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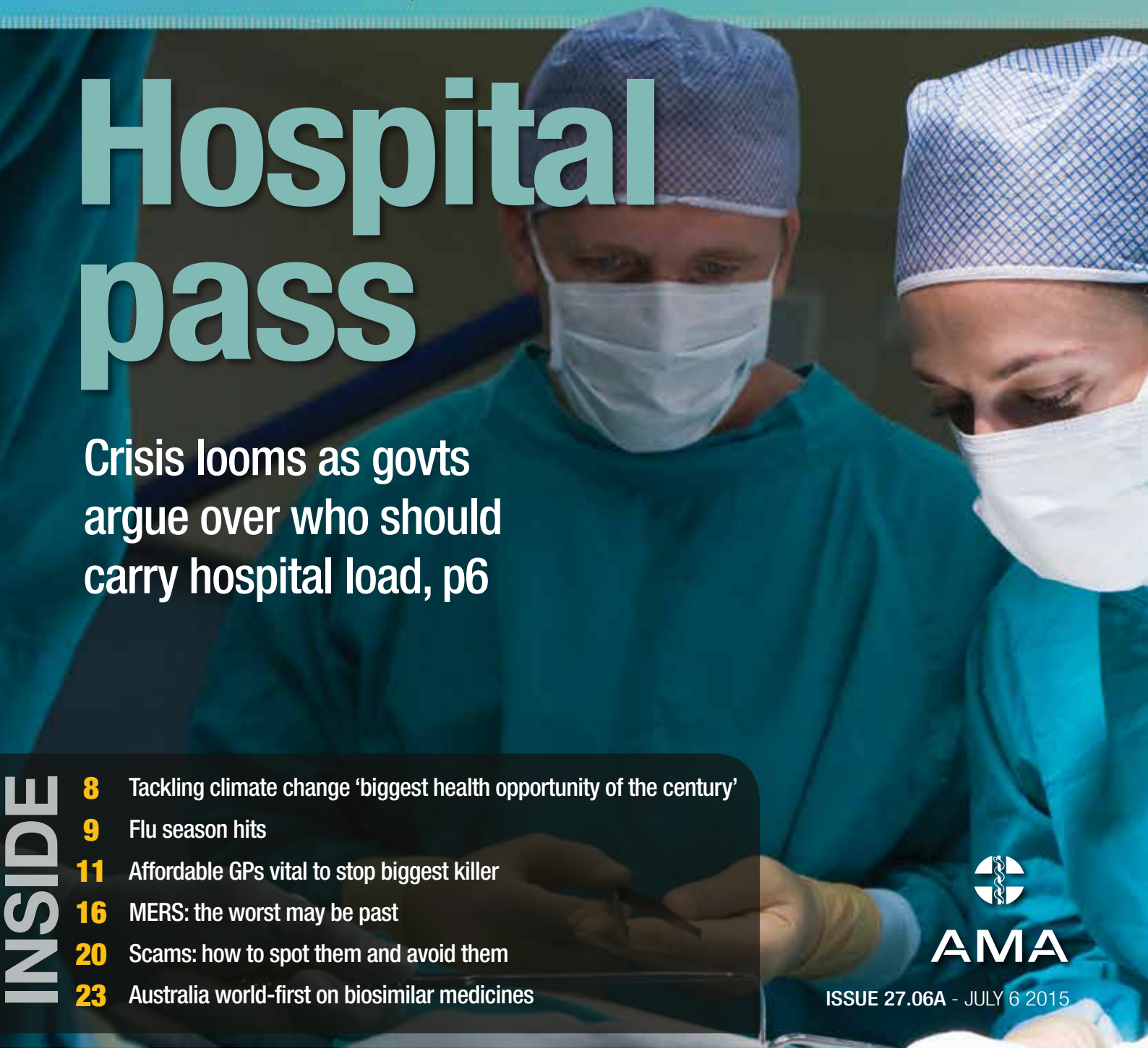

Hospital pass

Crisis looms as govts argue over who should carry hospital load, p6

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YOU AND YOUR FAMILY DOCTOR: THE BEST PARTNERSHIP IN HEALTH

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In this issue

Columns

Public hospitals – will the states attack at retreat?

BY AMA PRESIDENT ASSOCIATE PROFESSOR BRIAN OWLER

The deliberate leaking – followed by the official release - of the Federation reform green paper in the final sitting week of Parliament in June has set up a possible heated exchange between the Commonwealth and the States at the COAG Leaders' retreat, which is to be held this month at a time and place yet to be announced.

One of the five options proposed in the paper is that the States and Territories could fund and operate the hospital system themselves.

> "It is cost shifting writ large. It is the ultimate blame game – shifting the blame totally to the States"

The idea that the Commonwealth would walk away from any responsibility for public hospitals would send a chill through State Treasuries, especially the smaller States and the Territories.

It also goes against the central theme of most health reform processes of recent years, including the National Health and Hospitals Reform Commission (NHHRC), which undertook considerable community and professional consultation on the subject of public hospital funding.

This option looks like another clever economic or tax policy, not a health policy. It looks like a catalyst for a GST debate.

The priority is shifting the cost, not sharing the health care responsibility across governments.

It is cost shifting writ large. It is the ultimate blame game – shifting the blame totally to the States.

There are four other options flagged in the green paper, three of which are complex and untested.

One is for the Commonwealth and States to jointly fund individualised care packages for people with chronic and complex conditions. Another is the establishment of regional agencies to purchase health services for local populations. And another is to establish an 'MBS' schedule for public and private hospital treatments.

The fourth, of course, is for the Commonwealth to be the single funder of health services. Sound familiar? We have been down this path before without satisfactory resolution. But it is an option that remains very much alive for many health commentators.

The Federation green paper for health has not progressed much from the NHHRC recommendations.

Regardless of green papers and commissions, the fact remains that there is a funding crisis facing the States and our public hospitals.

The Government spent the last week of Parliament before the break denying that it had stripped funding from public hospitals. But the Government's own Budget papers from 2014-15 tell a different story. The AMA has been pursuing this funding cut since Budget night last year.

The Federal Government may be denying it, but the States know it is a frightening truth.

NSW Treasurer Gladys Berejiklian has acknowledged that NSW would lose about $300 million in 2017 because of projected Federal budget cuts. She said there is no doubt this is a very serious issue for the future of her State. And this warning comes from a State with a Budget in reasonable condition.

The Federal cuts to public hospital funding will hit other States much harder. The Premiers and Chief Ministers know it.

There was talk that the Premiers, led by NSW's Mike Baird, would go hard at the most recent COAG meeting, but the confrontation did not eventuate. The Prime Minister cleverly took the heat out of the situation by calling the special COAG Leaders' meeting to discuss Federation reform, primarily health and education.

That meeting is happening this month. Will the States go on the attack at the retreat? Stay tuned.

Social media and the medical profession – no longer an optional extra

BY AMA VICE PRESIDENT DR STEPHEN PARNIS

social media n.

1. websites and applications that enable users to create and share content or to participate in social networking

A lot of my colleagues keep well away from social media, and there are times when I envy them, and think nostalgically of the world of twenty or more years ago. In my AMA role, and increasingly in my clinical and teaching roles, I just don't have that luxury. In my personal life, I also find it very valuable.

By social media, I'm referring to web-based platforms for discussion and the exchange of all manner of information. The most common platforms I use are Facebook, Twitter, and Youtube, though there are many others as well.

I probably fit a typical demographic – mid-forties, married with kids, used Facebook since 2007, Youtube for probably five years, and Twitter since my college's annual scientific meeting in November 2012. All of these had a novelty value, but they have quickly become an essential part of my personal and professional communications repertoire.

The use of social media is a huge part of my daily life, and in ways I never expected it to be.

To use just a few examples, in the last few days on Twitter, I followed snippets of the Health Minister's Budget speeches, retweeted an AMA message on the link between alcohol and domestic violence, posted a series of statements for Men's Health Week, and congratulated the new American Medical Association President after watching his touching acceptance speech. I also posted photos of my kids on Facebook for family and friends, read reviews of an upcoming holiday destination, communicated with family in Europe via Facebook Chat, participated in a discussion with my colleagues at the hospital on readiness for a case of MERS, and did a refresher in CXR interpretation.

Social media presents an opportunity to access or contribute to vast amounts of information with incredible speed, and to interact with individuals or tens of millions.

As doctors, we need to understand the strengths and weaknesses of social media, because that's where our patients seek information and share opinions. It's also where, as a profession, we can learn and share knowledge in ways we are only beginning to understand – as an example, the recent phenomenon of FOAM (Free Open Access Meducation) is here to stay.

Social media presents the opportunity to educate and support millions with compelling evidence about the benefits of a healthy diet, or misguide them with pseudoscience to enable paranoia and fear about vaccinations to take hold and cause real harm.

Like anything of value, social media can be used or abused. Here's where careful consideration matters, and a few of my own thoughts about maximising the benefits and minimizing the risks of social media are that:

- critical appraisal of information is as important on a Twitter link as it is in a hard copy of a journal article;

- think twice and be certain of your reasons before posting anything critical of others, because it's impossible to erase;

- the lines between personal and professional aspects of our lives are becoming increasingly blurred, so consider your audience carefully, as there can be extensive overlap. In the same way, privacy for ourselves and others can be easily undermined; and

- social media cannot substitute for the essentials of life, such as rest, recreation and relationships.

There is much more to consider in the colliding worlds of social media and medicine. Let's take appropriate care, but recognise the opportunities that await us.

The AMA – at your service

BY AMA SECRETARY GENERAL ANNE TRIMMER

> "It became clear from the responses of members to the President's email earlier in the year on sexual harassment that many doctors were not aware of the existing service, or how to access it"

In late April, the AMA entered into an agreement with the Australian Health Practitioner Regulation Agency on behalf of the Medical Board of Australia to manage the delivery of a national doctors' health service.

While there has been a service focused on doctors' health for many years, the range of services provided varies considerably from State to State, and is not available in some.

The Medical Board is keen to ensure both medical practitioners and students have uniform access to quality care wherever they are in the country.

The AMA is well placed to manage this. A company, Doctors Health Services Pty Limited, has been established as a wholly owned subsidiary of the AMA, with a Board of five, including two independent directors. There is also an Expert Advisory Council to advise the Board on clinical and related matters.

The AMA is keen to see the service evolve with the use of a national help line and web resources that make the service readily accessible to doctors and medical students no matter where they are based.

It became clear from the responses of members to the President's email earlier in the year on sexual harassment that many doctors were not aware of the existing service, or how to access it.

Another service launched by the AMA at the recent National Conference is a CPD tracker that supports the collection and reporting of CPD points and is consistent with Medical Board of Australia reporting obligations.

The CPD tracker is currently able to support compliance with multiple College requirements, and further Colleges will be added over time - the initial focus has been on those Colleges that do not have a similar tool.

You may have seen a recent email from the President on the subject. If not, you can learn more about the CPD tracker and *doctorportal learning* (which provides educational material), by visiting www.learning.doctorportal.com.au. The CPD tracker is a free benefit for members, as is the associated educational material.

Last month, members were sent an email asking for their views in response to a short series of questions about the health impacts of climate change, in the context of the AMA's revision of its position statement on the topic.

The AMA has not polled the broader membership on a policy matter previously but, given the very divergent views on this particular issue, it is a good way to measure where members stand.

The Canadian Medical Association uses a variety of e-tools to engage with its members, including a member e-panel, to survey member views to assist the CMA in policy development, and a member outreach program to understand and act on member needs.

The AMA would like to use more direct member engagement in the future to inform policy positions.

Govt ponders radical health funding overhaul as hospital crisis looms

The Federal Government could dump all responsibility for public hospitals onto the states or pay for hospital treatment through a Medicare-style benefit scheme under radical proposals being considered ahead of a national leaders' summit to discuss reform of the Federation.

An options paper prepared by the Department of Prime Minister and Cabinet canvasses an overhaul of Commonwealth health funding arrangements that could leave the states short of $18 billion a year or seem them bypassed altogether.

The Green Paper makes five suggestions, including the Federal Government shifting full operational and funding responsibility for public hospitals onto the states and territories, the creation of an MBS-style hospital benefits scheme, jointly funded individualised patient care packages, or the establishment of a single national or regional agencies to purchase health services.

