Flu Tablets, Nurofen Plus and Panadeine, currently available over-the-counter at chemists, be reclassified at schedule 4 medicines, which would mean they could only be dispensed with a prescription.

The change has been recommended amid reports an increasing number of patients are taking excessive quantities of codeine, often in conjunction with ibuprofen, causing severe gastrointestinal damage and internal bleeding.

Australians are heavy users of pharmacy-only codeine products – more than 1.3 million packets are sold each month – and more than 1000 people were treated for codeine dependency in 2012-13.

The proposed changes also come as the Government negotiates with the Pharmacy Guild of Australia over the next Community Pharmacy Agreement, which is due to come into effect from 1 July when the current $15.4 billion deal expires.

The Guild has been pushing for an enhanced role for pharmacists, including administering flu vaccinations and conducting health checks, to help offset reduced income growth from the dispensing of medicines under the Commonwealth's price disclosure arrangement with drug manufacturers.

But the Guild's bargaining position has been undermined by a Commonwealth Auditor-General report scathing about the current agreement, including revelations that funds earmarked for professional development had instead been diverted into a "communications strategy".

ADRIAN ROLLINS

As drug costs mount, approvals process comes under scrutiny

The way drug companies argue the case for subsidised access to their medicines could change after the Federal Government announced a review of submission guidelines.

As the Commonwealth comes under increasing pressure to give patients subsidised access to innovative but hugely expensive treatments for cancer, hepatitis, diabetes and other chronic or potentially deadly ailments, Health Minister Sussan Ley has launched a review of the Pharmaceutical Benefits Advisory Committee's submission guidelines.

It has already been proposed that medicines approved by regulators in the United States and Europe be automatically cleared for use by the Therapeutic Goods Administration, and there have been noisy complaints about the length of time taken for drugs used elsewhere to become available through the publicly-subsidised medicine system.

In order to be listed on the Pharmaceutical Benefits Scheme, drugs first have to be assessed for their efficacy and cost effectiveness by the PBAC, and Ms Ley said it was appropriate to examine the sort of evidence and other information the Committee was demanding from manufacturers.

"The PBAC Guidelines help ensure Australians have access to safe, clinically proven and cost-effective medicines as soon as possible," the Minister said. "It [the review] is particularly timely given emerging technologies and international calls for governments to subsidise drugs based on clinical evidence, as is the case with cancer drugs."

Early last month, Ms Ley announced $75 million had been provided to list three pharmaceuticals on the PBS – the multiple sclerosis treatment Lemtrada, pancreatic cancer medicine Afinitor, and central precocious puberty drug Lucrin.

The Government is also facing a huge $3 billion bill if it accepts a PBAC recommendation to subsidise the very expensive hepatitis C drug Sovaldi, and last month approved PBS listing of the melanoma drug Yervoy, which costs more than $120,000 for a course of treatment.

Ms Ley said the PBAC's Guidelines were used by pharmaceutical companies in preparing their submissions, and it was important to ensure they reflected international best practise, did not impose any unnecessary regulatory burden on the industry and yet safeguarded the sustainability of the PBS.

The Health Department is calling for tenders for the review.

ADRIAN ROLLINS

National system urgently needed to counter doctor shopping, drug deaths

Medical defence organisation Avant has joined calls for a national system to provide a real-time record of patient prescriptions amid an alarming rise in doctor shopping and deaths and hospitalisations involving the use of prescribed drugs of dependence.

Avant said the lack of national system to track prescriptions was putting patients at risk and leaving doctors prescribing opioids and other strong pain relievers exposed to legal action by depriving them of vital clinical information.

"Doctors are stuck. It's like they're prescribing blind, as they don't have the benefit of the complete clinical picture," Avant's Senior Medical Advisor Dr Walid Jammal said. "Avant is adding its voice to those of a number of coroners, health groups and colleges calling for a national real-time prescription monitoring system as a matter of urgency."

In the past two decades there has been a 15-fold increase in the prescription of opioids, and state coroners have expressed alarm at a concurrent jump in the abuse of prescription drugs, leading to dependency, harm and death.

In 2013, the Coroners Court of Victoria reported that almost 83 per cent of drug-related deaths involved prescription drugs, predominantly opioid analgesics and benzodiazepines.

Adding to the complexity, many GPs face demands from patients addicted to prescription drugs, or who want to sell them on the black market, Avant said, warning "this can lead to inappropriate prescribing to patients who should not receive drugs of dependence, and inappropriate non-prescribing to patient who should receive them".

In a position statement on the issue released on 23 April, Avant said the prescription of drugs of dependence was becoming an increasingly legally and clinically fraught area of medical practice, with GPs in particular falling foul of often confusing and contradictory laws and regulations regarding their use.

The defence fund said that since 2009 it had seen a 56 per cent jump in calls to its medico-legal advisory service from doctors prescribing drugs of dependence, and the issue was the cause of more than 230 claims made against medical practitioners, including accusations of over-prescribing, prescribing without authority and denial of a prescription, underlining the extent of uncertainty and concern among the medical profession.

Altogether, more than a fifth of doctor professional misconduct cases involved illegal or unethical prescribing as the primary issue, Avant said, and argued that the incidence could be reduced through better education about the legal and clinical aspects of prescribing drugs of dependence.

"In Avant's experience, many practitioners have little knowledge of their legal obligations around prescribing drugs of dependence and the regulations applicable in their state. In our view, there is also confusion amongst practitioners over the role of the PBS in providing authority to prescribe certain medications," it said.

Almost 90 per cent of doctors surveyed by Avant backed the call, and three-quarters said a national real-time prescription monitoring system would help them.

Coroners in three states have made repeated recommendations for the establishment of such a system, and Avant said its introduction was now a matter of urgency.

"This system will go towards supporting the safety of patients and minimising the risk of doctor shopping for the purpose of drug diversion or on-selling," the defence fund said.

ADRIAN ROLLINS

Costly anticancer drug gets first-line approval

Patients with the most serious form of skin cancer will have early and affordable access to the hugely expensive life-prolonging treatment Yervoy following its listing as a first-line treatment with the Pharmaceutical Benefits Scheme.

The drug, which harnesses the body's immune system to fight the cancer, has been shown to extend the lives of some patients diagnosed with advanced melanoma by up to a decade, but until now its massive cost – more than $120,000 for a course of treatment – has limited its use.

> "The study's authors said the results 'add to the evidence supporting the durability of long-term survival in ipilimumab-treated patients with advanced melanoma'"

But manufacturer Bristol-Myers Squibb said its listing as a first-line treatment gave treating doctors more options to attack the disease sooner following diagnosis.

The decision came as the Government's key medicines adviser recommended that another enormously costly melanoma treatment, pembrolizumab (marketed under the name Keytruda), be listed on the PBS.

The drug costs $150,000 to treat a single patient for a year, and the Pharmaceutical Benefits Advisory Committee has recommended the listing on the proviso that more robust evidence about its efficacy is forthcoming.

The Committee said it was "highly concerned" that public expectations about the effectiveness of the drug – patient groups told a committee hearing they believed there was a 90 per cent response rate to the drug – were far in excess of 33 to 37 per cent response rate observed in clinical trials.

It warned the manufacturer Merck Sharp and Dohme that should "modelled extent of benefits not be realised [in forthcoming study results], the Committee has recommended measures to minimise risk of unjustified health care expenditure".

In a statement from Bristol-Myers Squibb, specialist medical oncologist at Cairns Hospital Dr Megan Lyle said advanced melanoma was a very aggressive cancer, and average life expectancy following diagnosis was six to nine months.

But a study published in the *Journal of Clinical Oncology* in February found the median survival rate among 1861 advanced melanoma patients treated with Yervoy (the brand name of ipilimumab) rose to 11.4 months, and around one in five survived for three years.

The study's authors said the results "add to the evidence supporting the durability of long-term survival in ipilimumab-treated patients with advanced melanoma".

"Yervoy is the first registered treatment to demonstrate long-term survival in some patients," Dr Lyle said. "Oncologists can now offer patients the chance to access this potential benefit when they are newly diagnosed."

Unlike drugs that directly attack the tumour, Yervoy works to recruit the body's immune system to attack the disease by enabling the activation and proliferation of immune cells.

Yervoy is among a number of very expensive treatments that have appeared on the market in recent years, prompting governments to cast an increasingly critical eye over their performance and claimed benefits before deciding whether to subsidise supply.

To help manage the risk, the Australians Government in 2010 introduced the Managed Entry Scheme, under which high cost medicines can be dropped from the PBS if they do not perform as expected.

In 2013, Yervoy's manufacturer become the first drug company to agree to provisional listing under the arrangement.

Swirling controversy about soaring medicine costs has been fuelled by a US study that has found 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.

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 *Journal of Economic Perspectives* 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.

ADRIAN ROLLINS

Free lunches are fine, says competition watchdog

Drug companies will have to disclose all payments and gifts provided to doctors except for food and drink under conditional arrangements approved by the consumer watchdog.

The Australian Competition and Consumer Commission has given Medicines Australia until October next year to ensure that all "transfers of value" made by pharmaceutical firms to doctors – except meals and beverages – are publicly disclosed, tightening reporting provisions set out in the industry's new code of conduct.

The ACCC said it was concerned that, in the latest version of the code, doctors had to consent to having the details of individual payments disclosed (otherwise they would be included in aggregate figures), and could withdraw consent after receiving any transfer of value.

The ACCC said it accepted that the new transparency regime, which was developed in consultation with the AMA and other medical groups, was a "significant and important" change toward greater transparency, but Commissioner Dr Jill Walker said it needed to go further.

"Having taken this crucial step, it is important to ensure that the significant benefits of the regime are realised," Dr Walker said. "In this context, the ACCC is requiring the regime to be strengthened to ensure that all relevant transfers of value are reported, and that the data is accessible."

Under the code's reporting regime, all transfers of value to health professionals including sponsorships and speaking and advisory board fees, are to be disclosed.

But Medicines Australia has set a $120 cap on how much can be spent on any one meal and said such payments would not be included in the disclosure regime – a decision the ACCC has accepted.

