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Time for health

Now the election's over, let's unfreeze Medicare, fund hospitals, invest in GPs, rural and Indigenous health

INSIDE

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In this issue

Cover: AMA President Dr Michael Gannon talks to the media

E-health penalties unfair: Gannon

AMA President Dr Michael Gannon pressed for increased investment in primary care in a meeting with Liberal leader Malcolm Turnbull during the Federal Election campaign

The AMA is calling for a moratorium on changes that will penalise general practices thousands of dollars if they do not upload patient health summaries to the My Health Record system, with less than a quarter of practices indicating they will be able to comply with new rules introduced earlier this year to the Practice Incentives Program (PIP).

The AMA has written to Health Minister Sussan Ley and Shadow Health Minister Catherine King urging them to commit to a suspension of rules that came into effect last month, under which practices that fail to upload shared health summaries for at least 0.5 per cent of their standardised whole patient equivalent each quarter are not eligible for payment under the newly-branded PIP Digital Health Incentive.

An AMA survey of medical practices found that just 24 per cent considered themselves able to comply with the requirement, while 39.5 per cent said they were unable to, and 36 per cent were unsure. Those that could not comply estimated it would cost them, on average, $23,400 a year in lost PIP incentive payments.

AMA President, Dr Michael Gannon, said the rule was grossly unfair and premature because the My Health Record system was still a work in progress and had substantial flaws that compromised its clinical usefulness.

“The AMA has strongly backed the introduction of a national e-health record because of the real benefits it could provide for patient care,” Dr Gannon said. “It is definitely the way of the future.”

“But the My Health Record system is plagued with shortcomings that need to be fixed before the Government tries to foist it on patients and practices,” he added. “We just have to get it right before we start telling GPs that we are withdrawing payments that are crucial to the functioning of your practice because you cannot make it work.”

But Health Minister Sussan Ley talked down concerns about the ePIP requirement, and told *Medical Observer* the rules were not onerous.

“To receive this practice incentive payment, all we are asking is for a general practice to upload five shared health summaries from each GP every three months,” the Minister told *MO*.

“It is not a big ask. They get paid more for doing so, and ultimately it makes it easier for both patient and medical practitioner to instantly access important health information and patient records.”

Another financial blow to GPs

But the AMA survey found that losing the ePIP payment could be a big financial blow to practices.

Of those practices unable to meet the new eligibility requirement, around a third estimated it would cost them up to $15,000 a year in lost incentives, 29 per cent reported it would cost them up to $30,000 a year, almost 20 per cent forecast an annual loss of up to $45,000 and 12 per cent put the annual cost at up to $60,000.

Dr Gannon said this amounted to a significant financial blow to practices already struggling under the burden of the Medicare rebate freeze.

“The extension of the rebate freeze has already pushed many practices to the financial brink, and the last thing they need is to have thousands more ripped away from them because of a flawed process to introduce a national e-health record system,” he said. “The Health Department should call a halt to the process until its gets the My Health Record system sorted out.”

The Health Department has pushed ahead with the new eligibility requirements even though doctors and other health care providers will not be able to view records created as part of a trial of My Health Record’s opt-out arrangements until mid-July, and issues affecting the extent to which doctors can rely on the record are yet to be resolved.

System grows, doubts remain

So far, around 2.7 million consumers have an e-health record, and 8554 health care organisations are registered to access the Personally Controlled Electronic Health Record (PCEHR) system, including 5391 general practices.

E-health penalties unfair: Gannon

... from p3

Official figures show that, as of 16 June, 383,000 hospital discharge summaries have been uploaded, along with almost 105,000 shared health summaries, 16,475 specialist letters and 12,512 diagnostic imaging reports.

Ms Ley said the creation of shared health summaries had accelerated, and around 6000 were now being uploaded each week.

Despite this, the AMA survey, which was conducted last month and involved 658 practices across the country, shows many are wary of using the system in its current configuration.