Although many of the factors forcing health costs up have little to do with the structure of the Federation, the *Reform of the Federation Green Paper 2015* said improving the way the health system was funded and operated could improve prevention and care while making better use of funds – particularly by providing funding on the basis of outcomes rather than activity.

The paper has been released as the Abbott Government engages in a high-stakes stand-off with the State and Territory governments over public hospital funding following the decision in its 2014 Budget to walk away from funding guarantees made under the National Health Reform Agreement and reducing the indexation of post-2017 funding to CPI plus population growth, ripping $57 billion out of the public hospital system over 10 years.

The inadequacy of the indexation formula has been highlighted by Australian Institute of Health and Welfare figures showing in the five years to 2013-14, hospital admissions grew by an average of 3.3 per cent a year and their expenditure rose by 4.4 per cent annually, while over the same period the population increased by just 1.6 per cent and inflation averaged less than 2.5 per cent a year.

The AMA is a fierce critic of the Budget decision, which President Professor Brian Owler warned created an "impending crisis" for the nation's public hospitals.

Professor Owler said public hospitals were facing a "perfect storm" of increasing demand, missed performance targets and major funding changes.

"The combination of these factors will have devastating consequences for our public hospital system," he told the AMA National Conference in late May.

The Federal Government has decided to withdraw around $80 billion in Commonwealth funding for hospitals and schools over the next decade to pressure the states into looking at alternate sources of revenue, including increasing the GST or broadening its base.

As the Federal, State and Territory leaders prepare to discuss such options at their retreat later this month, South Australian Premier Jay Weatherill has suggested the GST be extended to include financial services.

Professor Owler said that, whatever the funding model that might be developed, it needed to ensure public hospitals were given the resources they need to meet the growing demand for care while also providing the quality teaching and training that the next generation of doctors required.

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He said that pushing responsibility for public hospital funding back to the states and territories without providing them with the means to generate more revenue would be "irresponsible".

New South Wales Premier Mike Baird recently described public hospital funding as the most significant finance issue facing the states and territories, and Professor Owler said he was particularly concerned about prospects for the smaller jurisdictions, some of which had areas of significant disadvantage and inequitable access to care, but which had limited revenue-raising capacity to fund improvements on their own.

"If the planned changes [announced in the 2014 Budget] go ahead, there will be serious consequence for frontline clinical services," he said.

His NSW counterpart, Dr Saxon Smith, warned that if the Commonwealth persists with its 2017 indexation change, the subsequent plunge in services would be equivalent "to closing five-and-a-half hospitals the size of Westmead over the next few years".

ADRIAN ROLLINS

How to pay for health?

Government funding reform options (as set out in Department of Prime Minister and Cabinet's *Reform of the Federation 2015 Discussion Paper*)

Option 1 States and territories handed full responsibility for public hospitals – the Commonwealth would withdraw all funding

Option 2 **Hospital benefit scheme**

The Commonwealth would establish an MBS-style benefit scheme to fund a proportion of the cost of each hospital procedure, with the states and territories asked to cover any gap between benefit and service cost.

Option 3 **Individual care packages**

The Commonwealth, states and territories jointly fund individualised care packages for patients with, or at risk of developing, chronic or complex conditions.

Option 4 **Regional Purchasing Agencies**

The two tiers of government would jointly establish agencies to purchase health services for patients in their catchment areas.

Option 5 **National Health Purchasing Agency**

Commonwealth-funded agency to commission full suite of services, from primary through to acute, to meet community need.

Tackling climate biggest 'global health opportunity' in 100 years

The effects of climate change are already being felt and it presents a "potentially catastrophic" threat to human health unless urgent action is taken to rein in carbon dioxide emissions, according to a report by the respected *Lancet* Commission on Health and Climate Change.

In findings that reinforce AMA warnings about the need for governments to prepare for the inevitable health effects of climate change and extreme weather events, the *Lancet* Commission said that the world was at risk of undoing half a century of gains in global health and development.

The Commission's report, *Health and climate change: policy responses to protect public health*, warned that unless there was a change of course, the world was on track to exceed 2900 billion tonnes of carbon dioxide emissions within the next 15 to 30 years, forcing global average temperatures up by between 2.6 and 4.8 degrees Celsius by the end of the century.

But the Commission said that, rather than being viewed as a burden, addressing climate change should be seen as "the greatest global health opportunity of this century".

"Many mitigation and adaptation responses to climate change are 'no regret' options which lead to direct reductions in the burden of ill health, enhance community resilience, alleviate poverty, and address global inequity," the report said.

AMA President Professor Brian Owler said the *Lancet* report, prepared by a collaboration of European and Chinese climate scientists, geographers, social and environmental scientists, engineers, health professionals, energy policy experts and political scientists, provided further evidence on the need for global action to combat and mitigate the effects of climate change on human health.

"It is the AMA's view that climate change is a significant worldwide threat to human health that requires urgent action, and we recognise that human activity has contributed to climate change," Professor Owler said. "There is considerable evidence to encourage governments around the world to plan for the major impacts of climate change, which include extreme weather events, the spread of diseases, disrupted supplies of food and water, and threats to livelihoods and security."

Earlier this year, Professor Owler helped launch an Australian Academy of Science report, *Climate change challenges to health: Risks and opportunities*, that detailed the likely health effects of climate change, including increasingly deadly heatwaves, the spread of food and water borne illnesses and diseases like malaria, and the death and damage caused by more frequent and extreme storms, droughts and floods.

> "Governments around the world are preparing to attend the United Nations' Paris Climate Change Conference in November, and the AMA President said there was an urgent need for action"

Governments around the world are preparing to attend the United Nations' Paris Climate Change Conference in November, and the AMA President said there was an urgent need for action.

"The evidence is clear – we cannot sit back and do nothing," Professor Owler said. "Governments must prepare for the inevitable health and social effects of climate change and extreme weather events."

The *Lancet* Commission has called for the framework for an international carbon pricing mechanism to be established in the next five years, along with a rapid expansion in the use of renewables and the speedy phase out of coal-fired power.

In a rallying call for the medical community, the Commission said that, until now, health effects had been largely ignored in the international debate over climate change, but doctors needed to help lead a shift in focus that would bring the consequences of rising global temperatures into sharp relief.

"Health professionals have worked to protect against health threats such as tobacco, HIV/AIDS and polio, and have often confronted powerful entrenched interests in doing so," it said. "Likewise, they must be leaders in responding to the health threat of climate change. A public health perspective has the potential to unite all actors behind a common cause – the health and wellbeing of our families, communities and countries."

Professor Owler said the Abbott Government should use the Lancet Commission report and the Australian Academy of Science study as key references in the development of the action plan it takes to the Paris Climate Change Conference.

ADRIAN ROLLINS

Signs not good for flu season

Parts of Australia are on track for their worst flu seasons in years, with infection rates in the north and south of the country already far ahead of last year.

As at 5 June, 9213 laboratory-confirmed cases of the disease had been notified to health authorities, compared with 6225 cases at the same point last year.

Queensland (2757 confirmed cases) and South Australia (1742 cases) have, proportionately, been the hardest hit, while the rate of infections in both New South Wales and Victoria have so far been relatively low.

But the slow start to the flu season in the two most heavily populated states is little cause for complacency.

The Influenza Specialist Group warned that the flu season had not yet begun in earnest, and was likely to develop in the next four weeks.

Evidence from last year suggests there is every reason to be concerned.

While there were less than laboratory-confirmed cases by the end of May 2014, that number quickly accelerated as flu season hit, and by year's end there were 67,854 confirmed cases nationwide, almost double the long-term average of 34,523.

Promisingly, early figures suggest vaccinations are helping to reduce the number and severity of infections.

The pilot Flu Tracking surveillance system, a joint University of Newcastle, Hunter New England Area Health Service and Hunter Medical Research initiative that collects data from a weekly online survey, has so far identified only low levels of influenza infection.

But it found that 3.4 per cent of those not vaccinated against the flu suffered fevers and coughs, and 2.1 per cent had to take time off work, while among those vaccinated, 2.7 per cent had coughs and fevers and 1.6 per cent reported having to take sick leave.

The results underline calls from AMA Vice President Dr Stephen Parnis for people, particularly elderly and vulnerable patients and health professionals, to make sure they are vaccinated against the flu.

Dr Parnis said it was important for doctors, nurses and other health workers to get the flu vaccine, for the sake of their own health as well as that of their patients.

The National Seasonal Influenza Immunisation Program started late this year, the delay caused by a rush to include vaccines covering two new strains of the virus one of which caused havoc in the northern hemisphere.

In the US alone, around 100 children were reported to have died from the flu during the northern flu season, and there was also widespread illness among the elderly.

For the first time under the national immunisation program, Australians have access to single-dose vaccines covering the four most common flu viruses, including three quadrivalent formulations.

The World Health Organisation and the Australian Influenza Vaccine Committee have recommended that vaccines this year cover one existing and two new strains – the California H1N1-like virus that has been in circulation since 2010, the Switzerland H3N2-like virus and the Phuket 2013-like virus.

But Chief Medical Officer Professor Chris Baggoley has been forced to issue an urgent warning to health professionals after it was revealed that at least nine young children had been injected with the Fluvax vaccine despite explicit directions from the Government and the manufacturer that it was potentially dangerous to use on those younger than five years.

The ban has been in place since several young children given Fluvax in 2012 suffered fevers and febrile convulsions, and part of the reason for the delay in starting this year's flu immunisation program was to ensure that suitable vaccines were available for the very young.

ADRIAN ROLLINS

Deadly hitchhiker threat to young

Researchers have warned of the risk of measles outbreaks among infants, adolescents and young adults because of gaps in the nation's immunisation coverage against the potentially deadly disease.

While the World Health Organisation has declared Australia measles-free, infectious disease experts have cautioned parents and health authorities that they need to remain vigilant about maintaining high rates of vaccination because of the vulnerability of young people no longer exposed to wild versions of the infection.

A study in the Health Department's latest *Communicable Diseases Intelligence* report found the incidence of measles plummeted following the commencement of mass vaccination programs in the 1980s and 1990s, and was now at a level "consistent with elimination of indigenous measles in the country".

Since the last big outbreak in the early 1990s, when almost 10,000 people caught the disease and four died, the rate of infection has plunged. Between 2000 and 2011, 990 cases were notified but none were fatal.

However, although the disease is no longer considered to be endemic, it is still being brought into the country by people travelling from regions where it is common, raising the risk of infection for vulnerable groups, particularly the very young.

Children are not eligible for their first measles vaccine until they are 12 months, and national figures for 2000 to 2011 show the incidence of the disease was highest in this age group, reaching a peak of 3.8 per 100,000 in 2011.

Next most vulnerable were children aged between one and four years, followed by adolescents aged 10 to 19 years and young adults aged 20 to 34 years.

The authors of the study, who were from the Health Department, the National Centre for Immunisation Research and Surveillance and the Australian National University, speculated that infants could be particularly vulnerable because of a decline in maternal antibodies in women with vaccine-acquired immunity.

"It has been postulated that because measles is becoming rare, the lack of natural boosting thorough exposure to wild virus in both vaccinated women and women with past infection has consequently resulted in infants becoming more susceptible," they wrote. "It is therefore important…that timely vaccine uptake among infants occurs at the recommended 12 months of age."

They also highlighted gaps in coverage caused by the staggered introduction of mass vaccination programs in the 1980s and 1990s.

In particular, they noted that those born between 1968 and 1982 were "particularly susceptible as low vaccine coverage existed when they were infants and circulation of wild virus was becoming less common". In addition, people in this age group missed out on a second round of vaccinations for adolescents carried out between 1994 and 1998, while a 2001 immunisation campaign aimed at reaching many of them had only limited success.