"In reaching this view, the ACCC notes that food and beverage costs are secondary to the more direct transfers of value, a $120 per meal cap applies, and that ongoing reporting would impose a significant administrative burden on companies," the regulator said.

But the ACCC warned it would reconsider its position if there was a significant and unreasonable jump in spending on food and drinks.

And the watchdog cautioned that its authorisation of the code did not amount to endorsement: "Rather, it provides statutory protection from court action for conduct that meets the net public benefit test, and that might otherwise raise concerns under...competition provisions".

AMA Council of General Practice Chair Dr Brian Morton told *The Age* it was common sense to exclude capped meals from the disclosure regime, and dismissed as "insulting and naïve" suggestions doctors would be influenced in their clinical practise by a free meal.

ADRIAN ROLLINS

INFORMATION FOR MEMBERS

Mental health survey for GPs

General practitioners are being invited to take part in a brief survey to identify current practices when working with families where a parent has a mental illness.

GPs are often the first point of call for a person seeking help for a mental health problem, and it has been estimated that more than 12 per cent of all GP visits in a year are mental health-related.

The Children of Parents with a Mental Illness (COPMI) national initiative – funded by the Federal Government to benefit children and families where a parent experience mental illness – is collating information on the process a GP follows when a parent with a mental illness seeks help.

Participating GPs are asked to fill out an anonymous and confidential questionnaire which takes about 20 minutes to complete.

It can be found at: http://monasheducation.az1.qualtrics.com/SE/?SID=SV_29uecngqheOp3Xn

Once completed, GPs will also be invited to take part in a 30 minute telephone interview. If you are involved in the interviews you will receive a $75 Coles/Myer gift voucher for your time.

If you want any further information about the study, please contact Dr Caroline Williamson at COPMI – williamsonc@copmi.net.au

Rebate freeze will leave mentally ill 'in the cold'

Many people suffering mental illness will be left stranded without treatment unless the Federal Government drops its plan to freeze Medicare rebate indexation to mid-2018, psychiatrists have warned.

The AMA Psychiatrists Group said the prolonged indexation freeze would push up out-of-pocket costs and increase the financial pressure on patients using the private system, which treats about 70 per cent of all mental health patients.

"Given that many patients treated in the private sector find it difficult to access appropriate care in an already stretched public sector, there are concerns that this would leave many patients and their families 'in the cold'," the report said.

In the lead-up to the federal Budget, the AMA has intensified the pressure on the Government to dump the rebate freeze, warning it will push up patients costs, reduce access to care, cut bulk billing rates and force some GP clinics to close.

But Health Minister Sussan Ley has indicated there will not be a change of policy in the Budget, though she hinted at the possibility the freeze could end early if a review of the Medicare Benefits Schedule and other efficiency measures delivered sufficient health budget savings.

In a report to the AMA Federal Council, the AMA Psychiatrists Group also expressed alarm at what it said was an increasing push by insurers to demand patients divulge details of their medical records.

The group said patients often gave funds access to their medical records "because they are too afraid of losing their insurance cover if they refuse".

The group said that both it and the Royal Australian and New Zealand College of Psychiatrists were concerned about the development, which was "eroding the confidential and therapeutic nature of the relationship between a patients and a psychiatrist".

"In some cases, this can have a clinically detrimental effect on the patient," the report said.

The RANZCP, supported by the AMA Psychiatrists Group, has launched an investigation into the issue.

In its report, the group also highlighted the valuable work being undertaken by the Private Mental Health Alliance to help inform mental health policy.

The Alliance owns and operates the Centralised Data Management Service, which collects admission and discharge information from all private hospitals operating psychiatric beds.

"The CDMS has become the cornerstone for the provision of high quality mental health care in the private hospital sector," the group said. "The CDMS is helping the private sector and the Australian Government answer fundamental questions that can be asked of any health system – who receives what services, at what cost, and with what effect."

The current agreement under which the AMA provides funding to the Private Mental Health Alliance expires in June, and negotiations are underway for a new three-year agreement from 1 July. The Federal Government has deferred a decision on any contribution it might make until after it has fully considered the outcomes of the National Mental Health Commission's review of services, which was publicly released last month. No announcement is expected until after the May Budget.

ADRIAN ROLLINS

Nation sleep-walking into anaesthetist glut

Anaesthetists are being hit by rising rates of unemployment and underemployment as swelling numbers of graduate compete for a shrinking number of positions.

In a sobering submission to the AMA Federal Council, the Anaesthetist Specialty Group reported that the rate at which people were entering the profession far outstripped growth in positions, shrinking opportunities and undermining wages and conditions.

The group reported that between 200 and 300 people are joining the profession each year, and the popularity of the specialty is high. Last year almost 10 per cent of final year medical students wanted to become an anaesthetist, and more than 1000 were currently enrolled in the Australian and New Zealand College of Anaesthetists training program.

It warned of a looming oversupply of anaesthetists caused by unfettered growth in training places, a slowdown in rates of retirement among senior specialists, shrinking employment opportunities in public hospitals and private clinics, and greater difficulty in gaining credentialing at private hospitals.

In the absence of official data, the report cited surveys conducted by the College and the Australian Society of Anaesthetists showing that, in 2014, 11 per cent of new Fellows had not found a job after 12 months, and 14 per cent reported being unemployed at some point in their first five years.

In addition, more than a third reported being underemployed and almost 30 per cent felt they were not getting sufficient variety of work to maintain their skills. Unsurprisingly, three quarters believed too many anaesthetists were being trained.

The group warned of signs employers were preparing to take advantage of the looming oversupply of anaesthetists by driving hard deals on pay and conditions.

“There appears to be an increase in the adoption of increasingly harsh contracts for salaried anaesthetists,” the report said. “Often, anaesthetists are informed non-signing of the contract, presented only a few days before the agreement was due to commence, will result in termination of employment.”

ADRIAN ROLLINS

Tech advances intensify demands on time-poor specialists

Radiologist workloads are increasing “exponentially” as the complexity of tests and demands on time multiply, intensifying workplace pressure and compromising training, the AMA’s Radiology Specialty Group has warned.

The group told the AMA Federal Council that technological advances meant diagnostic imaging tests were producing much more data than ever before, making the task of interpretation and diagnosis far more complex and demanding.

For instance, the group said, the data produced by a computed tomography scan of an oncology patient now took between 20 and 30 minutes to interrogate, much longer than a decade ago when data sets were much smaller.

But it said hospital administrators had not kept up with such changes, and time allowances had become increasingly inadequate.

Not only were radiologists interpreting bigger and more complex data sets, but were also being required to devote an increasing amount of time to multidisciplinary meetings.

The group said it took 60 minutes to prepare for a typical one-hour meeting, but because there was no billing involved, such demands were not taken into account when assessing radiologist productivity.

“[Multidisciplinary meetings], review of previous studies, ad hoc consultations and problem solving patient-related issues in the public sector take up about 20 per cent of a radiologist’s time in non-reporting patient management which is not recognised by hospital admin,” the report said, adding that this did not include time spent teaching a training registrars and trainees.

It warned that time constraints and other pressures were compromising training and imposing a significant burden on radiologists, particularly junior specialists.

“There is a shortage of staff, and the service requirements are impacting on training,” the group said. “The increases in workload are placing undue pressure on radiology trainees, in terms of on-call, supervision and checking of their reports, as well as apprentice model teaching.”

ADRIAN ROLLINS

Not so golden times for staph

Patients at some major metropolitan hospitals are up to three times more likely to contract the potentially deadly Golden Staph bloodstream infection than those being treated at similar institutions with better infection control systems.

While the number of hospital patients catching Golden Staph (Staphylococcus aureus) in the course of their treatment has fallen nationwide, dropping from 1721 cases in 2012-13 to 1621 last financial year – a 6 per cent improvement - analysis by the National Health Performance Authority has found a wide variation in rates of infection between comparable hospitals.

Unsurprisingly, the vast majority of infections (1310) occurred in the nation's major hospitals, and almost three-quarters (972) involved hospitals treating a relatively high proportion of patients considered vulnerable to contracting the disease.

But the ability of hospitals to curb spread of the disease varied greatly.

The NHPA reported that the rate of Golden Staph infection among major hospitals with more vulnerable patients ranged from 0.59 cases per 10,000 patient bed days at Wollongong Hospital to 2.32 at Sydney's St Vincent's Hospital. The average rate among such institutions was 1.28 in 2013-14.

There was a similar discrepancy among large hospitals with more vulnerable patients, from zero cases per 10,000 patient bed days at the Victorian Eye & Ear Hospital to 2.48 at Newcastle's Calvary Mater Hospital. The average rate was 1.15.

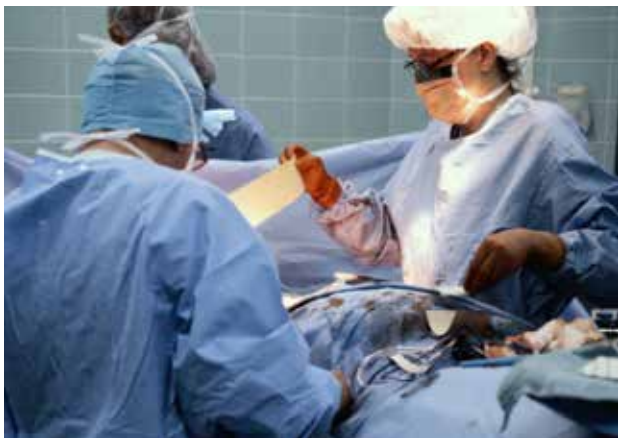
The findings have underlined calls for renewed emphasis on the importance of infection control measures in the nation's hospitals, particularly those with above-average rates of infection.

The Authority's Chief Executive Officer Dr Diane Watson said the public reporting of infection rates meant hospitals that were similar in size and function could measure how they were performing relative to their peers, spurring them to address any shortcomings.

"Differences in the rate of infection suggest there is an opportunity for hospitals to continue to learn from each other to lower infection rates," Dr Watson said.