Those practices that said that they would not be able to comply with the new rules had multiple concerns about the technology, including:

- that My Health Record was not a reliable source of clinical information for GPs (65.1 per cent);
- there was no demand from patients (66.7 per cent);
- there was no financial support for the extra work involved in preparing and uploading shared health summaries (67.5 per cent);
- there were unresolved issues regarding the security of the My Health Record system (61.5 per cent); and
- other health providers are not using the My Health Record and GPs see little value in using it (61.3 per cent).

But e-health advocates said many of these concerns were ill-informed or misplaced. They said the 4000 to 5000 discharge summaries and 6000 shared health summaries being uploaded every week should be considered reliable, and there had been no security breach of the My Health Record system. Furthermore, more than 560 public and private hospitals and community clinics were used the system, as were 1186 retail pharmacies and 157 residential aged care services.

Dr Gannon warned that rushing ahead with the My Health Record and linking it to PIP incentives risked undermining the support of the medical profession.

“Adopting the proposed moratorium is essential,” Dr Gannon said. “Otherwise, the Department may undermine support for My Health Record within general practice and do long-term damage to the goodwill of GPs, which is essential if a national e-health system is to be successfully rolled out.”

ADRIAN ROLLINS

Sharing can be caring

Health professionals back the use of technology to share patient information and improve the integration of care, but are wary it could result in information overload.

An international survey commissioned by electronics giant Philips has found that doctors and patients are both enthusiastic about the possibilities provided by so-called “connected care technologies” (which include wearable devices, apps and electronic health records) to improve health system integration.

The survey, which included 200 Australian health professionals and 2000 patients, found Australia scored above average on the international Future Health Index, which measures perceptions of health care accessibility and integration, along with the adoption of connected care technologies.

Australia scored highly on access to care, due to public hospital funding and universal health care through Medicare. But it was only average when it came to health care integration and the adoption of connected care technologies.

This is despite openness to the idea among both patients and doctors.

The survey found that around half of patients use connected care technologies to measure their health, and three-quarters would be comfortable sharing the information with their doctor – though only 32 per cent report they have done so.

For their part, a majority of health professionals who have had information shared with them by their patient report that it has helped them gain deeper insights into their patient’s health, has helped motivate patients to adhere to treatment, and has given patients a measurable goal to work towards.

But 54 per cent are concerned that connected care technologies will increase their workload by overloading them with data they do not need, and have limited time to process.

ADRIAN ROLLINS

Patient control undermines e-health record

Doctors and other health workers need to have access to core clinical information in electronic medical records if the Federal Government's My Health Record system is to deliver an improvement in patient care, the AMA has said.

Releasing the AMA's updated Position Statement, *Shared Electronic Medical Records 2016*, AMA President Dr Michael Gannon said that giving patients the ability to block or modify access to critical information such as medications, allergies, discharge summaries, diagnostic test results, blood pressure and advance care plans compromised the clinical usefulness of shared electronic medical records loaded on the My Health Record system.

"Doctors treating a patient need to be confident that they have access to all relevant information," Dr Gannon said. "Shared electronic medical records have the potential to deliver huge benefits by giving health workers ready access to critical patient information when it is needed, reducing the chances of adverse or unwarranted treatments and improving the coordination of care."

"But, if patients are able to control access to core clinical information in their electronic medical record, doctors cannot rely on it.

"Giving patients such control, as the My Health Record system does, is a big handicap to the clinical usefulness of shared electronic medical records."

The Federal Government launched My Health Record earlier this year to replace Labor's troubled Personally Controlled Electronic Health Record (PCEHR) system, and doctors and other health care providers will not be able to view records created as part of a trial of My Health Record's opt-out arrangements until mid-July.

The system, like the PCEHR, gives patients the power to control what goes on the health record, and who can view it.

The AMA said giving patients such control meant the My Health Record would never realise the full benefits of a national electronic health record system.

"All shared electronic health records must include core clinical information that is not subject to patient controls," the AMA Position Statement said. "Certainty that shared electronic health

records contain predictable core clinical information which is not affected, conditioned or qualified by the application of access controls, is critical to the achievement of the legislated objectives of the My Health Record."