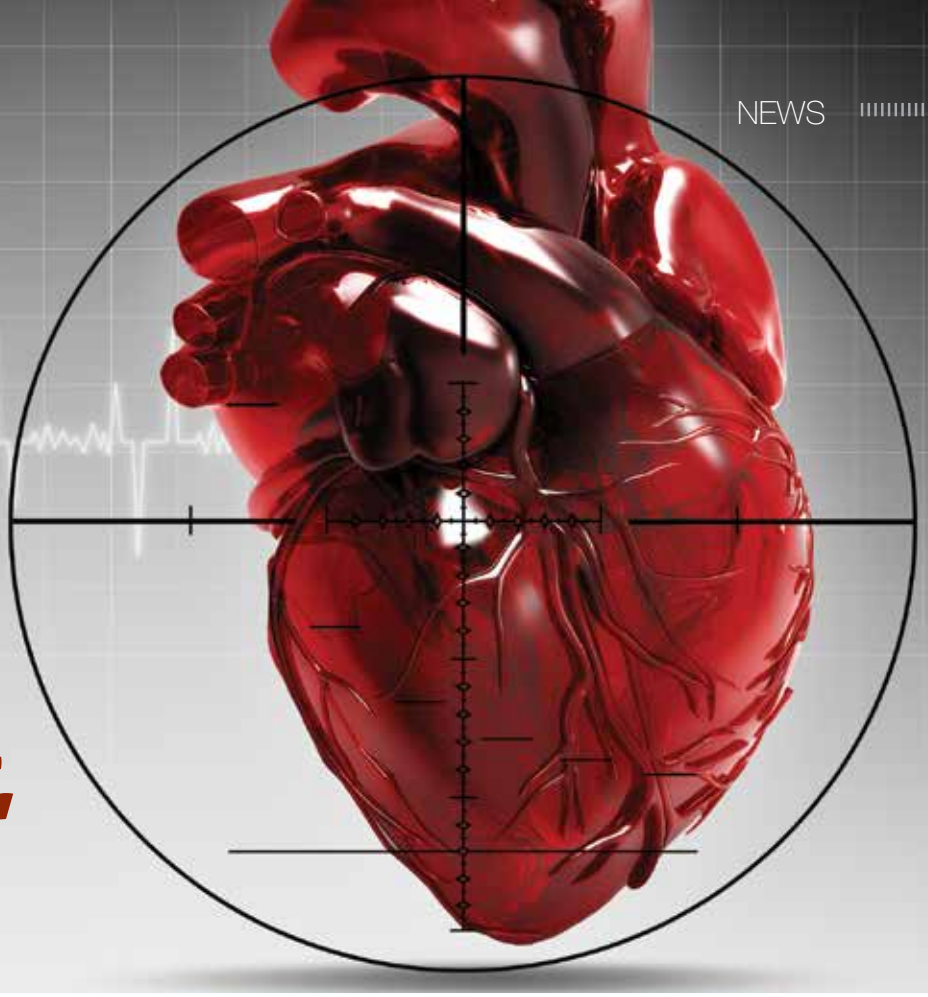
The researchers said there was a risk of under- or un-vaccinated young adults catching the disease while travelling overseas, and urged greater efforts to assess their immunity before they left the country.

"As most outbreak in Australia begin with an importation of measles from an endemic country, it is essential that measles immunity status be assessed when patients attend clinics to receive vaccinations for international travel," they said, citing research showing that just 4 per cent of travellers who attended hospital within two years of returning from abroad were vaccinated against measles, mumps and rubella.

"Clearly, age-specific vulnerability of populations exist[s], even though measles is so rare in Australia and, consequently, this may lead to outbreaks in these populations," the authors said. "Hence, there is an ongoing need to improve vaccine uptake in vulnerable populations."

ADRIAN ROLLINS

Keep GP costs down to win fight against rich world's biggest killer, OECD says



Decades of success in cutting deaths from heart attacks and strokes are at risk unless governments ensure patients have affordable access to primary health care, the Organisation for Economic Co-operation and Development has warned, adding to pressure on the Federal Government to dump its controversial freeze on Medicare rebates.

As the AMA intensifies its campaign against the four-year freeze, which is set to drive down GP bulk billing rates and force up patient out-of-pocket costs, the OECD has said that affordable and accessible primary care is essential if the world is to build upon a 60 per cent decline in the cardiovascular disease mortality rate in the past 50 years.

In a major report on cardiovascular disease and diabetes released overnight, the OECD said although massive strides had been taken in reducing deaths from cardiovascular disease (CVD), it still remained the most common cause of death in developed countries, and rising rates of obesity and diabetes threatened to slow or even reverse these gains without a greater focus on preventive health, accessible quality primary care and more effective hospital systems.

"The prospects for reducing the CVD disease burden are diminishing, and the pattern of declining mortality is coming to an end or even reversing amongst some population groups, particularly younger age groups," the *Cardiovascular Disease* and Diabetes: Policies for Better Health and Quality of Care report said. "Rising levels of obesity and diabetes are reducing our ability to make further inroads into reducing the CVD burden."

The OECD warned that, on current trends, almost 108 million adults across the OECD would have diabetes by 2030, while an extra 23 million would have greater health needs and a higher risk of complications.

The report paid much of the credit for the decline deaths from heart attacks and strokes in recent decades to public health campaigns, particularly on smoking.

All OECD countries have taken anti-tobacco measures including mass media campaigns, higher taxes, advertising bans and quit services, with the result that between 1997 and 2009 the proportion of adults lighting up daily fell from 28 to 20 per cent.

"Smoking policies have been shown to be highly effective. Tobacco control policies...have saved lives," the OECD said.

It said that although evidence about the effectiveness of Australia's world-leading tobacco plain packaging laws was still being gathered, the initiative "may provide the next set of policy instruments for governments to help further reduce the harmful impact of smoking".

But governments have so far been much less successful in curbing rates of obesity and diabetes, which the OECD said would instead revolve around the strength of a country's primary health care system.

"Primary care is the centre of the health care system, and is particularly so for CVD and diabetes," it said, emphasising the importance of affordable and accessible quality care.

Keep GP costs down to win fight against rich world's biggest killer, OECD says

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"A highly accessible primary care system has the capacity to reduce inequalities in health outcomes and deliver care to those who stand to benefit most," the report said. "This is particularly important for diseases such as diabetes, which is far more prevalent among lower socio-economic groups."

It is a timely warning as the AMA ramps up its campaign against the Federal Government's plan to freeze Medicare rebates until mid-2018.

AMA President Professor Brian Owler has criticised the policy as a "co-payment by stealth" because rising practice costs will force many GPs to dump bulk billing and charge their patients out-of-pocket fees.

Professor Owler said this was concerning because it raised the risk that patients would put off seeing their GP until their health problem became so serious it required hospitalisation.

It is a concern shared by the OECD, which warned that how primary care was funded had "enormous implications" for access to care and health.

"Higher out-of-pocket costs will lead to a lower use of primary care services, particularly among the poor," it said. "By foregoing routine visits...patients are exposed to greater risk leading to a worsening of health status.

"It is therefore essential that primary care remains highly accessible to all.

"Good access is a necessary requirement to enable primary care practitioners to have regular contacts with patients, assess patient risk, monitor progress, deliver care and adjust treatments when required."

As part of its report, the OECD examined ways to improve the quality of primary and acute care, including using digital technology to share up-to-date patient information and monitoring their health, as well as pay-for-performance schemes, better hospital access and public reports on the relative performance of hospitals and other health services.

It found that although there was some evidence that pay-for-performance schemes, under which doctors are paid for outcomes – usually in chronic and preventive care – can achieve some improvements, this is often highly contingent on a range of other conditions being in place, meaning great care had to be exercised in implementing such a payment model.

While lauding the success of recent decades in curbing CVD mortality rates, the OECD nonetheless said that it remained the "number one killer" in most member countries, and there were concerns about riding rates of obesity and diabetes, and gaps between recommended health care and that which was actually provided.

The Organisation said it was not just a matter of more money.

"The evidence on what constitutes good quality care has been in the public domain for decades, but many OECD countries are still coming to terms with the changes that need to be made in their health systems to deliver such care," it said.

The OECD said that one of the most significant challenges was to take evidence about best treatment and make it part of everyday practice.

ADRIAN ROLLINS

INFORMATION FOR MEMBERS

Free tool to track registration requirements

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

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

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

The AMA CPD Tracker can be used to:

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

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

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

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

To register for the product, please sign up here.

Australia good, but can do better, on heart disease and stroke

Australia has one of the lowest mortality rates from cardiovascular disease in the developed world, but the nation has been told it needs to consider taxes on sugar-rich and unhealthy foods to combat rising obesity and diabetes.

Australia's cardiovascular disease (CVD) mortality rate fell to 208 per 100,000 people in 2011, 30 per cent below the average among Organisation for Economic Co-operation and Development member countries of 299 per 100,000, and the potential years of life lost to circulatory diseases dipped to 372 per 100,000, 36 per cent below the OECD average of 581 per 100,000.

> "The OECD has also echoed warnings from the AMA about the dangers of deterring patients from seeing their doctor by imposing out-of-pocket costs"

In a report released overnight, the OECD attributed the nation's success in driving down deaths from heart attacks and stroke to accessible, high quality health care and effective public health policies, particularly in reducing smoking.

The Organisation said comprehensive tobacco control measures, including a hefty excise, mass media campaigns, advertising and smoking bans and, most recently, tobacco plain packaging laws, had helped drive the smoking rate down to 12.8 per cent last year, one of the lowest in the OECD and well below the average of 20.9 per cent among member countries in 2012.

But the OECD warned the nation needed to overcome several challenges if it was to cement and build upon its success in reducing CVD mortality.

It cautioned that Australia's high obesity rate - 28.3 per cent, almost double the OECD average of 18 per cent – threatened to drive up the incidence of CVD unless it was addressed, and noted that the nation's spending on preventive health measures had slipped to just 1.8 per cent of total health expenditure, well below the OECD average of 2.9 per cent.

In its first Budget, the Abbott Government abolished the Australian National Preventive Health Agency and absorbed its functions with the Health Department, heightening concerns of a loss of national focus and leadership on preventive health measures.

The OECD has also echoed warnings from the AMA about the dangers of deterring patients from seeing their doctor by imposing out-of-pocket costs.

AMA President Professor Brian Owler said the Government's four-year freeze on Medicare rebates would create a patient co-payment "by stealth" by forcing doctors to reduce bulk billing and charge out-of-pocket (OOP) expenses.

The OECD said that Australian patients already faced higher than average out-of-pocket costs, and cautioned that "higher OOP costs will lead to a lower use of primary care services, particularly among the poor".

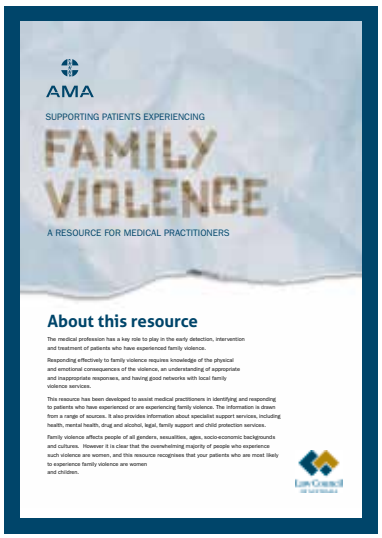
Nonetheless, the Organisation said access to primary care in Australia was "generally good", and the nation's heavy use of cholesterol-lowering drugs – the highest in the OECD – showed there was ready access to medication.

The OECD report came two days after research was published estimating that 60,000 patients stopped taking cholesterol-lowering statins after the ABC television program Catalyst questioned their safety.

The OECD said Australians with CVD had access to good quality acute care. The 30-day case-fatality rate for acute myocardial infarction patients was 4.4 per cent, one of the lowest rates in the OECD, while case-fatality for stroke patients was around the OECD average and the proportion of stroke patients treated in dedicated facilities was higher than many other comparable countries.

The OECD said the country needed to curb the rise in obesity if it was to make further inroads into CVD fatality rates, and suggested it consider measures adopted in other countries, such as taxes on unhealthy or sugar-rich food and drinks and the development of nationally-co-ordinated health promotion programs.

ADRIAN ROLLINS



Curb the drinks to cut the violence

Australian of the Year Rosie Batty has backed calls for a crackdown on sales of alcohol, including an end to 24-hour trading and a buyback of liquor licenses, as part of efforts to stamp out family violence.

Echoing the AMA's call last year for governments nationwide to take strong action to curb alcohol-related violence, Ms Batty has urged national leaders including Prime Minister Tony Abbott and Opposition leader Bill Shorten to adopt a set of proposals developed by the Foundation for Alcohol Research and Education (FARE) to reduce the saturation of alcohol in the community.

"There is not, and can never be, an acceptable level of family violence," Ms Batty said. "Prevention must be our ultimate goal, and we must do everything in our power to stop it."

Ms Batty's plea has underlined the outcomes of the National Alcohol Summit organised by the AMA last October that called for a consistent national approach to the supply and availability of alcohol, including statutory regulation of alcohol marketing and a review of taxation and pricing arrangements.