While the number of Golden Staph infections is declining, it remains a significant killer. Between 20 and 35 per cent of patients who contract the disease in their bloodstream die from this or a related cause, while most of the remainder face a prolonged stay in hospital.

The risk is heightened by the spread of antibiotic-resistant



strains of the bug, particularly methicillin-resistant Staphylococcus aureus (MRSA).

Australian National University infectious diseases expert Associate Professor Peter Collignon told the ABC the NHPA report showed there was significant scope for improvement in the infection control procedures of many hospitals.

"What it does show is that when you look at hospitals in the same groups, there are quite wide variations and to me that means that we can do better than what we are doing now," A/Professor Collignon said, emphasising the importance of regular hand washing and tighter procedures around the use of intravenous lines.

Sydney's St Vincent's Hospital, shown to have the second-highest Golden Staph infection rate among the country's major and large hospitals, said that since then it had completely overhauled its infection control procedures.

Chief executive Associate Professor Anthony Schembri told the ABC that between July last year and March this year its infection rate had virtually halved to 1.3 cases per 10,000 bed days thanks to changed protocols around central and peripheral intravenous line use, upgraded aseptic techniques and surgical site infection prevention.

A/Professor Schembri added the hospital had also launched a major campaign on hand hygiene.

A/Professor Collignon said the long-term decline in Golden Staph infection rates underlined the importance and effectiveness of hand washing and other infection control measures.

ADRIAN ROLLINS

AMA in the news

YOUR AMA HAS BEEN ACTIVE ON POLICY AND IN THE MEDIA ON A RANGE OF ISSUES CRUCIAL TO MAKING OUR HEALTH SYSTEM BETTER. BELOW IS A SNAPSHOT OF RECENT MEDIA COVERAGE.

PRINT/ONLINE

Medics to fix 'fear' culture, *The Daily Telegraph*, 4 April 2015

A change in the way doctors and nurses report abuse is needed to buck the scourge of sexual harassment and protect whistleblowers within the medical industry. AMA President A/Professor Brian Owler was committed to bringing about cultural change within the profession.

$8.40 more to see doctor, *Herald Sun*, 7 April 2015

Patients could be paying up to $8.40 for a visit to the doctor by 2018, more than they would have paid under the GP co-payment. AMA President A/Professor Brian Owler said the lazy policy would mean fewer patients would be offered bulk-billing.

Religious belief saw mum and baby die, *The Daily Telegraph*, 8 April 2015

The AMA has defended doctors at a top Sydney hospital forced to let a heavily pregnant woman and her unborn child die after the mother refused a blood transfusion because she was a Jehovah's Witness. AMA Vice President Dr Stephen Parnis said doctors could not force a patient to accept treatment.

Not in the script – chemists selling your data, *Sunday Mail Adelaide*, 12 April 2015

Some chemists are selling their patients' prescription information to a global health information company, which sells it on to drug firms, trying to boost their sales. AMA Chair of General Practice Dr Brian Morton called it an amazing invasion of privacy for purely commercial reasons.

Coalition's 'no jab, no pay' policy ties benefits to immunisation, *Australian Financial Review*, 13 April 2015

Australian parents will lose thousands of dollars' worth of childcare and welfare benefits if they refuse to vaccinate their children. AMA President A/Professor Brian Owler said the AMA backed the plan and said vaccination remained one of the most effective public health measures that we have.

Hospitals 'storm' warning, *Adelaide Advertiser*, 16 April 2015

The number of public hospital beds across Australia has fallen by more than 200 and no State has met emergency department targets. AMA President A/Professor Brian Owler said hospital performance benchmarks are not being met and things will only get worse as funding declines.

AMA hospital report card gives states fuel for fight, *The Australian*, 16 April 2015

Tony Abbott will face heightened pressure to reverse cuts of $80 billion to health and education, with a snapshot of public hospital performance handing the states fresh ammunition to press home their case. AMA President A/Professor Brian Owler will use the report to warn the Government that its extreme public hospital cuts are unjustified.

Church no longer exempt for jabs, *Hobart Mercury*, 20 April 2015

A religious exemption loophole, that allowed parents who opposed vaccinations to continue to receive childcare and family tax payments has been scrapped. AMA President A/Professor Brian Owler praised the move.

AMA warns against continued freeze on rebates, *ABC News*, 22 April 2015

AMA President A/Professor Brian Owler said at a time when the Government should be increasing its investment in general practice, the Medicare rebate freeze will eat away at the viability of individual practices.

Rape row over new anti-jab campaign, *Adelaide Advertiser*, 23 April 2015

A Facebook graphic on the Australian Vaccination Network site that compares vaccination to rape has been condemned by doctors, the Rape Crisis Centre, and politicians as abhorrent and insulting. AMA President A/Professor Brian Owler said the post undermines the organisation and shows lack of intelligence and common sense.

Doctors back review of Medicare rebates, *West Australian*, 23 April 2015

Doctors have backed a sweeping review of the Medicare Benefits Schedule, but warned the Federal Government not use it as an excuse to cut patient services. AMA President A/Professor Brian Owler agreed the MBS was outdated and said any savings from the review should be reinvested into the health system.

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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.

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Aussie in sick new IS video, *Sunday Herald Sun*, 26 March 2015

The shocking new public face of Islamic State death cult is an Australian doctor. AMA President A/Professor Brian Owler said he was appalled that any medical professional would want to work for terrorists.

Transparency on dug company payments and trips a step closer, *The Age*, 28 April 2015

Patients will find out what payments and educational trips their doctors have received from drug companies. AMA Chair of General Practice Dr Brian Morton said it was insulting and naïve to suggest doctors would be unduly influenced by a free meal.

Terror doctor free to practise, *Adelaide Advertiser*, 28 April 2015

The Medical Board is refusing to deregister the former Adelaide doctor who left Australia to join the Islamic State terrorist group. AMA Vice President Dr Stephen Parnis said he expected the Medical Board to look closely at the case from legal and professional standards perspectives.

Scientists call for action on disease risks from climate change, *Sydney Morning Herald*, 30 April 2015

The Australian Academy of Science has released a report which shows a range of tropical diseases becoming more widespread in Australia due to climate change. AMA President A/Professor Brian Owler said the report should be a catalyst for the Abbott government to show leadership on reducing greenhouse gas emissions and mitigating their effects on health.

RADIO

A/Professor Brian Owler, 774 ABC Melbourne, 7 April 2015

AMA President A/Professor Brian Owler talked about the decision to axe the proposed $5 Medicare co-payment in favour of an alternative Government plan to freeze the amount received by doctors in rebates.

Dr Stephen Parnis, 6PR Perth, 13 April 2015

AMA Vice President Dr Stephen Parnis discussed the use of the welfare system to boost immunisation rates. Dr Parnis said in the 1990s the Howard Government also linked immunisation to social security, which resulted in a big increase in vaccination rates.

A/Professor Brian Owler, Radio National, 16 April 2015

AMA President A/Professor Brian Owler discussed Federal funding for health. A/Professor Owler said the health system has never been adequately funded and doctors and nurses have done well to meet a rise in demand.

A/Professor Brian Owler, 2SM Radio, 16 April 2015

AMA President A/Professor Brian Owler talked about the use of paw paw for chronic back pain. A/Professor Owler said paw paw is a well-known treatment, but that people do not tend to use it as much nowadays.

A/Professor Brian Owler, 4BC Brisbane, 16 April 2015

AMA President A/Professor Brian Owler talked about the issue of health funding and the AMA Public Hospital Report Card. A/Professor Owler said the issue is capacity and resources, and that he is concerned about the future given reduced Commonwealth funding.

Dr Stephen Parnis, 2GB Sydney, 23 April 2015

AMA Vice President Dr Stephen Parnis talked about the recent Facebook post from the Australian Vaccination Skeptics Network, which compares forced vaccination to rape. Dr Parnis said the campaign shows how disgraceful and unhinged some anti-vaccination campaigners are.

A/Professor Brian Owler, 2UE Sydney, 28 April 2015

AMA President A/Professor Brian Owler talked about the Medical Board's handling of the case of an Australian-registered doctor who has joined Islamic State. A/Professor Owler said he understands the Medical Board is working with security agencies to ensure that the public is safe, and to prevent any possibility of Dr Kamleh returning to Australia to continue practising medicine.

A/Professor Brian Owler, ABC NewsRadio, 30 April 2015

The Australian Academy of Science is warning of the impacts of global warming predicting food and water shortages, along with extreme weather events. AMA President A/Professor Brian Owler said climate change has been a political battleground and that Australia is not ready to cope with its impacts.

AMA in the news

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TELEVISION

A/Professor Brian Owler, Channel 9, 16 April 2015

AMA President A/Professor Brian Owler talked about the AMA's Public Hospital Report Card. A/Professor Owler said many hospitals are not reaching targets in the emergency department treatment and elective surgery wait times.

Dr Stephen Parnis, Channel 9, 12 April 2015

AMA Vice President Dr Stephen Parnis talked about the Government's announcement that childcare rebate payments will be cut for families who do not vaccinate their children. Dr Parnis said the children involved are innocent, and their futures need to be insured.

A/Professor Brian Owler, ABC News 24, 16 April 2015

AMA President A/Professor Brian Owler discussed the crisis in Australia's public hospitals as Commonwealth funding is wound back. A/Professor Owler said the Commonwealth are not living up to their responsibilities to fund States and Territories properly to run hospitals.

A/Professor Brian Owler, Channel 9, 22 April 2015

AMA President A/Professor Brian Owler discussed welcoming the plans for a major review of the Medicare Benefits Schedule. A/Professor Owler said the review is clinician-led and is not just about finding savings.

A/Professor Brian Owler, Sky News, 29 April 2015

AMA President A/Professor Brian Owler discussed the future of the public hospital system if Federal Government cuts come into effect. A/Professor Owler said state governments lack the capacity to increase revenue to pick up the slack.

A/Professor Brian Owler, ABC News 24, 30 April 2015

AMA President A/Professor Brian Owler called on the Federal Government to show leadership on climate change or risk the health of Australians. A/Professor Owler said there was overwhelming scientific consensus that the climate is changing and there will be consequences for health.