An AMA survey of 658 medical practices, undertaken last month, found many GPs were reluctant to use the system, partly because of a lack of confidence in the reliability of information it contained.

Dr Gannon said the AMA encouraged individuals to take responsibility for their health and strongly supported the idea of a national shared health summary system, but it had to be fit for purpose.

The AMA added that in 'break glass' emergency situations, implied consent must sometimes be assumed to allow access to the full medical record.

The Association said the system should also provide protections for doctors who acted in good faith but missed or were unable to locate critical data "because it is buried in a sea of electronic documents".

The AMA Position Statement on *Shared Electronic Medical Records 2016* can be found here https://ama.com.au/position-statement/shared-electronic-medical-records-revised-2016

ADRIAN ROLLINS

Medibank actions 'unconscionable': ACCC

The consumer watchdog is taking the nation's largest health insurer to court alleging it engaged in misleading and unconscionable conduct after it reduced benefits without informing policyholders.

In damning accusations that reflect widespread public discontent over the conduct of private health funds, the Australian Competition and Consumer Commission has launched legal action against Medibank Private claiming it deliberately withheld information about a cut in benefits for in-hospital radiology and pathology services to make money and avoid hurting its image ahead of its public float.

In a strongly-worded statement, the ACCC claimed Medibank made a calculated decision to keep communications about the change "contained and reactive" for fear that if it was disclosed members might leave the fund, and the bad publicity could damage its reputation and "have a negative impact on its planned initial public offering of securities".

The issue arose when, in September 2014, Medibank terminated and phased out agreements with pathology and radiology providers to pay the gap for in-hospital services. As a result, the ACCC said, policyholders were left with average out-of-pocket expenses of $151 for pathology services, and $83 for radiology services.

The ACCC alleges Medibank failed to give members with advance notice of the changes despite previously committing to do so, and that representations it made that members would not face out-of-pocket expenses for in-hospital pathology and pathology services were, from 1 September 2014, false and misleading.

"Consumers are entitled to expect that they will be informed in advance of important changes to their private health insurance cover, as these changes can have significant financial consequences at a time when consumers may be vulnerable," ACCC Chairman Rod Sims said. "Private health insurers must ensure their disclosure practices comply with the Australian Consumer Law."

Medibank has rejected the ACCC's allegations.

"Medibank take sits obligations under the Australian Consumer Law seriously, and has appropriate processes in place to ensure compliance," a spokesman for the health fund said. "We have been working cooperatively with the ACCC throughout its investigation."

AMA President Dr Michael Gannon welcomed the ACCC's action.

Dr Gannon said the AMA has long been highly critical of the actions of insurers making changes to their health cover without informing policy holders, and it was pleasing to see that at least one was now being held to account.

"It has become a distressingly common experience for patients to think they are covered for the cost of medical treatment, only to find that they are lumbered with unexpected out-of-pocket costs," Dr Gannon said.

"It is completely unacceptable for insurers to make changes to the cover they provide without informing policyholders, and it is very important that this type of behaviour is now being called out."

The ACCC's action follows the release earlier this year of the AMA *Private Health Insurance Report Card*, which showed that many policies offered by health insurers were no better than junk, while others did not provide the cover expected.

The AMA's analysis of the 40,000 policies offered by the nation's 33 private health funds has found that Medibank Private, NIB, HCF, HBF, which together account for more than 55 per cent of the health insurance market, are marketing products that, because of multiple exclusions, provide barely more cover than Medicare or, in many instances, provide no additional entitlement at all.

Health Minister Sussan Ley has commissioned a review of the private health insurance industry amid widespread discontent about rising premiums and shrinking cover, and the Coalition has promised that if it is re-elected it will institute a rating system for health cover and "weed out" junk policies by mandating a minimum level of cover.

Dr Gannon said it was time insurers were held accountable for their actions, which often caused great financial and emotional distress for patients caught unaware by surprise out-of-pocket expenses.

"Policyholders need to know exactly what they are covered for and are entitled to, rather than being hit with shock bills when they are ill or at their most vulnerable," he said.