AMA President Professor Brian Owler, who convened and led the Summit, said at the time that alcohol misuse was one of the country's major health issues, with estimates that the damage it caused through violence, traffic accidents, domestic assaults, poor health, absenteeism and premature death, cost the community up to $36 billion a year.

"Alcohol-related harm pervades society. It is a problem that deserves a nationally consistent response and strategy," Professor Owler said.

In recognition of the fact that often family doctors are the first port of call for victims of domestic violence, the AMA, in conjunction with the Law Council of Australia, last month released a toolkit providing guidance and resources for GPs in helping patients who have been attacked by their partners.

The *Supporting parents experiencing family violence – a resource for medical practitioners* toolkit can be downloaded at: https://ama.com.au/article/ama-family-violence-resource

The plan to prevent alcohol-related family violence developed by FARE, launched by Ms Batty on 17 June, calls for those applying for liquor licenses to be subject to more stringent approval process, a restriction on trading hours, a liquor licensing freeze or buybacks in saturated areas, an end to 24 hour licences and an extra levy on alcohol to help pay for the costs incurred by governments in responding to family violence.

FARE said alcohol was a factor in 65 per cent of family violence incidents reported to police and almost half of child abuse cases. In addition, more than a third of those who murdered their partner had been drinking prior to the attack.

Chief Executive Michael Thorn said a tough problem called for tough solutions.

"Alcohol's involvement in family violence is undeniable," Mr Thorn said. "Governments must acknowledge the vast research and the irrefutable evidence that clearly links the availability of alcohol with family violence, and act accordingly. In practice, that means putting public interests ahead of the alcohol industry and being prepared to say no to liquor licence applications that put people at greater risk of harm."

The FARE plan echoes the recommendations of last year's AMA Summit in emphasising measures aimed at preventing alcohol-related harm while simultaneously urging ongoing funding for vital alcohol support and treatment services.

Professor Owler said that although individuals and communities had a role to play, governments – particularly the Commonwealth – needed to be far more active in tackling the issue.

"Too many times we hear that it's all about personal responsibility. It's rubbish," Professor Owler said. "Personal responsibility is important, but we can't rely on the personal choices of others for our own safety and health. Governments can influence behaviour through deterrents but, most importantly and more effectively, through shaping individual and societal attitudes to alcohol."

For more information on the AMA National Alcohol Summit, visit: https://ama.com.au/ausmed/end-cheap-grog-and-saturation-marketing-alcohol-summit-tells-govt

The National Alcohol Summit communique can be viewed at: https://ama.com.au/media/ama-national-alcohol-summit-communique

ADRIAN ROLLINS

Bad hearts, poor kidneys cause many an early death

Indigenous people are more than twice as likely as other Australians to report they are in poor health, suffering disproportionately high rates of chronic and life-threatening diseases and impairments that have a significant effect on their quality of life.

> "Cardiovascular disease is the biggest killer, causing a quarter of all Indigenous deaths between 2008 and 2012"

In a sobering reminder of just how far there is to go to close the health gap between Indigenous and on-Indigenous Australians, the Australian Institute of Health and Welfare has reported that Aboriginal and Torres Strait Islander people are far more likely to have cardiovascular diseases, breathing problems, mental illness, diabetes, kidney disease, and to have problems with their hearing and sight.

Underlining the scale of the health problems afflicting Indigenous Australians, the Institute estimated that each year they collectively lose 100,000 years of life to premature deaths caused by chronic diseases, disability and injuries.

Cardiovascular disease is the biggest killer, causing a quarter of all Indigenous deaths between 2008 and 2012, followed by cancer (20 per cent of deaths) and injuries and poisonings (15 per cent).

But, in some respects, the burden of diabetes weighs even more heavily on the Aboriginal and Torres Strait Islander community.

The Institute's *The health and welfare of Australia's Aboriginal and Torres Strait Islander peoples 2015 report* (http://www.aihw.gov.au/publication-detail/?id=60129550168) shows 11 per cent of Indigenous adults had diabetes in 2012-13, while a further 4.7 per cent were at risk of developing the disease.

Related to this, almost 2 per cent had long-term kidney disease – almost four times the rate of the broader community.

This comes at an enormous cost to the community. In 2012-13 alone, Indigenous adults were hospitalised almost 175,000 times because of chronic kidney disease, almost all of them to undergo same-day dialysis. In all, this accounted for almost half of all hospitalisations of Aboriginal and Torres Strait Islanders.

The health disparity between Indigenous Australians and the rest of the community were further underlined by a separate Institute report showing Aboriginal women were twice as likely to die because of complications arising from pregnancy and childbirth.

Between 2008 and 2012, 105 women died from complications of pregnancy and childbirth, a rate of 7.1 deaths per 100,000 women. But among Indigenous women the rate (13.8 per 100,000) was double that among non-Indigenous mothers (6.6 per 100,000).

The results have highlighted calls from the AMA and other health groups for governments around the country to redouble their efforts to the close the health gap.

AMA President Professor Brian Owler said that although there had been some encouraging improvements in child and maternal health, much more needed to be done.

Professor Owler said recently that access to primary health care was especially important in addressing Indigenous disadvantage.

"Achieving equality in health and life expectancy for Aboriginal and Torres Strait Islander peoples is a national priority, but there is still a way to go before we see meaningful and lasting improvements," the AMA President said. "There is a need for a concerted effort to fund and resource primary health care service providers to detect, treat, and manage chronic health conditions in Aboriginal and Torres Strait Islander communities."

He said the Federal Government should immediately scrap the Medicare rebate freeze, which would hit Aboriginal community controlled health services and Aboriginal Medical Services particularly hard and hold back efforts to close the gap.

National Aboriginal Community Controlled Health Organisation Chair Matthew Cooke said that, despite some progress in reducing infant mortality, the Institute report highlighted continuing major shortcomings, including for teenagers.

The report found Indigenous children aged between 15 and 18 years were far more likely to be imprisoned than their non-Indigenous counterparts, and were five times more likely to take their own lives.

ADRIAN ROLLINS

MERS: worst may be past

The World Health Organisation has indicated that the Middle East Respiratory Syndrome (MERS) outbreak that as at late last month had claimed 27 lives in South Korea may have passed its peak.

While warning that it was critical health authorities closely monitor the situation, the WHO's Emergency Committee has nonetheless declared that South Korean efforts to track and quarantine infected people had "coincided with a decline in the incidence of cases".

Since the first case was reported in South Korea in May, 172 people in the North Asian country are confirmed to have been infected with MERS, and almost 6000 were placed in quarantine at home or in medical facilities.

Fears that the disease might spread further in the region were fuelled when Thai officials reported a visiting businessman from Oman had fallen ill with the disease, and 59 people who had been in contact with have been placed in quarantine and no further infections have been confirmed.

The WHO praised South Korean health authorities for rapidly alerting their Chinese counterparts about an infected traveller, who was quickly located and isolated.

The World Health Organisation's Emergency Committee, which met late last month to discuss the outbreak, said it was not yet serious enough to warrant the declaration of a public health emergency, and advised that travel restrictions and airport screening were not necessary.

Nonetheless, the Committee warned the outbreak was "a wake-up call" for governments about the speed with which serious infectious diseases could spread "in a highly mobile world".

"All countries should always be prepared for the unanticipated possibility of outbreaks of this and other serious infectious diseases," it said. "The situation highlights the need to strengthen collaboration between health and other key sectors, such as aviation, and to enhance communication processes."

No cases have been reported in Australia, and a Federal Health Department spokeswoman said the risk of MERS arriving in Australia was considered to be low, at least for the time being.

But health and border protection authorities are on alert for the disease, and the Federal Government is planning to warn Australians travelling overseas, particularly to the Middle East as part of the Hajj pilgrimage, about MERS and what precautions they need to take to minimise the chances of infection.

Though Korean authorities have been praised for the strength of recent actions to control the spread of MERS, serious shortcomings in their initial response have been blamed for helping the outbreak gain momentum.

The WHO Emergency Committee detailed a number of factors that helped the disease spread, including ignorance of MERS among health workers and the broader public; "suboptimal" infection prevention and control measures in hospitals; keeping patients infected with MERS in crowded emergency departments and wards for extended periods; the behaviour of patients in going to several different doctors and hospitals for treatment; and the custom of family and friends staying with their infected loved ones in hospital.

"There are still many gaps in knowledge regarding the transmission of this virus between people, including the potential role of environmental contamination, poor ventilation and other factors," the Committee said, though adding that there was no evidence of sustained transmission in the community.

ADRIAN ROLLINS

INFORMATION FOR MEMBERS

Essential GP tools at the click of a button

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

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

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

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

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

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

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

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

Pharmacists too risky for the pill

A push to allow pharmacists to supply the pill without prescription has been knocked back amid concerns it would increase health risks and encourage misuse of the medication.

In a decision welcomed by the AMA as a victory for women's health, Health Department Secretary Martin Bowles has rejected a suggestion that prescription-only oral contraceptives be rescheduled as schedule 3 medicines, which would allow women to bypass their doctor to get a new supply.

The proposal was made amid efforts to expand the scope of pharmacist practice, with proponents arguing that, following an initial consultation with their GP, women should be able to get oral contraceptives on demand from a pharmacist, which would be more convenient for them and less costly for the Government.

Under the plan, pharmacists would be able to supply the pill after conducting a blood pressure check and running through a checklist to identify any potential risks or contraindications.

But the AMA condemned the idea, warning that it would put women at risk because pharmacists did not have the skills or training to assess and monitor the health of those taking oral contraceptives.

In a submission to the Therapeutic Goods Administration's Advisory Committee on Medicines Scheduling, the AMA argued that taking oral contraceptives was not without risk, so their use needed to be carefully considered and regularly monitored by skilled practitioners.

Documented side effects of the pill include blood clots, stroke, heart attack and diabetes, all of which are exacerbated by smoking.

"Assessment and monitoring by medical practitioners of women considering oral contraceptives is essential to ensure risks are minimised," the AMA submission said. "This requires an initial, and then episodic, medical consultation/s to assess whether it is appropriate to start, continue, change or even cease an oral contraceptive and replace it with another contraceptive option."

The Association warned that pharmacists had neither the skills nor training to make these decisions, and trying to capture all these considerations with a questionnaire grossly underestimated the complexity of the assessment involved.

The AMA added that a pharmacy was "not the place" for such detailed and sensitive discussions.

In ruling to maintain the status quo, Mr Bowles accepted arguments that pharmacists did not have the training to assess patients, noting that during the first 12 months risks could be particularly acute, and that using the pill might mask more serious health issues including migraine, thrombosis, stroke and cancer.

The Health Department Secretary also raised concerns about a heightened potential for misuse of the medication, including the possibility that women might try to get the pill under false pretences, or use it inappropriately, such as to treat painful heavy bleeding, which could lead to future fertility problems.

Mr Bowles was dismissive of suggestions a checklist could be used as a substitute to assessment by a trained medical practitioner: "The use of a checklist is not considered an adequate alternative to comprehensive medical evaluations."

He has issued an interim decision that the current listing of oral contraceptives as schedule 4 medicines "remains appropriate".

ADRIAN ROLLINS

'Cracking good' team supports life of service

Dr David Hollands

A rural GP with a "cracking good" health team and a life-long fascination with the life of birds is among AMA members recognised in the 2015 Queen's Birthday honours.

Dr David Hollands who, with his wife Margaret, has lived and worked in the east Victorian town of Orbost more than 50 years, was awarded a Medal of the Order of Australia for his many decades of service to his community, as well as his enormous contribution to ornithology.

In an interview with his local newspaper, the *East Gippsland News*, Dr Hollands recalled how, when he and his wife first arrived in Orbost not long after migrating from Britain, local doctors were expected to do "almost everything", from delivering babies and stitching up cuts to dealing with major trauma cases.

"There was nothing like the air ambulance or helicopter evacuations," he told the East Gippsland News. "People expected that the local doctor would cope with almost everything."

Dr Hollands was among 20 GPs, specialists, researchers and educators recognised for their significant contributions to the health of the community and their services to medicine in the Queen's Birthday Honours List.

AMA President Professor Brian Owler said the diversity and breadth of the accomplishments cited in the awards were testament to the significant contribution to the community made by medical practitioners every day.