Your AMA Federal Council at work

WHAT AMA FEDERAL COUNCILLORS AND OTHER AMA MEMBERS HAVE BEEN DOING TO ADVANCE YOUR INTERESTS IN THE PAST MONTH:

Name	Position on council	Activity/Meeting	Date
A/Prof Brian Owler	AMA President	Meeting with Australian Health Practitioner Regulation Agency (AHPRA) and the Medical Board of Australia	5/3/2015
		Meeting with Royal Australasian College of Surgeons and Australian Plastic Surgery Association Presidents	4/3/2015
Dr Brian Morton	AMA Chair of General Practice	GP Roundtable	8/4/2015
		UGPA	25/03/2015
		GP Roundtable	17/3/2015

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Your AMA Federal Council at work

WHAT AMA FEDERAL COUNCILLORS AND OTHER AMA MEMBERS HAVE BEEN DOING TO ADVANCE YOUR INTERESTS IN THE PAST MONTH:

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Dr Stephen Parnis	AMA Vice President	Meeting with Australian Health Practitioner Regulation Agency (AHPRA) and the Medical Board of Australia (MBA) on improving practitioner experience with notifications	5/3/2015
Dr Andrew Miller	AMA Federal Council Representative for Dermatologists	PBS Authority medicines review reference group	13/4/2015
		MSAC (Medical Services Advisory Committee) Review Working Group for Skin Services	20/2/2015
Dr Antonio Di Dio	AMA Member	Meeting with Australian Health Practitioner Regulation Agency (AHPRA) and the Medical Board of Australia (MBA) on improving practitioner experience with notifications	5/3/2015
Dr Roderick McRae	AMA Federal Councillor - Salaried Doctors	Meeting with Australian Health Practitioner Regulation Agency (AHPRA) and the Medical Board of Australia (MBA) on improving practitioner experience with notifications	5/3/2015
Dr Susan Neuhaus	AMA Federal Councillor - Surgeons	Meeting with Australian Health Practitioner Regulation Agency (AHPRA) and the Medical Board of Australia (MBA) on improving practitioner experience with notifications	5/3/2015
Dr Robyn Langham	AMA Federal Councillor - Victoria nominee and Chair of AMA Medical Practice Committee	Australian Health Practitioner Regulation Agency's (AHPRA) Prescribing Working Group (PWG)	5/3/2015
Dr David Rivett	AMA Federal Councillor	IHPA Small Rural Hospitals Working Group	5/2/2015
Dr Chris Moy	AMA Federal Councillor	PCEHR Safe Use Guides consultation (KPMG/ACSQHC	11/3/2015
		NeHTA (National E-Health Transition Authority) Clinical Usability Program (CUP) Steering Group	10/3/2015
Dr Richard Kidd	AMA Federal Councillor	PCEHR Safe Use Guides consultation (KPMG/ACSQHC)	10/3/2015
		Gateway Advisory Group	6/2/2015

Saving Anzacs – the heroic role of medics at Gallipoli

AMA President Associate Professor Brian Owler, New Zealand Medical Association President Dr Mark Peterson (on A/Professor Owler's left) and members of the Turkish Medical Association observe a moments silence at a memorial commemorating the Dardanelles campaign at Canakkale, Turkey the day before Anzac Day.

AMA President Associate Professor Brian Owler and New Zealand Medical Association President Dr Mark Peterson attended a special ceremony at Canakkale in Turkey on 24 April as guests of the Turkish Medical Association to pay tribute to the doctors and other health workers who risked death and serious injury to care for the injured and dying from all sides of the Gallipoli landing 100 years ago.

Below are extracts from the speech they jointly delivered.

"Each year on Anzac Day, New Zealanders and Australians mark the anniversary of the Gallipoli landings of 25 April 1915. On that day, thousands of young men, far from their homes, stormed the beaches on the Gallipoli Peninsula.

For eight long months, New Zealand and Australian troops, alongside those from Great Britain and Ireland, France, India, and Newfoundland battled harsh conditions and the Ottoman forces desperately fighting to protect their homeland.

The landings occurred in the wrong locations. Instead of gentle slopes, there were steep cliffs and the ravines that would later bear the names of Australians and New Zealanders.

Casualties were heavy right from the start. In the first four days of the campaign 3300 wounded passed through the 1st Australian Casualty Clearing station. By the time the campaign ended, more than 130,000 men had died. Of the 14,000 New Zealanders who fought on the Gallipoli peninsula, 5212 were injured and 2779 were killed over a period of 240 days. Australian fatalities totalled 8709 and more than 19,000 were injured.

The Medical Corps faced huge difficulties and medical arrangements came in for much criticism.

A key difficulty was the lack of communication between the different elements of the medical service. Before the landings started, a draft plan to deal with casualties had been worked out. Tent subdivisions were to be set up on the beach. A medical officer was to triage the wounded, with the seriously wounded to be evacuated to vessels offshore—but only once all the troops had been landed—and the slightly wounded to ambulances. The MO would be notified when the ships were full and would move the wounded onto the next vessel.

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Saving Anzacs – the heroic role of medics at Gallipoli

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The reality was very different. The final draft of the medical arrangements had not been received by the Australian and NZ divisions. Communication was poor.

Radio transmissions were not permitted. A signal telling the assistant director of medical services of the ships available to him took two days to cross one kilometre of water.

With no way of contacting the ships, requests for more vessels for the wounded were not received. No triage took place on shore...the wounded were mixed up and were brought out to troopships that were still laden with troops.

> "The point of the matter is that there was totally inadequate medical and nursing attention on several boats. How this came about it is hard to explain because several army corps proclamations warned the men to expect heavy casualties, so the slaughter on April 25th was not unexpected"

All the ships were filled with wounded by the end of the first night.

Those on shore faced bitter cold and intense sniper fire. Treatment for the wounded was basic. Morphia was given by mouth; splints were improvised with rifles and bayonets.

Stretcher bearers struggled up and down narrow tracks, most having removed their white markers to avoid being shot.

For those wounded on Gallipoli, the wait for treatment and evacuation was often long and agonising. Poor planning and the sheer scale of casualties overwhelmed the available medical resources, and poor coordination and mismanagement meant that many serious cases were left on the beach too long; once on board they found appalling conditions.

There were no beds. Some were still on the stretchers on which they had been carried down from the hills. The few Red Cross orderlies were terribly overworked. For 12 hours on end an orderly would be alone with 60 desperately wounded men in a hold dimly lit by one arc lamp. None of them had been washed and many were still in their torn and blood-stained uniforms. There were bandages that had not been touched for two or three days. Most of them were in great pain, and all were patched with thirst.

AMA President Associate Professor Brian Owler was in Turkey for the Anzac commemorations as a guest of the Turkish Medical Association.

Writing from the Dardanelles, a sergeant attached to the Medical Corps sent back graphic details about the treatment of Australian wounded:

"After the first fighting a ship came alongside, and at midnight the first batch of wounded were brought on board. Some had their legs off, others lad no arms or hands, some were without fingers or toes. A lot of the poor fellows had terrible head-wounds. Some had their ears blown off, and others their eyes shot out. Nearly all had to be operated on, and this was done by lamp light."

The role of the ambulance men and stretcher bearers was crucial during the campaign. Writing for *the Colonist* magazine in 1915, a correspondent described the chaos they faced and the price they paid:

"Too high an eulogium cannot be pronounced on the ambulance department. Unable to take cover, and continually working in fire-swept zones, their casualties have been abnormally high. Dressing station staff are continually being renewed."

Although acknowledging the bravery of those who cared for the wounded, other contemporary accounts strongly criticised the lack of planning that had gone into the medical arrangements:

"The point of the matter is that there was totally inadequate medical and nursing attention on several boats. How this

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Saving Anzacs – the heroic role of medics at Gallipoli

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AMA President Associate Professor Brian Owler: 'The best way to honor the memory of the ANZAC's is to advocate for peace'.

came about it is hard to explain because several army corps proclamations warned the men to expect heavy casualties, so the slaughter on April 25th was not unexpected.

"Of course, many of the transports went back laden with wounded, but these had in many cases just discharged troops a few hours before, and were quite unsuitable for the nature of work they were called upon to perform."

Along with the inherent dangers of war, the threat of illness was never far off. Bodies piled up around the encampments attracted flies, and the stench was sickening.

Severe diarrhoea caused by amoebic dysentery and typhoid fever badly affected all those on shore. The conditions resulted in swarms of disease carrying flies.

This could prove as much of a challenge as the enemy. The role of the flies was recognised and a stricter public health regimen came to exist. Waste was disposed of by burning, and care was taken not to leave rations that would attract flies.

Due to these measures deaths due to communicable disease was lower for the AIF in 1915, with around 600 deaths, compared with the South African Wars for the British, where two soldiers died of communicable disease for every soldier lost in battle.

Finally, perhaps the best way to understand what it was like for those who were here at that time is to hear it in their own words. The following extracts are taken from correspondence to the Editor of the New Zealand Medical Journal from a medical officer:
— *Gallipoli, 18th June, 1915.*

"...For the last two months we have had a hell of a time. We have had to be within half a mile of the firing line the whole time, and for the last two months we have done all our work under continuous fire.

Our operating tent is a most amusing sight; it is more like a sieve than a tent, and yesterday I had my sterilising orderly knocked over by a bullet while at work. I lost five killed and 15 wounded of my own men. I have been very lucky myself, and though I have been hit twice—once by shrapnel and once by the fuse of a shell—I have only been bruised.

I am afraid the casualty list will be a big shock in New Zealand. We are now acting as a clearing station on the beach, where we do all necessary operations. We have done scores of trephinings and laparotomies with suturing and resections of gut. No abdominal wounds survive if not operated on. There are always multiple perforations, and very often the gut is torn completely across".

This was the first time that both Australia and New Zealand had fought under their own flags. The ANZACs were conscious of this.

When the ANZACs set sail from Albany in Western Australia, they were expecting to go to Europe. The ANZAC troops diverted to Egypt where they continued training. They did not come to fight the Turk and had no idea that they would do so when they enlisted. Turkey had decided to align with Germany quite late and did so for self preservation as much as anything else.