The AMA Private Health Insurance Report Card 2016 is at https://ama.com.au/ama-private-health-insurance-report-card-2016

See also: Medibank hid changes for profit: claim

ADRIAN ROLLINS

Medibank hid changes for profit: claim

Medibank Private hid cuts to in-hospital pathology and radiology cover to pump up its profits and boost its sale price, the Australian Competition and Consumer Commission has alleged.

The ACCC claims that the nation's biggest health fund was motivated by profit and commercial advantage in failing to disclose to its members a change in cover that would leave them out-of-pocket for in-hospital pathology and radiology services.

The consumer watchdog said that Medibank "knew or expected" that many of its members incorrectly believed all of their in-hospital medical expenses were covered, and that most members did not make inquiries about out-of-pocket expenses before being admitted to hospital.

The ACCC said that not only was the insurer wary of the potential loss of members and damage to its brand if the change was publicised, but was concerned that such a disclosure, just two months before its public float, would hurt its market value.

"Medibank calculated there was a risk that the publicity around the benefit change would damage Medibank's brand and reputation, and have a negative impact on its planned initial public offering of securities," the ACCC said.

ACCC Chairman Rob Sims told the Sydney Morning Herald that the initial public offer was "a very relevant background factor, so one can draw inferences. Certainly, it makes logical sense this is the time when you're trying to maximise your earnings".

The health fund, with 3.9 million members, also saw an opportunity to boost its bottom line by hiding the benefit change from members, according to the watchdog.

"Medibank estimated the change would lead it to making substantial financial gains, including from not paying the gaps, and from not paying the medical claims of members who left Medibank after becoming aware of the change," the ACCC said.

The alleged improper behaviour involved members of both Medibank Private and its offshoot ahm, and the policies involved included Medibank's Basic Hospital, Mid Hospital, Standard Hospital, Top Hospital and Ultra Health Cover, and ahm's Budget Hospital, Basic Hospital, Classic Hospital and Top Hospital.

The ACCC said Medibank had made no changes since its behaviour was uncovered, and the watchdog indicated it would seek declarations, injunctions, compensation orders, pecuniary penalties, findings of fact, corrective notices and costs in the action before the Federal Court.

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

Beware insurer tax relief claims: ACCC

Australia's consumer watchdog has warned people not to be taken in by misleading claims about the tax benefits of taking out private health insurance.

The Australian Competition and Consumer Commission (ACCC) says it is concerned that some private health insurers and comparison websites may be misrepresenting the circumstances in which taking out private health insurance before June 30 will help people reduce their tax burden by avoiding the Medicare Levy Surcharge.

The ACCC says that, based on income, most Australian households are not required to pay the Medicare Levy Surcharge, and so will not save on tax by purchasing private health insurance.

Only individuals with a taxable income above $90,000 and couples with a taxable income above $180,000 will avoid the surcharge by taking out private health insurance. Households earning below that amount, which is the majority of Australian households, are not liable for the surcharge in the first place.

ACCC Chairman Rod Sims said the 'save on tax' claims promoted by many private health insurers and comparator websites may result in consumers rushing to purchase private health insurance to avoid a tax that most consumers don't have to pay.

"The ACCC considers that these companies are potentially misleading consumers and gaining an unfair competitive advantage by making representations that leverage off many consumers' lack of knowledge about the application of the Medicare Levy Surcharge," Mr Sims said.

"Private health insurers should be upfront and clear with consumers about the benefits and conditions of their policies, including the circumstances in which any tax savings may occur.

"The ACCC is currently assessing some of the representations made by the health insurance industry and may take enforcement action against the more problematic claims or where businesses continue to make misleading 'save on tax' claims."

Mr Sims said competition and consumer issues in the health and medical sectors were an enforcement priority for the ACCC.

The AMA has also taken action to monitor health insurance industry practice by launching the *Private Health Insurance Report Card*, designed to help people stay more informed about how the market operates and enable them to make better informed choices regarding their health cover.

The Report Card, which was released in March, addressed two of the biggest gripes of policyholders – gaps and shortcomings in cover, and out-of-pocket fees.