Among the recipients is South Australian GP Dr Anh-Tuan Ngo, who had been a doctor in the South Vietnamese army and came to Australia as a refugee with his family in 1984. Since arriving in Australia, Dr Ngo has worked tirelessly, not only to look after his patients, but to serve the local Vietnamese community and support other veterans of the Vietnam War.

Another to be made a Member of the Order of Australia was Victorian GP Dr Barry Christopher who, in addition to his work as a doctor, campaigned for decades to advance Indigenous rights.

In the late 1950s, Dr Christopher became President of the Victorian Council for Aboriginal Rights, and was a founding member of the Federal Council for the Advancement of Aborigines and Torres Strait Islanders.

Dr Hollands' experience is indicative of how important is the role performed by many doctors in their community.

Working in an area that included 35 saw mills as well as major interstate roads, Dr Hollands and his wife – also a doctor – saw plenty of horrific accidents.

"Industrial health and safety was non-existent and alcoholism was absolutely rife – people would arrive at work on Monday still half pickled. So we had an enormous amount of trauma," he said, adding that the number and severity of road accidents they attended were "just incredible".

He recounted how 35 people were injured when a tourist bus overturned late at night, and he and another doctor worked for 48 hours straight at the Orbost Hospital, "non-stop setting fractures and sticking tubes in chests and sewing people up".

Asked about his award, he said that although receiving it was "very nice", much was due to a "cracking good team", including his wife, two other doctors and devoted and capable nursing and surgery staff.

In addition to his medical work, Dr Hollands has also been recognised for his enormous contribution to the study of birds.

He told the *East Gippsland News* of his life-long fascination with ornithology, and his is the author of numerous books including *Owls, Frogmouths and Nightjars of Australia, Owls – Journeys Around the World*, and *Kingfishers and Kookaburras*.

"I've been a fanatical birder since about eight, so I'm getting an award for something I really love doing," Dr Hollands said.

Professor Owler said Dr Hollands, Dr Ngo and Dr Christopher were examples of the major contribution made by many AMA members to aspects of life well beyond medicine, and were deserved recipients of Queen's Birthday Honours.

ADRIAN ROLLINS

Flawed broadcast prompts thousands to dump vital drug

Almost 3000 people are at heightened risk of a fatal heart attack or stroke as the result of the broadcast of a controversial television program questioning the safety of prescribed cholesterol-lowering medications.

A University of Sydney study published in the *Medical Journal of Australia* has estimated that around 60,000 people stopped taking prescribed statins immediately after the ABC's Catalyst science program in October 2013 called into question the link between cholesterol and heart disease and included claims that statins were toxic.

The Sydney University researchers found that in the weeks after the two-part program was broadcast, the number of statins being dispensed dropped by 2.6 per cent – and by more than 6 per cent among patients not taking other medications – and that the effect was sustained.

The researchers warned that the "significant and sustained" decline in statins dispensing following the *Catalyst* broadcast meant it was likely that 60,897 people had stopped taking their medication, potentially causing preventable – and possibly fatal – major vascular events in up to 2900 people.

"The prevalence of statin use in Australia, and the established efficacy of these drugs, means that a large number of people are affected, and may suffer unnecessary consequences," they warned.

Claims made in the *Catalyst* program about the usefulness and safety of statins are at odds with established medical advice and were met with a storm of criticism from health experts.

The ABC subsequently withdrew the program after an internal review judged that it had breached standards on impartiality.

But there are signs that the show has had a long-lasting effect on perceptions regarding the safety of statins. The Sydney University researchers said that, as at mid-2014, there was no sign of a rebound in the dispensing of statins after the sudden drop following the Catalyst broadcast.

The phenomenon has underlined the need for the media to be very careful about the way they report health issues.

The number of statins dispensed dipped sharply in 2012 following publication of a story about the risk of diabetes and dementia associated with statins use, and a 2007 news broadcast associating osteonecrosis of the jaw with bisphosphonate use provoked a 30,000 plunge in prescriptions.

NPS MedicineWise, which advises on the safe and effective use of drugs, has urged patients who have stopped taking their statins after watching the *Catalyst* program to immediately see their doctor.

Chief Executive Dr Lynn Weekes said that although all medicines carried risks as well as benefits, "we also know it's very clear that people at high risk of a heart attack or stroke benefit substantially from statins".

"It is worrying...that such a large number of people have stopped taking their prescribed statins," Dr Weekes said. "Someone prescribed a statin is likely to be at higher risk of stroke or heart attack. For these medicines to reduce that risk, they need to be taken every day, and for the long term."

ADRIAN ROLLINS

Scamming scammers and the scams they peddle

- a users guide to spotting and avoiding scams

BY JOHN ALATI, FEDERAL AMA SENIOR INDUSTRIAL AND LEGAL ADVISER

Anyone with an email address has probably at some point received an unsolicited offer, often from someone claiming to be in Africa, to unlock a multi-million dollar reward simply by providing their bank account details.

It is a well-known and fairly transparent scam that has been tried virtually from the moment the internet came into existence.

But the "art" of scamming has evolved, and scammers are using increasingly sophisticated ruses and techniques to bully or trick people out of their money.

The AMA is constantly on alert to scams and dubious business practices that target small businesses – especially doctors.

Doctors are very busy and may have little time to devote to invoices and requests for payment, particularly for amounts that appear small. However, it is worth taking the time to reflect and check on any business offer or 'invoice' that seems dubious. Don't just pay it regardless of how demanding or 'official' it appears.

With so much personal, professional and business information available on the internet it is not hard for scammers to trawl websites, aggregate information and present it in official looking correspondence. There may be information available about you and your business on the internet that you did not know is publicly available.

Some of the more well-known scams that have targeted medical practices include:

Directory listings

For example, the 'Australasian Health Professionals Directory' – based overseas, it bills medical practices for a listing on its website. Many practices were approached with the offer of a free listing in the directory, but the fine print of the contract showed that the listing in fact costs $1300 a year for a minimum of three years, and would continue for a further year if not cancelled.

Scamming scammers and the scams they peddle

... from p20

Honour societies

Some honour societies are well known and it may suit some people to respond positively to an invitation to join them. However, some are simply scams which will start you on some type of 'free' membership, then try to hard sell you, flatter you or scam you into purchasing a high level, very expensive membership, trying to convince you it is appropriate for your professional and personal status. Think very carefully about whether these societies are legitimate and can offer you anything of value.

In recent months, a number of other scams have emerged.

Trademark renewal scam

Essentially a directory listing scam, this dubious practice involves correspondence suggesting that a business trademark need to be renewed. The information these scammers obtain is publicly available on the IP Australia website. Renewal is normally done through IP Australia: http://www.ipaustralia.gov.au/, but a number of overseas-based entities offer a 'trademark listing' service which is most likely to be worthless to Australian businesses. IP Australia has a list of 'unsolicited IP services' on its website: http://www.ipaustralia.gov.au/ip-infringement/unsolicited-ip-services/.

Arrest scam

In April we were contacted by the Australian Crime Commission (ACC) and advised of a scam targeting doctors. It involves persons calling doctors, purporting to be a an 'officer', 'agent' or 'sergeant' from the ACC, stating that there was an outstanding warrant for the doctor's arrest and that she or he had to pay money to the caller or the police would attend shortly to arrest them. Of course, this was a scam.

Tax debt scam

We have not had specific information about this scam targeting doctors but it does target individuals and businesses, so it could affect doctors. This scam is similar to the ACC scam above. It involves people calling purporting to be from the Australian Taxation Office (ATO) attempting to force people to pay a fake tax debt over the phone and threatening arrest if they don't comply. It seems the callers can be very aggressive. This scam may be particularly menacing for those who believe they may legitimately

owe money to the ATO. The ATO does make contact with people by phone in some circumstances, but staff would always provide their name and affiliation. ATO staff do not threaten jail or arrest if people do not pay when contacted. The ATO does not demand that people load money onto a prepay card at the post office. If you have doubts, you can confirm the name and title of the caller and call the ATO switchboard to speak with that person.

Some scammers will simply take your money and run, and you'll never hear from them again. In order to stay just within the law some will provide a dubious service or even a product but it will be of little or no value. Websites that create lists are a classic example of this. This makes it very difficult to challenge them as their practices may be legal in the sense that you are getting something for your money, but they are far from ethical.

Often these services are based overseas, so pursuing legal rights against them would be a very difficult, expensive and probably futile exercise. Some of the risks involved in being the victim of a scam or dubious business practice include:

- expending money, sometimes significant sums of money on nothing of value;
- great stress and time involved in dealing with the consequences of a scam;
- giving your personal information to overseas entities that will not adhere to Australian privacy laws;
- identity theft; and
- ongoing uncertainty about what information scammers have about you.

... from p21

How to spot a scam

There are several behaviours and characteristics that should put you on alert for a possible scam, including:

- People who 'cold call', making contact with you out of the blue to sell you something or demand payment. This form of contact is particularly risky.
- People who try to pressure you into signing now – using lines such as 'this offer is only available today'. High pressure selling may indicate a scam.
- People who insist that someone in your practice has previously authorized a particular purchase. This is a classic scam.
- Companies based overseas with no local address or agent, or Australian businesses with no street address. This is often a sign that a business does not want to be traced. However, be careful as there are services available in Australian capital cities which will provide a street address for the purposes of correspondence, but which are little more than a mail processing centre and not an actual business address.
- Businesses that try to make out that you have 'won' something or have been 'chosen'.
- People who tell you that you should sign a document, but 'it isn't binding'. If anyone wants you to sign something, it is usually intended to be binding.
- Pre-populated forms requesting payment for something that you were not expecting. Check these carefully.
- Fine print on a form that really is too fine to read. Enlarge it on a photocopier and read it! You might be shocked at what you see.
- Scammers usually want your signature on a piece of paper. Do not be rushed into signing anything. Beware of documents that seem to be asking you to simply sign to confirm that your name and address details are correct. There may be more to it and you may be committing to something you did not realise.
- Many dubious agreements will not use a dollar sign ($) anywhere on the document because this is what our eyes tend to scan for. Instead they use the term 'AUD' which is less likely to be picked up with a quick scan.

Some ways to minimise the risk of being scammed:

- Do not give your credit card or bank account details to any person unless you are absolutely sure they are legitimate.
- Train your staff to recognize problems and potential scams. It is often junior staff that scammers target.
- Make sure you have procedures in place to clarify who can sign for purchases or any document on behalf of the practice.
- Have salespeople put everything to you in writing. If they are legitimate they will have no problem setting out their proposition in an email.
- You may find it helpful to refuse cold calls, just like you can refuse junk mail. Of course, make sure you are not hanging up on patients.
- Return any unsolicited goods unopened, to the sender. Note the time and date of doing so. Take a photograph of the goods. Keep copies of any correspondence that scammers send you.
- Check a company's ABN or ACN on the ASIC website. This is not a guarantee of legitimacy but it means a company is registered in Australia and may at least be traceable.
- Be careful of scammers who send you a document then make a follow up phone call. Regardless of what you say to them on the phone, they may use the contact to 'confirm an order', especially if they manage to get the name of someone in your practice. Remember, scammers have no hesitation in lying about what was said over the phone.
- If you are thinking of dealing with a company that you have not previously dealt with, check with other practices or colleagues in your area to see if they have dealt with the company in question, and what their experience has been.
- Regularly check the Scamwatch website: http://www.scamwatch.gov.au/content/index.phtml/tag/SmallBusinessScams
- Never agree to anything on the spot. Always take time to consider your options, do some research and make a calm, considered decision as to whether the product or service on offer is worth the price, or indeed anything at all. You can also ask the caller where they obtained your information, but don't expect a straight answer.

The AMA is always interested in hearing about scams, rip-offs and other dubious business practices, and will always alert members when we become aware of them. If you have any queries or personal experiences, please contact the AMA.

Australia takes world lead in 'biosimilar' use

Pharmacists will be able to supply patients with similar versions of prescribed medicines following a world-first recommendation by the influential Pharmaceutical Benefits Advisory Committee.

In a decision that has dismayed some health advocates, the Committee has advised that drugs that are found to act in the same way as a patented medicine can be offered to patients as a substitute when they are having their prescription filled.

The use of so-called 'biosimilar' pharmaceuticals is clouded in controversy amid concerns that there is limited evidence as to the safety and efficacy of the practice, and the possibility that neither patients nor the prescribing doctor may be fully aware of what drug is being used.