So we had ANZACs and Turks fighting not because of their antipathy between our nations but rather we had two groups of nations fighting on behalf of other nations. A mystery of human behaviour – but perhaps also another reason for empathy and respect between soldiers in the field.

For Australia and New Zealand, there was a realisation of their unique identities. They were egalatarian. The British class system was an enigma to them. They did not bow to rank but they followed orders.

Anzac Day grew out of this pride. First observed on 25 April 1916, the date of the landing has now become a crucial part of the fabric of national life – a time for remembering not only those who died at Gallipoli, but all who have served their country in times of war and peace.

We also remember the doctors and health care workers that served in war – many of whom paid the ultimate price. We remember their sacrifice and thank them for it. However, the best way that we honour their memory is to advocate for peace.

Lest we forget."

Health on the hill

POLITICAL NEWS FROM THE NATION'S CAPITAL

Ley wants 'bipartisan national approach' to mental health

The Federal Government wants to set up an all-government working group dedicated to overhauling the nation's dysfunctional mental health system following a searing critique from the National Mental Health Commission.

Health Minister Sussan Ley said the Commission's "disturbing" analysis showed clear failures in the system, and argued the need for a co-ordinated national approach to improve the care of the mentally ill.

"The National Mental Health Commission's Review...paints a complex, fragmented, and in parts, disturbing picture of Australia's mental health system," Ms Ley said. "I acknowledge there are clear failures within both the mental health sector and governments, and we must all share the burden of responsibility and work together to rectify the situation."

The Minister said the scale of the problem meant it required more than a band-aid approach, and that consultation and collaboration between governments was essential.

"I intend to seek bipartisan agreement to revive a national approach to mental health at tomorrow's COAG meeting of Health Ministers," she said.

In its four-volume report, released by the Government last month after copies were leaked to the media, the Commission questioned the effectiveness of almost $10 billion spent each year on mental health services, and urged an increased focus on prevention and early intervention.

"It is clear the mental health system has fundamental structural shortcomings," the review said. "The overall impact of a poorly planned and badly integrated system is a massive drain on peoples' wellbeing and participation in the community."

The Commission has argued that changing to a "stepped care approach", with a major focus on prevention and early intervention, would reduce the severity and duration of mental health issues, ultimately slowing demand for expensive acute hospital care and lowering the incidence of long-term disability.

Controversially, the Commission recommended the Commonwealth reallocate "a minimum" of $1 billion from acute hospital funding to community-based mental health services from 2017-18.

But AMA President Associate Professor Brian Owler has rejected the suggestion, warning that public hospitals were already under-resourced. The AMA's annual Public Hospital Report Card showing the nation's hospitals are struggling to meet performance benchmarks under pressure from a remorseless increase in demand from patients and a squeeze on funding.

The Report Card found there had been improvements in patient waiting times for treatment, by the AMA President warned these gains were threatened by the Federal Government's move to take almost $3 billion from public hospital finding by 2017, and to cut the indexation rate of its subsequent contributions.

A/Professor Owler said the changes were creating a "perfect storm" for the nation's public hospitals, and would inevitably lead to longer waiting times for patients.

State and Territory leaders are expected to confront Prime Minister Tony Abbott over reduced Commonwealth hospital funding at a special leader's retreat in July. Treasury figures the Commonwealth will short-change them by $57 billion over ten years.

But Ms Ley moved to allay at least some of their concerns by rejecting the Commission's suggestion to reallocate a further $1 billion from hospitals.

"The Government does not intend to pursue the proposed $1 billion shift of funding from state acute care to community organisations, as we want to work collaboratively in partnership with other levels of Government," the Minister said. "While many recommendations offer positive ideas, others are not conducive to a unified national approach."

ADRIAN ROLLINS

PHNs give many Medicare Locals new lease of life

Medicare Locals are involved in more than half the organisations selected by the Federal Government to succeed them, details of successful Primary Health Network applicants show.

The 28 preferred Primary Health Network operators announced by Health Minister Sussan Ley include at least 18 in which Medicare Locals are a dominant or major partner, including for PHNs in Northern and South Western Sydney, North West Melbourne, Gippsland, South Brisbane, Adelaide, Perth (both North and South), Tasmania, the Northern Territory and the ACT.

The Government has committed $900 million to create 31 PHNs to replace Labor's Medicare Locals scheme, which is being shutdown following the results of the Horvath Review that found many were top-heavy, expensive and failed in their primary goal of supporting seamless patient care.

Ms Ley said that, by being much more closely aligned with

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the boundaries of state Local Hospital Networks and having a clearer focus on outcomes, the PHNs would ensure far better integration between primary and acute care services.

The Minister said the PHNs would work directly with GPs, hospitals, other health professionals and the community to ensure better care, including by reducing the merry-go-round of treatment experienced by many patients with chronic and complex conditions.

"Primary Health Networks will reshape the delivery of primary health care across the nation," Ms Ley said. "The key difference between Primary Health Networks and Medicare Locals is that PHNs will focus on improving access to frontline services, not backroom bureaucracy."

But, ironically, Medicare Locals appear to be the backbone of many of the consortiums that have successfully tendered to operate PHNs – a fact acknowledged by the Minister.

Many of the successful PHNs were harnessing skills and knowledge from a range of sources, including allied health providers, universities, private health insurers and "some of the more successful former Medicare Locals".

"There's no doubting that, individually, there were some high-quality Medicare Locals across the country," Ms Ley said. "However, there were also plenty that haven't lived up to Labor's promise."

The AMA was a leading critic of Labor's Medicare Local scheme because it had limited the involvement of local GPs.

At the time the Horvath Review was released, AMA President Associate Professor Brian Owler said that while some individual Medicare Locals had performed well in improving access to care, "the overall Medicare Local experiment has clearly failed, largely due to deliberate policy decisions to marginalise the involvement of GPs".

Concerns have also been expressed that private health funds might try to use PHNs to interfere in the provision of primary care, and insurers Bupa and HCF have been involved in supporting tenders for four PHN consortia, including the Partners 4 Health consortium in Brisbane North, and the WA Primary Health Alliance covering the three Western Australian PHNs (Perth North, Perth South and Country WA).

But, according to an investigation by *Medical Observer*, the insurers will have no operational role and were involved strictly as support players.

Partners 4 Health is the trading name of Metro North Brisbane Medicare Local (MNBML), and Chief Executive Abbe Anderson told *Medical Observer* HCF and Bupa were just two of many groups that had backed the successful application from her organisation.

"While MNBML has the support of a wide range of key participants – including those listed – I think we had over 30 organisations that provided us with letters of support and endorsement in our application," Ms Anderson said. "But the PHN itself will be governed and managed by the same organisation that has been running the ML since its inception."

ADRIAN ROLLINS

Cash-strapped hospitals face FBT threat

Public hospitals could be hit by tax concession changes that would undermine their ability to attract and retain staff, the AMA has warned.

AMA Vice President Dr Stephen Parnis has urged the Abbott Government to proceed cautiously amid speculation that hospitals are being targeted to have their fringe benefit tax concessions reduced or abolished in next week's Federal Budget.

Dr Parnis said public hospitals relied heavily on the concessions to help them compete with the private sector in recruiting and retaining doctors and other highly trained staff.

"Traditionally, public hospitals have been a less attractive area of practice for doctors because private sector work generally attracts greater remuneration when compared with the salaries and conditions available to most doctors who work primarily in public hospitals," he said. "Ill-conceived and rushed reforms could significantly affect the ability of public hospitals to recruit and retain staff."

Even before any tax concession changes are made, there is mounting evidence that the public hospital system is under strain.

The AMA's Public Hospital Report Card, released a day before Prime Minister Tony Abbott met with the nation's premiers and chief ministers, showed that elective surgery waiting times remain stubbornly high (for the fourth year in a row the national median waiting time in 2013-14 was 36 days), admission delays remain unsatisfactory and the proportion of beds per population is shrinking.

Hospitals are missing key performance targets even before major Commonwealth funding cuts hit. In last year's Budget the Government announced changes that Treasury figures show will

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rip $57 billion out of the public hospital system in the next 10 years.

AMA President Associate Professor Brian Owler warned the looming funding cuts would create "a perfect storm" for public hospitals already struggling to cope, and would cause patient waiting times to blow out.

"Public hospitals and their staff will be placed under enormous stress and pressure, and patients will be forced to wait longer for their treatment and care," he said. "Funding is clearly inadequate to achieve the capacity needed to meet the demands being placed on public hospitals."

Hopes of short-term funding relief for cash-strapped public hospitals were dashed when a meeting of the nation's political leaders last month decided to defer discussions on the issue to a special retreat to be held in July.

Indicating that there will be little new spending on public hospitals in next week's federal Budget, Mr Abbott convinced his State and Territory counterparts to delay talks on health financing for consideration as part of proposals to reform the Federation.

Mr Abbott said the country needed to take a "very holistic look" at the way it funded public hospitals to ensure "we get the best possible value for our dollar, because we're under pressure".

"Sure, the states and territories are under pressure for their hospital funding, but we're under pressure for our tax take," the Prime Minister said. "No-one is volunteering to pay more tax. So, we need to handle this in a way which acknowledges the need for ever-better health services, but which also appreciates that resources are not unlimited, and that's what we want to be able to discuss in an honest and candid and collegial way as part of the leaders retreat later on in July."

In a letter to Assistant Treasurer Josh Frydenburg, Dr Parnis urged the Government to take a similarly considered approach to any change to hospital tax concessions.

He said the current framework of concessions have developed over 25 years to support the ability of hospitals to recruit and hold on to high-quality staff.

He warned any watering down of FBT or other tax concessions would hit regional hospitals particularly hard.

The Federal Government has already initiated a review of the overall tax system, and Dr Parnis said there should not be any pre-emptive changes to tax arrangements until the process had "run its course".

"It would be premature for the Government to do anything until this work is completed, [and] it would be disruptive and counterproductive to hit the overburdened public hospital sector with another Budget shock," the AMA Vice President said.