It set out the level of cover each of the nation's 35 insurers provides and it details differences in the benefits paid by eight funds for 22 common procedures, including birth, hip and knee replacement, cataract surgery, coronary bypass, vasectomy, haemorrhoid treatment and breast biopsy.

The Report Card showed that the benefits paid by insurers varied considerably, and the AMA strongly recommended that patients seek an estimate from their doctor, and then talk with their insurer before treatment.

The AMA has also raised concerns about the operations of websites that compare health insurance policies, warning that they often earn exorbitant commissions from insurers, which could act as an incentive to get consumers to switch policies. It has called for a greater level of transparency and government scrutiny.

DEBRA VERMEER

Committee backs AMA on primary care

"The House of Representatives Standing Committee on Health handed down its report on Chronic Disease Prevention and Management in Primary Health Care last month, noting that the groundwork for improvements to the primary health care system already existed"

A parliamentary committee has called on the Federal Government to consider reforms to the Medicare Benefits Schedule to help GPs better manage chronic disease in patients.

The House of Representatives Standing Committee on Health handed down its report on *Chronic Disease Prevention and Management in Primary Health Care* last month, noting that the groundwork for improvements to the primary health care system already existed.

"It is clear, however, that this cannot occur without cooperation, coordination, evaluation and adequate data and records to support Primary Health Networks in fulfilling their important role as coordinators of care," the committee said.

"Performance measurements, expansion of chronic disease items, improved referral and rebate claiming processes and encouraging private health insurers to manage their members in cooperation with the primary health care system is a clear goal."

The AMA made a submission to the inquiry in August last year, noting that primary health care was critical to providing quality, effective and empowering health care for people with chronic disease.

"With more than half of all potentially preventable hospital admissions due to chronic conditions, costing more than $1.3 billion a year, there are significant benefits in ensuring access to timely, clinically necessary and well-coordinated health care," the AMA said.

The AMA called for reform of the MBS to restructure specific chronic disease management (CDM) items to cut red tape and reflect modern clinical practice.

It also called for formal engagement protocols between Primary Health Networks (PHNs) and Local Hospital Networks (LHNs) to work together on areas such as transitioning patients out of hospitals and into aged care.

It recognised that there was scope for private health insurers to explore the potential for greater engagement with general practice, but urged caution on expanding their role into a managed care model.

The Committee picked up many of the AMA's recommendations.

It recommended the Government investigate expanding the number of allied health treatments that can attract an MBS rebate within a year, on the proviso that the patient has the relevant General Practitioner Management Plan and Team Care Arrangements in place.

It also recommended that the Government examine reforms to the MBS to allow for a practitioner to claim a rebate for a chronic disease management consultation and a general consultation benefit, for the same person on the same day.

It recommended considering expanding the Practice Incentives Program to include programs for breast, bowel and skin cancer screening, as well as the Integrated Health Check developed by the National Vascular Disease Prevention Alliance.

"Preventive health promotion as well as expanded health checks will help to provide the awareness and early detection required to help combat these diseases," the committee said.

"The Health Care Home trials which are expected to commence in 2017 will help to improve this outcome, and with appropriate funding, privacy considerations, capture and consolidation of data, and a focus on research and improvement, the cooperative care goals required to improve chronic disease primary care can become a reality."

MARIA HAWTHORNE

Women GPs earn less, more cost-effective

> "The research showed that female GPs on average worked 31.8 hours of clinical care per week, compared with their male counterparts, who worked 40.9 hours per week. Women GPs managed 1.63 problems per encounter, compared with 1.51 problems for male doctors"

Female general practitioners in Australia are earning less than their male colleagues, not just because they are working fewer hours, but also because they are spending more time with patients.

Christopher Harrison, a senior researcher with the University of Sydney's Family Medicine Research Centre, said that female GPs earn 6 per cent less per hour than their male peers, primarily because they spend longer in their consultations with patients.

Mr Harrison said that during these longer consultations, female GPs managed more problems for patients than their male peers, with the extra time and attention offered by women considered effective.