> "... the fact that many expensive and widely-used medicines were coming off-patent in the next five to 10 years provided an opportunity for companies to make more affordable biosimilar drugs"

But, though Health Minister Sussan Ley has been at pains to distance herself from the PBAC's decision-making process, she has made it clear that its recommendation complements the Federal Government's efforts to hold down growth in Pharmaceutical Benefits Scheme spending by encouraging the use of cheaper alternatives to off-patent drugs.

The PBAC said the safety of patients was paramount, and only biosimilar medicines that had been approved by the drugs watchdog, the Therapeutic Goods Administration, as a safe and equally effective treatment would be considered for listing on the PBS.

Already, pharmacists can suggest the use of generic medicines as a substitute for an off-patent prescription drug. But, unlike generics – which are usually formulated exactly the same as the original patented medicine – biosimilars act in the same way as the original 'biologic', but may be slightly different.

The PBAC was keen to reassure the public that although biosimilars might not be exactly the same as the original drug, "we would not [be] recommending them as substitutable with each other unless the PBAC is sure of their equal safety and effectiveness".

It said the fact that many expensive and widely-used medicines were coming off-patent in the next five to 10 years provided an opportunity for companies to make more affordable biosimilar drugs.

Ms Ley said the recent rapid growth in the use of biologic medicines, some costing many thousands of dollars per treatment, meant it was essential the both the Government and regulators have policies in place to make the best possible use of scarce health funds.

The Health Minister said patients would not be compelled to choose a cheaper treatment.

"Doctors and specialists would continue to have a say over whether or not substitution should occur for a patient when writing their script," she said, adding that patients would continue to have the ultimate choice over whether they receive the original patented medicine or a biosimilar substitute.

Both the PBAC and the Government are worried that the introduction of biosimilars may become clouded by the spread of what they consider misinformation, as has occurred in other countries.

But some critics argue Australia is being too hasty in allowing the use of biosimilars.

The Australian Rheumatology Association believes not enough account has been taken of the potential risks of using biosimilar drugs.

President Dr Mona Marabani detailed a number of concerns, including the possibility that the prescribing doctor and their patient may not know exactly what drug was being given; that a patient's immune system might react to a change in drug; that little is known about the safety of switching multiple drugs; and that there is scant evidence about the use of biosimilar drugs on people with auto-immune arthritis.

Dr Marabani said other countries like the United Kingdom – where automatic substitution of drugs by pharmacists is not allowed and they are obliged to supply the product specified on the prescription – had taken a more cautious approach.

"This proposed possibility of random, multiple drug substitutions is charting new territory," Dr Marabani warned, adding that although the Association had "no problem" with patients embarking on a course of treatment using a biosimilar, "but we do not support a system permitting multiple substitutions of drugs, because the consequences are unknown."

ADRIAN ROLLINS

Rubella, mumps could soon be history

Rubella has been all-but eliminated and the country may be close to getting rid of mumps amid evidence of an increase in vaccination rates.

Research published by the Commonwealth Health Department in its latest *Communicable Diseases Intelligence* report suggests that rubella, a mild infection in adults that can nonetheless cause severe congenital abnormalities in unborn babies, is no longer endemic, while the country is close to eliminating mumps despite a recent upsurge in notifications of the disease.

Four years after the Americas were declared rubella-free, researchers from the National Centre for Immunisation Research and Surveillance said it was now so rare in Australia – aside from cases involving infections imported from overseas - that arguably the country met all the criteria for the World Health Organisation to declare it eliminated.

To be declared rubella-free, a country or region must have a low incidence of infection, with only sporadic imported cases with limited spread, high levels of immunity and a robust immunisation program.

Between the mid-1990s and 2005 the average annual notification rate for the disease tumbled from 14.8 per 100,000 to 0.23 per 100,000 by 2005, and there have been just two reported cases of congenital rubella syndrome since 2008. The proportion of imported rubella cases, meanwhile, climbed from 9 to 27 per cent between 2005 and 2012, and the immunisation rate has held above 91 per cent.

The researchers said it only remained to improve surveillance, including genotyping infections to establish their origin, to demonstrate the absence of endemic strains and have Australia declared rubella-free.

Researchers have also held out hope that mumps may soon be eliminated from Australia, if it is not already.

Mumps became a notifiable disease in 2001, and its incidence peaked at 2.8 per 100,000 in 2007 before slipping below 1 per 100,000 by 2012.

As with other countries, there has been an increase in the average age of people with mumps following the introduction of universal child vaccination in 1989. Between 2008 and 2012, it was much more common among 25 to 34-year-olds (1.7 cases per 100,000) than among young children. Those aged one to four years had the lowest incidence, just 0.5 per 100,000.

But researchers admitted that, despite high vaccination coverage against mumps (94 per cent for the first dose of the measles, mumps, rubella vaccine and 90 per cent for the second dose), there was an increasing trend in mumps notifications and the likelihood its incidence was being under-reported.

Nevertheless, that said it was possible that Australia was among those countries to have achieved, or come close to, eliminating the disease, adding that, “sporadic outbreaks in highly vaccinated populations may be due to the force of infection after virus introduction from an endemic area into high-density, high contact environments”.

They concluded that the trend toward increased notifications required careful monitoring.

The possibility that rubella and mumps may soon be eliminated, if they are not already, has come amid evidence that the nation’s vaccination rate is increasing.

The Federal Government has mounted a crackdown on parents who refuse or fail to ensure their children are vaccinated, threatening to withhold benefits worth thousands of dollars from families and abolishing all but medical exemptions.

But even before these latest measures were announced, figures from the Australian Childhood Immunisation Register show vaccination rates were rising in mid-2014, reaching 91.5 per cent of one-year-olds (up 0.6 of a percentage point), 92.8 per cent of two-year-olds (up 0.2 of a percentage point) and 92.2 per cent of five-year-olds (up 0.3 of a percentage point).

ADRIAN ROLLINS

Insurance premium hikes waved through by Minister

Health Minister Sussan Ley did not challenge or knock back some of the biggest premium increases proposed by health insurers in years, it has been revealed.

Government officials have told a Senate Estimates hearing that Ms Ley did not reject any premium increases proposed by insurers prior to announcing approval for an average 6.18 per cent rise this year, following a 6.2 per cent hike in 2014.

Private Health Insurance Administration Council (PHIAC) Chief Executive Officer Shaun Gath told Labor Senator Jan McLucas that Ms Ley had not required any insurer to "show cause" for proposed rate hikes, or to make them re-submit a proposal.

But Mr Gath said this was because of an exhaustive process of investigation, negotiation and assessment undertaken by the Council before making recommendations to the Minister regarding premium increases.

He told the hearing that PHIAC assessed premium pricing according to three criteria: ensuring that insurers were raising sufficient revenue to remain financially viable; that the proposed price hike accurately reflected growth of business costs; and that the increase was competitive in the insurance marketplace.

Mr Gath said this approach, which had evolved in the past three years, involved "a lot of transparency, a lot of contact with the industry, a lot of clarity about our expectations, and also a very strong adherence to a competition-based model of pricing".

"It has become quite a complex and sophisticated process which goes much longer than a simple exchange of paper in a flurry before Christmas."

He said the proof of the success of the process was exactly that no proposed increases were challenged or rejected by either PHIAC or the Government.

"The reason that there was no return or show cause was that the process was designed to not to allow that to occur, because everybody knew…exactly what sort of pricing would be supported by PHIAC in its recommendation to the Government," Mr Gath said.

This year's increase, which came into force in April, drew criticism from the Opposition and consumer groups who complained that the average premium was growing a several times the rate of inflation.

The hike in premiums has fuelled concerns many consumers will downgrade their policies, leaving them with inadequate cover.

While the proportion of Australians with private health cover is growing – more than 47 per cent of the population had private hospital cover last year – doctors are worried that as premiums rise, more are opting for policies with multiple exclusions that often do not provide the benefits that they need.

> "The Ombudsman reported receiving almost 350 complaints about benefits in the 12 months to September last year"

AMA President Professor Brian Owler said the growth of such policies concerned the medical profession because they saw the consequences for their patients.

"Too often my members see patients who think they have cover, but don't, because they purchased a cheaper product several years ago," A/Professor Owler told a private health insurance conference late last year. "Treatment is planned, surgery is booked, only to be cancelled shortly beforehand because the patient is not covered."

The AMA's concerns have been echoed by the Private Health Insurance Ombudsman, who recently reported that policies with exclusions and restrictions regarding hospital-based treatment were a significant cause of consumer complaint.

The Ombudsman reported receiving almost 350 complaints about benefits in the 12 months to September last year, up from a little more than 250 in the same period a year earlier.

"There is demand from consumers for more affordable policies, particularly from younger people who may be taking out a policy for the first time, and from people who are purchasing health insurance primarily for tax purposes," the Ombudsman said. "One way insurers can reduce the cost of a policy is by restricting or excluding certain treatments on the policy."

ADRIAN ROLLINS

Non-communicable disease: will we rise to the global challenge?

BY **PROFESSOR STEPHEN LEEDER, EMERITUS PROFESSOR**
PUBLIC HEALTH, UNIVERSITY OF SYDNEY

Non-communicable diseases, or NCDs, include heart disease, diabetes, chronic obstructive pulmonary disease, mental illness and cancer and are today's heavy hitters everywhere, displacing communicable diseases from the top ranks of causes of lost productive years of life worldwide, including in low- and middle-income countries.

> "Tobacco control is the cheapest strategy and, when well done, actually makes money"

These disorders dominate our clinical agenda in Australia and other high-income countries. For example, a document entitled *The 2022 GP* from the UK College of General Practitioners neatly summarises their effects:

> "Though patients with long-term conditions account for around 29 per cent of the population, they make up 50 per cent of all general practice appointments, 64 per cent of all outpatient [visits] and 70 per cent of all inpatient bed-days, as well as 70 per cent of the total health and social care spend in England. That means that 30 per cent of the population accounts for 70 per cent of spending."

Given the frequency of chronic diseases and the effort needed to manage them, it is no surprise that the search for ways to prevent them occupies the attention of those responsible for providing and paying for services, summarised in the goal to 'keep NCDs out of hospital.'

But in low- and middle-income countries, where money spent on health care is a tiny fraction of what we spend - $60 a year per person in India, $70 in Sierra Leone, compared with $6000 in Australia - where these diseases are equally common as here, prevention is the only show in town for which tickets are within the budget. Tobacco control is the cheapest strategy and, when well done, actually makes money.

In regard to prevention, Australia is a hero on the international stage. According to figures from the Australian Institute of Health and Welfare, cardiovascular disease death rates fell from 831 per 100,000 people in 1968 to 183 per 100,000 in 2009, a fall of 78 per cent. Similar falls occurred simultaneously in North America and other wealthy countries. Studies of why this has occurred usually suggest that about half the fall is due to prevention and half – more lately – follows improved care. What is especially good to see is that deaths have come down in a major way among people of working age.

Tobacco control is a central plank in prevention of heart disease and stroke, as well as cancer. Australia is the envy of the world. In 2010, only 1 in 7 (14 per cent) Australians aged 14 and older smoked daily, compared with about half of all adults in the 1950s.

Beyond tobacco the picture is mixed. Alcohol consumption has increased, and its relation to heart disease is ambiguous at low dose. The quality of our food has improved and the Australian diet has changed in ways that we all notice in the supermarket and restaurant in the direction of fostering better health, with an abundance of salt-, sugar- and fat-reduced products. The market has voted in favour of healthier food. But has this really contributed to better heart health?

Those venturing into the field of nutrition and chronic disease do so with great bravery. Food and agriculture are such huge commercial enterprises that vested interest will always intrude into policy conversations seeking to make healthy choices easy, say through clear and simple food labelling. I recall hearing how the US salt industry (yes, salt!) was lobbying hard against salt reduction in processed food. Then there is the sugar industry, the corn syrup industry and so on. It is a veritable mine field where absolutely unarguable data supporting an intervention are hard to find in one's defence.

Measuring nutritional patterns is devilishly difficult compared with tobacco consumption. Surveys of Australian nutrition patterns in the past twenty years have shown that, while malnutrition remains largely confined to people and places of poverty, the average consumption of fruit and vegetables still falls seriously short of recommended levels. For example, 85 per cent of us don't meet the recommendation for vegetables, and only 50 per cent of us eat enough fruit.

Non-communicable disease: will we rise to the global challenge?