ADRIAN ROLLINS

Complaints system overhaul uncertainty

The nation's health ministers have put off consideration of a much-anticipated overhaul of the flawed doctors complaints system until August despite evidence it is causing severe distress and anxiety for many medical practitioners.

At its April 17 meeting, the COAG Health Council said consideration of the recommendations of the National Registration and Accreditation Scheme for Health Professionals review conducted by former WA Health Director General Kim Snowball, which is expected to propose changes to the notifications system, had been held over until mid-year.

In submissions to the review, the AMA called for major changes in the way complaints against doctors are handled.

The Association said there needed to be improved screening of complaints and notifications, greater transparency and fairness, and changes to make the scheme more responsive to medical practitioners and accountable to the medical profession.

AMA Vice President Dr Stephen Parnis said the notification process was often arduous and lengthy, with more than 30 per cent of investigations still open after nine months.

There are concerns the findings of the Snowball review have been pre-empted by the Australian Health Practitioner Regulation Agency, which last year released an action plan of changes to the complaints system.

Dr Parnis said AHPRA wanted more information to be provided to complainants, and a greater focus on improving the experience for consumers, when "in fact, efforts need to be directed to improving the investigation process – that is, the practitioner experience. Medical practitioners and consumers, equally, want a regulatory scheme that is timely, fair, transparent and effective."

The Snowball review also considered mandatory reporting rules for doctors treating other medical practitioners amid concerns they are deterring people from seeking treatment.

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Health on the hill

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Under the National Law, doctors in all states and territories except Western Australia are required by law to notify the Australian Health Practitioner Regulation Agency (AHPRA) if they believe a health practitioner they are treating has practised while drunk or on drugs, has engaged in sexual misconduct, has provided care in a way significantly at odds with accepted professional standards, or has an impairment that could put patient safety at risk.

The AMA has urged that other states adopt WA's policy of providing an exemption from reporting doctor-patients with an impairment.

ADRIAN ROLLINS

Big Food's resistance to health stars crumbling

Food industry resistance to the front-of-packet nutrition star rating system is crumbling, with cereal giant Kellogg's the latest to adopt the labelling scheme for its products.

Almost two years after the Health Star Rating system was approved by the nation's food and health ministers, Kellogg's has announced that, from June, the labelling scheme would be introduced across all 37 of its cereal products.

Under the system, which the AMA was involved in developing, food is awarded between a half and five stars depending on its nutritional value. The label also includes a panel detailing sugar, saturated fat, sodium and energy content.

While some Kellogg's products, including All Bran and Guardian, have been awarded five stars under the scheme, and the majority have four or more stars, several varieties aimed at children, including Coco Pops, Fruit Loops, Crunchy Nut and Nutri-Grain have just two stars and one, Crispix, has earned just 1.5 stars.

Assistant Health Minister Fiona Nash said that Kellogg's adoption of the voluntary scheme meant that soon the vast majority of breakfast cereals would carry a Health Star Rating, making it easier for "time-poor parents [to] make quick, informed choices...without taking precious time reading labels".

Monster Health Foods Company was an early adopter of the scheme, and other manufacturers has since joined them, including Sanitarium, Nestle/Uncle Toby's, Food for Health, Goodness Superfoods, Freedom Foods, Greens General Foods, Coles home brand and Woolworths' 'Macro' brand.

The increasing adoption of the scheme by industry has despite fierce resistance from some manufacturers.

Major food companies including McCain, Mars, PepsiCo, Mondelez, George Weston and Goodman Fielder are yet to implement the scheme.

A Mondelez spokeswoman told Fairfax Media the company, which owns of Kraft, Belvita and Philadelphia, was resisting the scheme because it was flawed.

"Our view is that the concept and formula underpinning the voluntary system fails to account for individuals' dietary requirements and takes an unrealistic view of portion sizes," she said.

The resistance has come despite industry's close involvement in developing the scheme over a two-year period prior to its adoption by the nation's food and health ministers.

Industry representatives publicly expressed dissatisfaction soon after the system's formal adoption, and a Federal Health Department website promoting the Health Star Rating system was controversially taken down in early 2014 at the direction of Senator Nash's office.

The Minister's then-Chief of Staff, Alistair Furnival, who had directed the take-down, was subsequently forced to resign after it was revealed he co-owned a consultancy that had major food manufacturers among its clients.

The website was reinstated last December, a move welcomed at the time by AMA Vice President Dr Stephen Parnis, who said giving consumers quick and easy nutritional information was an important tool in helping improve food choices and reducing obesity.

Estimates suggest that almost two-thirds of adults, and a quarter of children, are overweight or obese, meaning a huge proportion of the population will be at risk of diabetes, heart disease, stroke and other complex, chronic and expensive health problems unless more is done to trim the nation's waistline.

Dr Parnis said he hoped that the Health Star Rating scheme would encourage manufacturers to reformulate their products and make them more nutritious in order to earn more stars.

Manufacturers have four years to voluntarily adopt the system, and Dr Parnis said the AMA would support a move by the Government to subsequently make it mandatory.

The Health Star Rating System website can be viewed at:

http://www.healthstarrating.gov.au/internet/healthstarrating/publishing.nsf/content/home

ADRIAN ROLLINS

Funding modern general practice

BY DR TIM ROSS, GP AND NATIONAL MEDICAL DIRECTOR, BUPA.

Dr Ross will be presenting at the AMA National Conference, Policy Session 1: *Funding quality general practice – is it time for change?* on Friday, 29 May.

The practice of medicine is facing a fundamental shift in how health care is provided.

The advent of new technologies is bringing the management of people's health back to them, in their own home, and on their own person.

Traditional general practice of GPs sitting in consulting rooms, relying on patients visiting them, will soon be an occasional, rather than core, activity in primary care. General practice must engage with community models of care, leading the guardianship of masses of health information collected by patients themselves that will allow predictive medicine and proactive management by teams of health professionals working in partnership with patients.

Similarly, funding models for the provision of health care will need to adapt to new models of care.

This is a difficult concept to address when government funding for health is at a breaking point and will not continue to be sustainable from current funding sources.

Historically, funding is provided primarily on an activity-based, one-to-one, basis, with little recognition for quality or health outcomes. Community-based management of chronic disease and some acute presentations is currently, on the whole, poorly evolved, fragmented and under-utilised.

New medical graduates are not being attracted to general practice due to continued attacks on funding and turf wars with other health professions.

But there is a key opportunity for GPs to show leadership by offering up new models of care with new models of funding.

Quality care in multidisciplinary teams is the future of primary care, and funding models will have to reflect this. While we have witnessed the demise of solo GPs, similarly the classic general practice in the suburban converted house will go the same way in the next 20 years.

GP-led primary care centres will provide community health hubs to interact with patients through numerous formats. They will evolve to include specialist rooms, day surgery, pharmacies and allied health. Some visionaries have already been operating this model for 10 years.

Young GPs have all completed postgraduate training to become a general practitioner. They wish to be rewarded appropriately for their work, to be recognised for quality outcomes, and to maintain their professional independence.

While some have the desire to own their own practices, most are happy to work within larger, well supported, multidisciplinary centres. This environment supports flexibility and the creation of their own career path. Research, teaching, procedural work, cosmetics and consulting services are all other skills that complement core general practice and broaden the career experience.

To be guaranteed a salary, as well as earning a percentage of billings, being rewarded for health outcomes, and sharing in the success of the team practice, is a viable and appropriate model for funding modern general practice.

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

Research

Sugar substitute still unproven to prevent tooth decay

There is limited evidence that a widely used sugar substitute – xylitol – is effective in preventing dental cavities in children and adults, despite wide spread claims of its effectiveness, research has found.

Xylitol is a naturally occurring alcohol found in most plant material, including many fruits and vegetables. It is widely used as a sugar substitute in sugar-free chewing gums, mints, and other lollies.

Researchers gathered data from more than 10 different studies and found that levels of tooth decay in children were 13 per cent lower in those who used a fluoride toothpaste containing xylitol for three years compared with those who used a fluoride-only toothpaste. However, the researchers suggested that these results might have only been relevant to the population studied, and there was little to no evidence of any benefit for other xylitol-containing products.

Lead researcher, Philip Riley from the University of Manchester, said "this Cochrane review was produced to assess whether or not xylitol could help prevent tooth decay in children and adults. The evidence we identified did not allow us to make any robust conclusions about the effects of xylitol, and we were unable to prove any benefit in the natural sweetener for preventing tooth decay."

The research was published in the *Cochrane Library*.

X-rays used to test effectiveness of Alzheimer's drug

Researchers from the St Vincent Institute of Medical Research have used high intensity x-ray beams to discover the structure of a drug in advanced clinical trials to combat Alzheimer's' disease.

Professor Michael Parker and his team used high intensity x-ray beams from the Macromolecular Crystallography beamlines at the Australian Synchrotron to visualise the drug's structure at a resolution powerful enough to see how the drug, which is an antibody, interacts with a toxic peptide thought to be the cause of the disease.

Professor Parker said the study explained how the drug recognised the toxic peptide and, in doing so, laid the foundation for improving the therapies. He said this level of understanding was essential and was informing the development of a second generation of drugs. "Based

on this new information, and with the success of current clinical trials, we are already developing a second generation antibody," Professor Parker said.

The research was published in *Scientific Reports*.

Lung cancer patients not getting personalised treatments

Research from a global survey of lung cancer oncologists have found that despite 81 per cent of newly diagnosed advanced non-small cell lung cancer (NSCLC) patients being tested for Epidermal Growth Factor Receptor (EGFR) mutation, the majority were not receiving personalised treatments for their cancer type and mutation subtype.

One in four advanced NSCLC patients were started on first-line treatment before their mutation test results were available. The main reason given was that results were not available in time to guide treatment decisions. Patients who have advanced EGFR-mutation lung cancer can benefit from targeted treatments, and recent research has shown that a specific targeted therapy extended overall survival of patients with the most common type of mutation (Del19) when compared to chemotherapy.

Dr James Spicer from King's College London said "on average, EGFR mutations are relatively high across the globe; however, we should be aiming for every suitable NSCLC patient to be tested, and every patient receiving an appropriate treatment for their type of lung cancer. These new survey results highlight there is still work to be done in emphasising the importance of obtaining EGFR test results prior to the initiation of treatment, and using this vital information to select optimum therapy."

The survey was conducted by Boehringer Ingelheim – for more information visit - http://lifewithlungcancer.info/egfrtesting.html

KIRSTY WATERFORD

Research

Detecting malaria – it's all in the breath

Diagnosing malaria may soon be as simple as undergoing a roadside breath test in what could be a major advance in the detection and treatment of a disease that kills more than 500,000 people every year and infects around 200 million.

A collaboration of Australian researchers from the CSIRO, the QIMR Berghofer Medical Research Institute and the Australian National University has discovered that the concentration of sulphur-containing chemicals in human breath varies with the onset and progression of malaria, opening up the possibility for a novel, cheap and effective method to diagnose the disease at an early stage.

The researchers found that chemicals normally virtually undetectable in human breath increased markedly among volunteers infected with a controlled dose of the disease.

The discovery arose out of two independent studies being conducted to test experimental malaria treatments. In the course of the investigation, the researchers identified four sulphur-containing compounds whose concentration varied over the course of the infection.

"The sulphur-containing chemicals had not previously been associated with any disease, and their concentrations changed in a consistent pattern over the course of the malaria infection," Professor James McCarthy, Senior Scientist in Clinical Tropical Medicine at QIMR Berghofer, said. "Their levels were correlated with the severity of the infection and effectively disappeared after they were cured."

CSIRO Research Group Leader Dr Stephen Trowell said what was particularly significant was that the concentration of these chemicals increased from the nascent stages of the infection, boosting the chances of very early diagnosis and treatment.

Currently, most malaria diagnoses involve drawing a blood sample and using a microscope to look for parasites – a cumbersome and invasive process that has changed little in more than 130 years.

But Dr Trowell said the discovery raised the possibility of developing a simple breath test to screen for the disease, which could make task of controlling and eventually eliminating malaria much more feasible.

The researchers have begun collaboration with colleagues in regions where malaria is endemic to see whether the technique works in the field, and work is also being undertaken to develop more cost-effective sensing equipment.

The research has been published in the *Journal of Infectious Diseases*.

ADRIAN ROLLINS

Immune system malfunction could cause Alzheimer's

US scientists have linked Alzheimer's disease to an immune system malfunction, opening up new areas of inquiry for the possible development of a cure for the debilitating disease.

Researchers from Duke University in North Carolina discovered that immune cells that normally protect the brain instead begin to consume a vital nutrient called arginine in Alzheimer's patients. When the researchers blocked this process with a drug, they were able to prevent the formation of plaques that develop in the brains of people with Alzheimer's.

The findings are based on research using mice and, while techniques tested on animals cannot be guaranteed to work the same way in humans, the discovery is seen as particularly encouraging because it reveals the previously unknown role played by the immune system and arginine in the development of Alzheimer's.

Lead researcher Professor Carol Colton from Duke University said that Alzheimer's research had been dominated by an attempt to understand the role of amyloid – the protein that builds up in the brain to form plaques – but that a focus on arginine and the immune system could yield new discoveries.

"We see this study opening doors to thinking about Alzheimer's in a completely different way, to break the stalemate of ideas in Alzheimer's disease," Professor Colton said.

"The field has been driven by amyloid for the past 15, 20 years and we have to look at other things because we still

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Research

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do not understand the mechanism of the disease or how to develop effective therapeutics."

The drug Difluromethylornith, used in the research, is already being investigated for use in cancer treatment.

There are currently 342,000 Australians living with Alzheimer's disease and 1.2 million people caring for them. Without a major medical breakthrough, it is predicted 900,000 Australians will be living with the disease by 2050.

Alzheimer's Australia chief executive Carol Bennett told the *Adelaide Advertiser* it was imperative to find a cure for the disease or at least delay its onset and progression.

The research was published in the Journal of *Neuroscience*.

KIRSTY WATERFORD

Hearing loss may be in the genes

Researchers from Los Angeles have discovered that some people may be more genetically susceptible to noise-induced hearing loss than others.

The study found that the Nox3 gene, which is almost exclusively expressed in the inner ear, is a key gene for susceptibility to noise-induced hearing loss.

Previous gene association studies on noise-reduced hearing loss in people were small, and their results had not been replicated.

Btu the University of Southern California undertook a genome-wide association study, involving a search of the entire genome to identify common genetic variants, to see if any of those variants were associated with the hearing loss trait.

Lead researcher, University of Southern California Professor Rick Friedman, said understanding the biological processes that affect susceptibility to hearing loss due to loud noise exposure was an important step in reducing the risk.

The researchers said their findings meant that those at higher, genetic risk for hearing loss could be advised to take additional precautions to protect their hearing before being exposed to hazardous volumes of noise.

"We have made great advances in hearing restoration, but nothing can compare to protecting the hearing you have and preventing hearing loss in the first place," Professor Friedman said.

The study was published in *PLOS Genetics*.

KIRSTY WATERFORD

Passive smoking linked to heart disease

It has been long known that children exposed to passive smoking are at heightened risk of respiratory illnesses, but fresh research has now also linked it to cardiovascular disease.

Researchers from the University of Tasmania have found that children exposed to parental smoking while growing up had approximately twice the risk of developing plaque in their carotid artery 26 years later.

However, they noted that children of parents who smoked but took care to minimise the exposure of their offspring had significantly lower rates of carotid plaque in adulthood than children of parents who smoked in close proximity to their children.

Arterial plaque is linked to heart disease.

Lead author Dr Costan Magnussen and collegues tracked participants in the Cardiovascular Risk in Young Finns Study who had blood samples taken in 1980 when they were aged between three and 18 years. Carotid ultrasound data collected from the same people in 2001 and 2007 was then compared with childhood cotinine levels – cotinine is a biomarker of passive smoke exposure – and information from questionaries on parental smoking behaviour.

Regardless of other factors, the risk of developing carotid plaque in adulthood was almost two times (1.7) higher in children exposed to one or two parental smokers compared with children of parents who did not smoke.

Dr Magnussen said the researchers had been able to establish that the risk to children from passive smoke extended well into their adult life, and that these risks were not confined to respiratory illnesses.

"The impact on cardiovascular health in adulthood is significant, "Dr Magnussen said.

The work by the Tasmanian team built upon research published late last year that showed that passive smoking in childhood was associated with long-term damage to the structure of arteries in adulthood.

The research was published in *Circulation*.

KIRSTY WATERFORD

TPP close to clearing major hurdle

The controversial Trans-Pacific Partnership trade deal has moved a large step toward completion after a last-minute deal between Republicans and the White House looks close to delivering President Barack Obama crucial “fast track” authority to negotiate the agreement.

The TPP, which would encompass 12 countries – including Australia - that together account for about 40 per cent of global production, has been mired in controversy over the secrecy of negotiations and concerns it will contain provisions that increase the cost of life-saving drugs by extending pharmaceutical patents and will enable companies to challenge governments that enact public health policies such as tobacco plain packaging.

Congressional leaders have agreed on the terms of a Bill that would give President Obama Trade Promotion Authority, which is crucial to the future of the TPP because it would give him the power to negotiate a deal that would be subject to a simple yes-or-no vote in Congress, with no amendments.

This would give other negotiating partners, including Australia, confidence that the negotiated terms of the agreement would not be subsequently changed by political horse-trading in Congress.

But the vote on the Bill could be close.

While most Republicans in the Congress – where they hold a majority in both chambers – are expected to support the Bill, the TPP is fiercely opposed by many Democrat members of Congress because of concerns the agreement would lead to job losses and lower wages, particularly in the country’s embattled manufacturing industry.

And analysts warn that the terms of the Bill impose lengthy delays in getting any trade accord approved, with the possibility that it might not reach Congress until October, when the selection process for presidential candidates will be well underway, increasing the risk the TPP will become a political football among presidential hopefuls.

Under the deal struck by the White House with the Republicans, the President will have to notify Congress of the accord’s completion 90 days before he intends to sign it, and the full agreement will have to be made public for 60 days before the president gives his final assent and sends it to Congress. Congress could not begin considering it for 30 days after that.

ADRIAN ROLLINS

TPP fears despite Government assurances

There is mounting disquiet the massive Trans-Pacific Partnership trade deal will saddle the country with more expensive medicines and hobble public health measures despite assurances to the contrary from the Federal Government.

Public health experts have warned a leaked draft of the deal's investments chapter show the agreement would enable companies to sue governments over public health policies that harm their interests.

La Trobe University public health expert Deborah Gleeson, Australian National University Professor of Health Equity Sharon Friel and ANU Research Fellow Kyla Tienhaara wrote in *The Conversation* that although the draft chapter contained a footnote specifying Australia would be exempt from so-called investor-state dispute settlement provisions, this exclusion was conditional and limited.

The analysis came as the World Medical Association Council passed a resolution calling on government's negotiating trade deals to ensure that public health was prioritised over commercial interests by including wide exclusions for health policies and did not include provisions that compromised access to medicines and diagnostic, therapeutic and surgical techniques.

In particular, the WMA urged governments to oppose provisions to allow patenting of diagnostic, therapeutic and surgical techniques, the prolongation of patents by making minor changes to existing drugs, and the manipulation of patent conditions to block the entry of generic substitutes.

Trade Minister Andrew Robb has insisted the Government will not sign up to any deal that make the country worse off, and has negotiated 'carve-outs' from the investment provisions for health and environmental public policy.

Senior Coalition Senator Marise Payne told the Senate on 18 March that the Government would "not accept any outcome in the TPP that would adversely affect Australia's health system".

"We will not sign up to any international agreement that restricts the Australian Government's capacity to govern in Australia's own interests," the Senator said.

But AMA Vice President Dr Stephen Parnis told the ABC's *7.30 Report* that "the details really matter here".

"If he [Mr Robb] says the PBS is protected but the agreement extends intellectual property rights or patent laws I favour of pharmaceutical companies, then the reality will be the opposite," Dr Parnis said.