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The same trends apply to our children. School-based nutrition programs show considerable promise and evidence of effect in reducing child obesity. Increasing research and knowledge on the epigenetic influences of maternal and early childhood nutrition, for example by Fiona Stanley and colleagues in Perth, on subsequent risk of obesity, diabetes and heart disease is pointing with ever more urgency to the need for action by all of us, and a serious policy response for those at high risk, such as our Aboriginal communities.

According to the UN Food and Agriculture Organisation, Australians ate about 40 kilograms of beef per person in 2007, just ahead of the US. Adding in pig and poultry, we were the third highest nation of meat eaters. Those who eschew beef have virtue on their side when one considers the contribution of beef flatus to methane levels and hence, to global warming. Prudence suggests that we should all seriously reduce our portion sizes, the amount of salt and sugar we eat and alcohol we drink, and reduce the amount of meat we consume.

Rates of people who are overweight and obese are continuing to rise in Australia, and the nation currently has one of the highest rates of obesity in the world. In 2007–08, 1 in 4 adults and 1 in 12 children were obese.

Preventing the NCDs is not adequately informed by science, in my view.

There is much more to learn about nutrition and its consequences for NCDs and how these are mediated. In the meantime, we can take comfort from the achievements to date – that tobacco can be controlled, that our diet can be relieved of unnecessary volume, fat, salt and sugar, and that we have an increasingly effective armamentarium of medical and surgical approaches for managing these problems.

Cost is a huge constraint. If we are to take global climate change seriously we should surely turn our minds also to how we can secure a global future where the burden of NCDs is lower. Like dealing with global warming, this may cost us money to achieve an equitable global solution.

Supporting the family doctor

BY DR BRIAN MORTON, CHAIR, AMA COUNCIL OF GENERAL PRACTICE

AMA Family Doctor Week 2015

YOU AND YOUR FAMILY DOCTOR:
THE BEST PARTNERSHIP IN HEALTH

At the recent AMA National Conference, during the *Funding quality general practice – is it time for change?* policy session, a number of speakers talked about the need to better support general practice, including through the adoption of different models of payment.

Some ideas were more radical than others, but all speakers emphasised the need to better reward and support the 'usual GP', that is, the family doctor, in providing quality, comprehensive and long-term care.

The policy session concluded with members of National Conference recognising that, while fee-for-service should remain the primary funding model for general practice, the AMA should remain open to other payment models that could complement this. This will guide the AMA's contribution to the Primary Care Review that has been established by the Federal Government.

As GPs, we are facing a number of challenges, both now and into the future.

Our patients are ageing and developing multiple chronic conditions, and they want greater access to personalised health care.

Simultaneously, GPs are seeking a better work/life balance, increasingly working in larger practices and in multidisciplinary teams, and our traditional role is under threat from other health professionals that want to expand their scope of practice.

Practice viability is under threat with each funding cut and inadequate indexation - let alone the current four-year freeze on indexation. Quality care is poorly remunerated, and we are under ongoing pressure to deliver more with less, and for less.

We need to be able to spend the time on patients that they need, including to educate them on the benefits of good nutrition and being active, as well as informing them how to implement the lifestyle changes that will enable them to lead healthy lives. To identify and manage their risk factors. To hear their concerns and work with them in treating or managing a health issue. To plan and coordinate their care.

GPs need the comprehensive care they provide to be recognised and rewarded. We need to be remunerated in a way that supports and encourages us to continually do better.

The valuable role that we play as family doctors will be once again honoured by the profession, and highlighted to the community and Government in the coming weeks as we approach AMA Family Doctor Week (19-25 July).

Join us in this endeavour by downloading the Family Doctor Logo and using it on your signature block or web profile. Members can download it here: https://ama.com.au/article/ama-family-doctor-logo.

You can also download the Family Doctor Week poster for printing or displaying on your website. It can be downloaded from here: https://ama.com.au/family-doctor-week-2015.

The AMA will take advantage of a number of opportunities in the coming months to advocate for improved funding arrangements to support both the profession and our patients. These include in providing input to the MBS Review Taskforce, the Primary Health Care Advisory Group and the House of Representatives Standing Committee on Health inquiry into Chronic Disease Prevention and Management in Primary Health Care.

Our key objective will be to ensure that the outcomes of these reviews support, not devalue, the family doctor in caring for patients.

Brave new world?

BY DR DAVID RIVETT, CHAIR, AMA RURAL MEDICAL COMMITTEE

I am tapping this column out at the AMA National Conference, as by the time it hits *Australian Medicine* I will be driving through south-western USA.

Several newsworthy points have come out of the Conference.

Federal Health Minister Sussan Ley declared, "I am totally passionate about rural and regional health". But, more worryingly, she then went on to declare, "we need to look at alternatives to fee-for-service funding", and added that "Primary Health Networks will enable doctors to work more effectively", which would be a "win for the states by reducing hospital admissions".

I don't know who has been in her ear about the Personally Controlled Electronic Health Record, but she went on to say that this would "produce savings of $2.5 billion per annum for Medicare and $1.6 billion per annum for the states within a decade". Well, pigs might fly. No mention was made of any additional funding to strengthen general practice to enable such savings to be realised.

"Clearer clinical compliance guidelines" were referred to by the Minister, hinting at likely future predetermined outcomes of the Primary Health Care Advisory Group, which seems set to restrict use of chronic disease management items to achieve budget savings.

Back on message, she pleasingly added that we need to encourage more generalists and not "super specialists", and that rural Australia needed the right skills in the right place.

Both the Minister and Shadow Minister Catherine King made positive noises about the 'Medical Home' concept. Capitation is now looming larger on the horizon, with all the challenges that entails.

The Primary Health Care Advisory Group, one of three enquiries set up by the Coalition to reform Medicare, and headed by Dr Steve Hambleton, is about to kick off and is due to report back by November this year, while the MBS review headed by Professor Bruce Robinson has a $30 million dollar budget over two years.

Having been heavily involved in the Relative Value Study to the point that it took up a large part of my life for several years, only to see it end in a nothing outcome when Government took one look at what fair rebates would cost and ran a mile, I cannot be optimistic about these reviews.

> "Both the Minister and Shadow Minister Catherine King made positive noises about the 'Medical Home' concept. Capitation is now looming larger on the horizon, with all the challenges that entails"

If I can make a single point it would be that any credible review of the MBS must toss out its current indexation formula, which each year takes dollars away from patient rebates. The review needs to find a robust replacement that takes account of rising practice costs.

Socio-economic status remains the single leading factor in predicting health outcomes. So, in an ideal world, the poorest and most disadvantaged should receive higher Medicare rebates (and the wealthy, less) to better enable access to medical care, and those with chronic diseases should perhaps also receive a further boost to rebates if they enrol with a single general practice to oversee and co-ordinate their care.

Cries from the middle and upper classes that they pay more in Medicare levies and taxes and should therefore get the same rebate would need to be dealt with by:

1. abolishing the Medicare levy, which sends a false signal that taxpayers have paid for their medical care; and
2. allowing private insurers to provide insurance for gaps in consultation fees.

Being vigilant about harassment

BY **DR ROD MCRAE**

The issue of harassment has been very topical in hospital workplaces lately.

Earlier this year, the issue of sexual harassment in the medical workplace achieved national prominence when a senior woman medical practitioner suggested young doctors should not report harassment because it might jeopardise their career.

The AMA responded quickly by encouraging any doctors who have experienced discrimination, harassment or bullying to speak up and seek help. Other medical organisations also spoke up.

As with domestic violence - while it is not all one-way traffic - it is predominantly women and juniors who are on the receiving end of such power plays.

In Australia, sexual harassment is recognised as a form of sex discrimination. In the workplace, we need to understand that comments of a vaguely sexual nature that make other people uncomfortable constitute sexual harassment.

In April, the AMA hosted a roundtable on the issue, chaired by the President, Professor Brian Owler. Among its outcomes, the roundtable concluded that:

- the medical profession needs to take leadership in addressing the issue;
- education, which must commence in medical school, is critical to changing culture;
- processes must offer a 'safe space' for people to raise issues of sexual harassment, free of shame, stigma or repercussions; and
- that the hardest thing to change will be the culture of the profession. This has to start with senior male members taking a leadership role and making it clear that sexual harassment is absolutely unacceptable. They need to demonstrate what is good, and point out what is not good, professional behaviour.

This is not only about sexual harassment.

Harassment can take on many forms, based on issues such as gender, culture or age. It can be overt, subtle, on-going, one-off or, in some workplaces, endemic. It can be physical, psychological or economic.

Workplace cultures of bullying and harassment are not unique to the health sector. International studies, particularly in the United States and United Kingdom, suggest disturbingly high levels of bullying, discrimination and mistreatment at all levels in the medical profession, from applying to medical school to success in examinations, job applications, and the allocation of awards to consultants.

The Fair Work Act includes anti-bullying provisions, including illustrative definitions. Bullying and harassment can be workplace health and safety issues, and even, in some cases, criminal issues.

As a profession, we need to look out for all our colleagues, particularly junior colleagues. Many young doctors report mistreatment of varying shades, from unpaid overwork to overt harassment. Our own surveys have found that more than half of junior doctors have been bullied in their clinical attachments, most likely by their supervisor.

It can also affect more senior colleagues. Some doctors might be mistreating others and not even realise that their behaviour is inappropriate.

We should not allow behaviour which is unacceptable in other professions to be normalised in medicine and legitimised by the high-pressure nature of the workplace. Even in this circumstance, all need to maintain good professional behaviour. It often takes a third party to recognise that particular behaviour is not appropriate.

Our profession should not tolerate any form of harassment in the workplace. It should certainly not get to the point where a doctor considers leaving the profession because of how they have been treated by colleagues.

We encourage those who experience harassment of any kind to speak up before it becomes unbearable. This might involve talking to a trusted colleague, but may also entail an official complaint. Hospitals and other employers must have clear policies for hearing and dealing with complaints.

Sometimes hard decisions have to be made and senior people might have to be confronted about their behaviour. This requires a clear, fair, consistent framework for appropriate behaviour.

Reform of the Federation

BY AMA PRESIDENT ASSOCIATE PROFESSOR BRIAN OWLER

The Commonwealth Government has committed to produce a White Paper on the Reform of the Federation, working with the states and territories.

According to the Government, the White Paper will seek to clarify roles and responsibilities to ensure that, as far as possible, the states and territories are sovereign in their own sphere. Defining roles and responsibilities in health are a critically important part of this process.

> "The AMA has been a catalyst for this discussion, helping to ensure that public hospitals funding is a main agenda item …"

At the time of writing, a Department of Prime Minister and Cabinet Discussion Paper detailing possible options for reform has just been released, and it is expected the Government will release a Green Paper later in the year, after further discussions with the states and territories. This will feed into the development of the Reform of the Federation White Paper, expected to be released in 2016.

Public discussion of the Reform of the Federation process and options for change has hardly begun, but the topic is warming up at heads of government level, and will be further fuelled by the release of the Government's discussion paper.

The AMA has been a catalyst for this discussion, helping to ensure that public hospitals funding is a main agenda item at the heads of government leaders' retreat later this month.

The Health Financing and Economics Committee considered the issue of reform of the Federation at its meeting on 14 February, and its discussions helped inform Federal Council deliberations in a policy breakout session at its meeting on March 13 and 14.

Immediately prior to the last COAG meeting on 17 April, the AMA released the *AMA Public Hospital Report Card 2015*, which highlighted the declining level of Commonwealth funding for public hospitals, and that public hospitals were not meeting key performance targets even with the current level of funding.

Public hospital funding was also a focus for a high profile and successful policy session at AMA National Conference on 30 May which outlined the impacts of inadequate funding on public hospitals in two states.

So, where is the Federation Reform process up to?

Later this month Australia's heads of government will have an opportunity to take a leadership approach to considering reform of the federation and how reform could help address some of the big issues facing Australia over the medium to longer term.

The best approach to future roles and responsibilities in health is one of those issues. We need to ensure this debate is framed in a useful way.

The discussion paper canvasses five options for health and hospitals: states and territories take full responsibility for public hospitals; a Medicare-type rebate scheme for all hospital treatments; states and Commonwealth jointly responsible for funding care packages for chronic and complex patients; regional purchasing agencies be funded to purchase health services; and the Commonwealth becomes the single funder of health services and establishes a health purchasing agency.

Early reporting has focused on whether particular proposals for reform will produce more or less accountability and efficiency. These are important features of any arrangements.

But they are not as important as whether reforms will deliver the capacity that public hospitals require to meet the needs of patients for timely and high quality hospital care.

If you ask any patient, they will be interested first and foremost in whether they and their families can expect to receive hospital care when they need it and to a high standard of quality. As doctors we have this interest in common.

This is the basic thing that our public hospitals absolutely need to get right. It's the first test that should be applied to any options for change.

HFE and other AMA committees will be considering the options to help the AMA influence the development of sensible and practical outcomes for health from the Reform of the Federation process. Your input and views will be valuable as part of this work.

Health on the hill

POLITICAL NEWS FROM THE NATION'S CAPITAL

Mental health experts given tight reform deadline

A group of mental health experts has been given just four months to develop a detailed plan for the Federal Government to implement far-reaching changes to the nation's disjointed mental health system.

A 13-member Expert Reference Group led by former Liberal ACT Chief Minister and *beyondblue* Chair Kate Carnell held its first meeting on 18 June, and has been given until October to finalise an action plan to implement a number of changes recommended by the National Mental Health Commission in its searing review of the system.

The tight timeline has been praised by Commission Chair Professor Alan Fels, who said the review he led had provided a practical plan for modernising and reforming the mental health system and it was vital that the process of reform get underway.

"It's important that implementation of the review's recommendations and actions commences as soon as possible, because the review lays out what is a long term plan for reforms," Professor Fels said.

The review found the mental health system was poorly planned and badly integrated, and urged an increased focus on prevention and early intervention.

Controversially, it called for at least $1 billion to be redirected from public hospitals to fund community-based mental health services - an idea immediately dismissed by Health Minister Sussan Ley.

But Ms Ley said the review showed there were clear failures in current arrangements and the Government was committed to "meaningful long-term reform".

The Minister said advice from the Expert Reference Group would help inform discussions she will have with State and Territory governments about developing a new National Mental Health Plan with much-improved co-ordination between federal, state and local bureaucracies and services.

"We have a real opportunity to deliver meaningful long-term reform through this Mental Health Commission Review, and this Government is committed to action," Ms Ley said. "However, it's clear...there are still implementation issues to be ironed out. That's why this Expert Reference Group is so important, to ensure the mental health sector and Government work together closely to ensure recommendations can be practically implemented as we finalise our action plan over the next few months."

Mental health groups have welcomed the formation of the Expert Reference Group, but its composition and tight time frame has drawn criticism from some.

Opposition mental health spokeswoman Senator Jan McLucas said although she had no problem with those appointed to the Group, it's membership should be broadened to include consumer and carer representatives.

Mental Health Australia Chief Executive Frank Quinlan told *The Australian* the group would be under "considerable pressure", and warned that, with so many programs scheduled to end by early next year or be subsumed into the National Disability Insurance Scheme, it was essential the advisory group laid out a properly costed plan to provide the high quality services and programs.

But *beyondblue* Chair Jeff Kennett welcomed the Government's urgency.

"I am pleased that the Minister has asked the group to get on with the job quickly. We don't need more drawn-out discussions about what is wrong with our mental health system. We already know it's a complex, fragmented and hard-to-navigate system, and the people who suffer the most are the very people and families who need the most help," Mr Kennett said.

"I hope as a result of the Expert Reference Group's advice and Government's quick response, some decisive and practical initiatives are identified and resolved, so people with depression, anxiety and at risk of suicide – and their families – get better outcomes.

"Let's not just talk about preventing illness and 'early intervention', let's make this a reality, so people don't have to reach crisis point before they can access services."

ADRIAN ROLLINS

PM dodges evidence to take tilt at windmills

Prime Minister Tony Abbott has linked wind farms to adverse health effects and his Government has created a Wind Farm Commissioner to hear complaints about their operation.

Declaring that he would like to see the number of wind generators around the country cut, Mr Abbott told Sydney broadcaster Alan Jones that he understood the concerns of those who complained inaudible low frequency sound generated by wind farms caused headaches, nausea, sleeplessness and other health problems.

Health on the hill

POLITICAL NEWS FROM THE NATION'S CAPITAL

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"I do take your point about the potential health impact of these things," the Prime Minister said. "When I have been up close to these wind farms, not only are they visually awful, but they make a lot of noise."

Mr Abbott made his comments just days after acoustic experts told a Senate inquiry there was no evidence that people were physically affected by low-frequency sound like that emitted by wind turbines.

Members of the Association of Australian Acoustic Consultants told the Senate inquiry into wind turbines on 10 June that several studies detected no perceivable physical reaction to so-called infrasound.

"We can measure the level of infrasound in a windfarm, and we know what that level is, and we can measure it inside rooms, and that has been done on a number of occasions," Chair of the AAAC's windfarm subcommittee, Chris Turnbull, said.

"If we replicate that level at the same character, and the same frequencies, that person is essentially exposed to the same level of infrasound in terms of character and level [as a windfarm]," he said. "To date, all of the studies have suggested that there is no reaction to that level of infrasound."

The testimony came weeks after the National Health and Medical Research Council released the results of a three-year investigation involving the review of more than 4000 papers that concluded there "is currently no consistent evidence that wind farms cause adverse effects in humans".

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

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

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

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

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

The NHMRC, however, has not closed the book on the issue, indicating that further research into the possible health effects of wind farms on people within 1500 metres "is warranted".

The latest furore over the health effects of wind farms has come just weeks after the Government negotiated a cut in the Renewable Energy Target (RET) from 41,000 to 33,000 gigawatt hours.

Mr Abbott lamented that the Government had been unable to secure an even deeper reduction, which was arrived at following months of haggling between the major parties that destabilised the renewable energy industry and deterred investors.

"What we did recently in the Senate was reduce...capital R-E-D-U-C-E, the number of these things that we are going to get in the future," the Prime Minister said, "I would frankly have liked to have reduced the number a lot more, but we got the best deal we could out of the Senate, and if we hadn't had a deal...we would have been stuck with even more of these things."

ADRIAN ROLLINS

Built like a tank!

BY DR CLIVE FRASER

I have wonderful memories, as a child growing up in Brisbane, of visits to the Queensland Museum at Bowen Hills.

They had butterflies, shrunken heads and a real live lungfish.

But, best of all, they had the only surviving World War One German A7V tank, affectionately called “Mephisto”.

The name was presumably from Mephistopheles, a demon in German folklore.

The tank was captured by Australian forces (mainly Queenslanders) in 1918 at Villers-Bretonneux, and the Aussie troops had to don gas masks when the Germans deployed chlorine gas.

Although Mephisto was destined for the British Imperial War Museum, it somehow ended up in Brisbane instead, and Queensland has been its home ever since.

It isn’t in operating order but, as a child, I always wondered how such a big lump of metal could move.

One of the most endearing comments that you can make about a car is to say that, “it’s built like a tank”.

That comment implies that the car is solid, reliable and unbreakable, and is entirely positive so long as you don’t say that the car drives like a tank too!

So it was with much fanfare that Russia recently unveiled a new vehicle which wasn’t made by Avtovaz, Avtotor or Avtoframos.

It wasn’t a Lada, and yes, it could easily claim to be built like a tank, because it was, in fact, a tank.

It is Russia’s all new T-14 Armata tank, which was due to be showcased to the world at a celebration in Red Square to mark the 70th anniversary of the end of the war against Germany in World War Two.

Unfortunately, as the whole world now knows, one of the T-14 tanks broke down for 15 minutes during a rehearsal and the driver poetically raised a red flag.

Just as well it wasn’t deployed in a battle situation, where a white flag would likely have been a safer option.

While Australia will soon stop making cars, Russia will be hoping that there will be a queue of buyers for its latest piece of military hardware.

Selling armaments to the rest of the world is, after all, a very lucrative business, and may help to pay for modernizing the old Soviet-era hardware.

Unlike automobiles, where makers brag about how many kilowatts and air-bags their model has, the specifications of the new T-14 will be a closely guarded secret for the foreseeable future.

Countries that sell weapons do tend to exaggerate their capabilities, and are also inclined to leave out all the bells and whistles in models destined for export.

Who knows - their customers might one day start shooting back.

But what is known about the Armata tank is that the turret is un-manned and controlled robotically.

That might mean that a fully robotic tank is not that far away.

Its 125 millimetre gun is said to be smooth-bored, and can fire missiles as well as shells.

That smooth bore gives the projectile a greater shell velocity, and the barrel a longer life.

But tanks aren’t all about who has the biggest err, um, you know, long pointy thing.

They are a compromise between mobility (speed), armour and fire-power.

In the case of anything made in Russia, that equation might also need to include reliability.

Will the Queensland Museum ever house a captured Russian T-14 tank?

Well, maybe.

We do after all still have Mephisto!

Safe motoring,

Doctor Clive Fraser
doctorclivefraser@hotmail.com

	Mephisto A7V	Armata T-14
First produced	1918	2015
Weight	33 tonnes	48 tonnes
Crew	18	3
Armour	15-30 mm steel	44S-SV-SH steel alloy
Main armament	57 mm gun	125 mm gun
Engine	2x4 cylinder 149 kW	12 cylinder X config 1120 kW
Speed	15 km/h	80 km/h
Range	80 km	500 km
Number produced	20	20

In praise of the unfashionable Muscat

BY DR MICHAEL RYAN

It's a fickle world sometimes in the wine business.

What was once great and esteemed can quickly come to be considered so second-rate that only alcoholics or the old would enjoy it. Such is the fate of the much-maligned liqueur, Muscat.

Australians can hold their heads high in the world of fortified wine.

Just as Port evolved in Portugal to cope with the country's warm climate, so table wines were developed for Australia's high ambient temperatures. By keeping sugar levels high and adding wine spirit, a finished wine product was created that could endure all sorts of travelling conditions, providing the displaced geographical drinker with a suitable table product.

The grape variety most commonly used to fulfil this purpose has been Muscat a Petits Grain, which is usually called Brown Muscat. However, Muscat as a grape name is quite diverse – they are around 200 varieties of Muscat, all of which have a "grapey" yet fragrant aroma.

The terroir is warm and dry. The grapes are naturally high in sugar and left late to harvest as they "raisin" up. As the water evaporates the sugar becomes concentrated, and the balance of acids and sugar define the grape's quality. The grapes are crushed and allowed to ferment as usual, but at a certain stage, the process is brought to a halt by the addition of brandy spirit.

The wine is then placed into oak barrels, usually old and big, and put in a warm part of the wine making facility; usually under the corrugated iron roof. Over time, natural evaporation occurs, resulting in concentrated wines. The loss of fluid is known as the angel's share.

The main areas of Muscat production are Rutherglen and Glenrowan in Victoria, though the Barossa also has some producers. Baileys, Morris, Yalumba and Seppeltsfield are the major producers, and a classification system for the Rutherglen region has been established. Under this system, Muscats are denoted – in ascending order of quality – as Rutherglen Muscat Classic, Grand and Rare.

Classic Muscat is between five and 10 years and has anywhere from 180 to 240 grams of residual sugar. Grand Muscat is slightly older, 10 to 15 years, with residual sugar of between 270 and 400 grams. At the top of the tree, the Rare is at least 20 years old, and has between 300 and 400 grams of sugar. Despite these surprisingly high concentration, the overall product is often an epiphany.

The younger Muscats have more florals and high acidity, and are considered less integrated. The older Muscats develop complex liquorice and chocolate toffee notes.

Traditionally, Muscats were drunk in cooler climates. In Australia, this means they should be served below room temperature. They punctuate the end of a meal and can be enjoyed with desserts, cheeses, dates and quince pastes. Chocolate and Muscat is a match made in heaven.

WINES TASTED

1. Morris Classic Liqueur Muscat - cedar brown in colour. Notes of honey, florals, abound. A luscious silky palate.
2. Seppeltsfield DP63 Grand Muscat - a deep tawny brown colour. Aromas of fruitcake, vanilla, florals and raisins. Super concentrated palate. Rich and powerful. Respected as a great example.
3. McWilliams Show Reserve Muscat - the base wines date back to 1965. This is Australia's most awarded wine, with more trophies and gold medals than Penfolds Grange. There is a golden hue around the thick liquorice-like colour. The bouquet is a heady mix of caramelised raisins and toffee notes, the aniseed herbal notes vacillate in the background. A few millilitres is all that is need to coat the tongue and excite the palate.

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