Dr Gleeson and her colleagues warned that not only are carve-outs for Australia in the agreement still up for negotiation, but are they limited to specific areas such as the Pharmaceutical Benefits Scheme, the Medicare Benefits Scheme, the Therapeutic Goods Administration and the Office of the Gene Technology Regulator.

They said the very broad definition of investments used in the TPP could well leave the Commonwealth exposed to the sort of legal action launched by major tobacco companies against the country's ground-breaking plain packaging laws.

The experts said a safeguard in the draft chapter to protect actions taken by governments to protect public health and safety included a loophole of a kind that was already being used by US investors in a case against a national park in Costa Rica.

"The problems and loopholes characterising the latest leaked TPP draft throw doubt on the Government's claims that it's taking the concerns of health stakeholders as seriously as the interests of big transnationals," Dr Gleeson and her co-authors said. "They highlight exactly why it's vital for the draft text to be made public and subjected to independent scrutiny before it is signed."

ADRIAN ROLLINS

INFORMATION FOR MEMBERS

Historic collection of radiology material

Interested in the history of radiology and radiation oncology?

The Royal Australian and New Zealand College of Radiologists houses one of the largest collection of historic material in Australia.

The Trainor/Owen Collection is a combined library, archive, and museum housing unique material relating to the history of radiology and radiation oncology.

The Collection includes an original print of Roentgen's report of his discovery of X-rays, early human and veterinary X-rays, historic apparatus and equipment, mementoes and ephemera including medals and stamps, photographs, rare books and deposited personal papers.

So on your next trip to Sydney, contact the Royal Australian and New Zealand College of Radiologists Archivist to organise a visit or contact them to pick their brains over all things radiology – archives@ranzcr.edu.au, 02 9268 9725.

Devastating effects of sports concussion acknowledged in massive US settlement

Former professional gridiron players will receive up to $5 million each as part of the settlement of a major court battle over concussion in sport in the United States.

A class action brought against the National Football League (NFL) by more than 5000 former players has been settled after a federal district court judge gave final assent to deal expected to cost the organisation $US1 billion over the next 65 years.

As part of the deal, the NFL has insisted that all retired players, not just those who took part in the lawsuit, be covered by the settlement, which was originally reached in August 2013 but failed to meet judicial approval until last month when caps on total damages and medical monitoring costs were removed.

In the case, the former players accused the NFL of failing to disclose the dangers of being concussed, amid evidence that thousands have suffered serious brain damage – including degenerative brain diseases – after experiencing multiple concussions and blows to the head while playing the sport.

Critics of the deal have complained that compensation will only be paid to ex-players with a narrow range of conditions, but lawyers for the players have urged acceptance of the settlement, arguing it would have been difficult to beat the NFL in a trial.

The NFL's general counsel Jeff Pash told the *New York Times* that, "as a result of the settlement, retirees and their families will be eligible for prompt and substantial benefits, and will avoid years of costly litigation that...would have an uncertain prospect of success".

The case has been followed closely in Australia, where doctors and current and former Australian Football League and National Rugby League players have raised fears about the long-term effects of repeated concussions suffered on the sporting field.

Two years ago former elite AFL footballer Greg Williams publicly disclosed concerns about the effect repeated concussions had had on his long-term health.

Mr Williams, who retired in 1997 after playing 250 games, reported he was suffering memory loss and erratic mood swings.

He was among a group of seven former AFL and NRL players who had suffered multiple concussions during their career who were tested by Deakin University researchers and found to have symptoms of chronic traumatic encephalopathy (CTE), a degenerative condition linked to early-onset dementia.

The AFL has responded to concerns about the long-term effects of concussion by introducing rules requiring players who receive significant blows to the head to be assessed by medical staff.

Under an upgraded system introduced this year, doctors are required to examine all players who receive a knock mid-game, with trainers expected to inform doctors if they see a player injured.

The League has also moved to create a list of symptoms that will automatically rule players out of games.

The AFL said that, as a result, more players were likely to be assessed for signs of concussion during games, with medical staff given 20 minutes to conduct an assessment.

Current and retired Australian football players are yet to launch legal action similar to that of former NFL players in the US, but medical practitioners, lawyers and player agents have warned it is only a matter of time before the AFL and NRL face law suits along the same lines.

ADRIAN ROLLINS

Decision Assist is promoting best practice outcomes in end of life care

In Australia, the demographics of death are changing. Today, most people die an expected death from one or a combination of various chronic progressive conditions. As most deaths are expected, death can be planned for and required care delivered in a pre-emptive fashion.

As primary health care providers for older Australians, including those in residential aged care facilities, GPs are uniquely placed to guide patients through their end of life care journey. Although GPs often indicate that they rarely practice palliative care, the changing demographics in Australia mean that GPs are increasingly caring for greater numbers of people with advanced chronic conditions that are likely to lead to death in the near future. For this patient cohort, early identification of needs will help promote the best quality of life. Given this, it may be beneficial for GPs to reconsider how they define and practice palliative care to help their patients, with malignant and non-malignant conditions, achieve optimal outcomes.

To support GPs to deliver palliative care and advance care planning to this patient cohort, the Australian Government has funded Decision Assist. The program provides a range of clinical support and specialised education initiatives for GPs and aged care staff. Many of the GP educational opportunities are accredited with the Royal Australian College of General Practitioners (RACGP) and the Australian College of Rural and Remote Medicine (ACRRM).

The GP palliative care education activities are based on a palliative framework of care. The framework uses three prognostic trajectories, to support GPs to proactively manage their patients' care as it transitions from curative to palliative and to facilitate a quality end of life according to patient preferences. It is founded on work undertaken in the UK[i] and Australia.[ii]

The framework commences with a trigger question "Would you be surprised if the person died in the next 6 to 12 months?" which is answered by the GP using clinical knowledge, personal knowledge of the patient, clinical intuition and/or by using clinical prognostication tools. This question can be embedded into routine practice in a systematic way, for example at the 75+ health check or during regular visits by this patient cohort.

If the patient has a prognosis of greater than 6-12 months (first trajectory), the answer to the surprise question is "yes". The associated key clinical process is advance care planning, an interactive ongoing process of communication between a competent person/substitute decision maker and all carers, focussing on the person's preferences for future care.

If the patient has a prognosis of less than 6-12 months (second trajectory), the answer to the surprise question is "no". The associated key clinical process is case conferencing aiming to identify clear goals of care so that all carers are "on the same page".

In the third trajectory, a diagnosis of dying has been made with a prognosis of usually less than a week. The key clinical process is development of a terminal care management plan to support the person to die at home or in an aged care facility.

The framework promotes proactive management of clinical needs that typically emerge in the last year of life, enabling plans to be developed in accordance with the patient's personal choices.

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Decision Assist is promoting best practice outcomes in end of life care

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GP education

The framework underpins the GP palliative care educational opportunities offered through Decision Assist. These include a ***clinical audit*** for GPs that is offered by the Australian and New Zealand Society of Palliative Medicine (ANZSPM) and offered during the 2014-2016 triennium. The audit has been allocated 40 QI&CPD points with the RACGP (enables GPs to meet their quality improvement activity requirements) and 30 PRPD points with ACRRM. It is an opportunity for GPs to review their approach to managing the care of older Australians with advanced life limiting conditions living in the community.

There is a ***case-based interactive workshop*** available, which is conducted at national and state GP conferences and also through organisations that provide education to GPs. The workshop is accredited for 3 QI&CPD points with RACGP and 2 core points with ACRRM.

An ***online education module*** is offered as an alternative to the workshop, which can be accessed via gplearning (RACGP members) or RRMEO (ACRRM) members. This module is accredited for 3 QI&CPD points with RACGP and 2 core points with ACRRM.

An Active Learning Module (RACGP)/Theory Practice Activity (ACRRM), is also available and is accredited for 40 QI&CPD points with RACGP and 30 PRPD points with ACRRM. It gives GPs an opportunity to increase their capacity to manage the care of older Australians with advanced progressive life limiting conditions living in the community.

From May 2015, GPs can also participate in an **online 'case of the month' discussion**, which will be moderated by a palliative medicine physician. Cases discussed will be typical of those seen in GP practices - older patients with life limiting conditions, both malignant and non-malignant, for example COPD, heart failure, dementia, frailty syndrome.

And in late 2015, Decision Assist is also planning a series of specialist advance care planning workshops for GPs at locations around the country.

Clinical support

In addition to these educational opportunities, Decision Assist has developed a suite of resources to make it more convenient and timely for GPs to access authoritative information on advance care planning and palliative care. These include a national Phone Advisory Service – **1300 668 908** – which has specialist palliative care staff available 24/7 to provide advice on all palliative care issues ranging from symptom control and medication management, to psychosocial support and bereavement advice.

For GPs seeking assistance with advance care planning, specialist operators are available on **1300 668 908** from 8am until 8pm daily, and can answer inquiries ranging from communications needs, to documentation, ethics and legalities. To ensure GPs are well supported in instituting the palliative approach, Decision Assist is also providing specially tailored education and training opportunities for Practice Nurses and aged care employees in both advance care planning and palliative care.

Get the App

The program is also soon to release a **mobile phone app** called 'PalliAGED', which will deliver an online tool for GPs to access prescribing and management advice as well as tips for identifying older patients who could benefit from a palliative approach to care. Download details are available at www.decisionassist.org.au

The Decision Assist program has been developed and implemented by a consortium representing leading national medical, aged care and academic institutions, including Austin Health, the University of Queensland, CareSearch, Queensland University of Technology, Leading Age Services Australia (LASA), Aged and Community Services Australia (ACSA) and Palliative Care Australia.

It aims to support the important work already being done by specialist providers in the sector, and prevent unwanted interventions, including hospital admissions, to ultimately assist older Australians access the type of care that best meets their needs and wishes during the final stages of life.

More information

For more information visit www.decisionassist.org.au

i Gold Standards Framework. [cited 1 April 2015]. Available from: www.goldstandardsframework.org.au

ii The Palliative Approach Toolkit - Module 1: Integrating a palliative approach. Brisbane: The University of Queensland; 2012.

AMA Member Benefits

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

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