The research showed that even taking into consideration the age of both patients and doctor and the level of patient health, people who saw female GPs tended to see their doctor less often in a year.

"Female GPs squeeze more into their consultations with patients," Mr Harrison said.

"They manage more problems per consultation, they are more likely to provide counselling to the patients, and are more likely to manage social problems that can affect patients' health.

"Potentially, this can have very positive impacts and mean that their patients need to be seen less often."

The research showed that female GPs on average worked 31.8 hours of clinical care per week, compared with their male counterparts, who worked 40.9 hours per week. Women GPs managed 1.63 problems per encounter, compared with 1.51 problems for male doctors.

They charged fewer standard MBS items (71.3 per cent compared with 77.6 per cent) and more long/prolonged MBS items (15 per cent compared with 8.9 per cent) and had significantly longer consultations (15.7 minutes compared with 14.1 minutes). They were also more likely to do non-billable work between encounters (14.1 per cent compared with 10.5 per cent).

Overall, the study found it took female GPs 28.5 hours to complete 100 encounters and they earn $4,926 ($173 per hour), while it took male GPs 25.3 hours, earning $4,647 ($184 per hour).

Mr Harrison and his team found there was evidence that while patients seeing female GPs visit their doctor less often in a year, they don't use hospitals at a greater rate.

Female GPs' use of pathology and counselling is still greater than male GPs, their use of referrals and imaging is similar to that of male GPs, while their use of medication is less overall.

"This suggests that the cost of care provided by female GPs may be less than that provided by male GPs," the research found.

Mr Harrison said the research concluded that multiple factors beyond the number of hours worked contributed to the gender pay gap among Australian GPs, and that the inequity should be addressed as part of the Medicare Benefits Schedule item review and the Department of Health's Primary Health Care Advisory Group.

The research was presented at the Primary Health Care Research and Information Service in Canberra in June.

DEBRA VERMEER

Concerns mount over AFP access to doctor's phone records

The AMA Federal Council has been asked to look into revelations the Australian Federal Police (AFP) has put at least one doctor involved in the health care of asylum seekers under surveillance.

An overwhelming majority of the 2016 AMA National Conference supported an urgency motion requesting that the Federal Council investigate the matter after it was revealed that the AFP has been monitoring a Sydney psychiatrist who criticised the treatment of asylum seekers in offshore immigration detention.

AFP officers accessed the phone records of Dr Peter Young, the former medical director of mental health services for Australian offshore detention centres, as part of an investigation into the leaking of medical records relating to Iranian asylum seeker Hamid Khazaei.

Mr Khazaei, 24, died in September 2014 in a Brisbane hospital after being airlifted from Manus Island, suffering from a skin infection which turned into septicaemia.

Documents obtained by the ABC in December that year revealed a 24-hour delay in acting on a request to move Mr Khazaei from Manus Island for urgent treatment, and a lack of antibiotics at the detention centre to treat his relatively minor infection.

Dr Young denies leaking the medical records.

But he told the ABC at the time that while recommendations were made and put through to the relevant decision makers in the department quickly, "the difficulty then becomes what happens through the internal processes in the department and the Minister's office. And often they come back with questions and further questions, and then all of that just delays the process".

Dr Young was subsequently contacted by AFP officers, who told him they were investigating a leak of information and invited him to participate in a recorded interview. He declined, and then used the Privacy Act to seek access to the files the AFP had compiled on him.

The heavily redacted files, comprising hundreds of pages of investigative file notes, state that Dr Young was a suspect because of "comments attributed to him being highly critical of [the Immigration Department] and IHMS [medical service provider International Health And Medical Services] in their handling of asylum seeker medical care" in two news reports.

Tellingly, the file note said: "Dr Young's phone did not identify contact with any media outlets or journalists during the period surrounding the publication of the media articles."

Revelations that the AFP had investigated Dr Young underline concerns that the controversial Border Force Act could be used to prosecute or intimidate medical professionals raising legitimate concerns about the treatment of their patients being held in immigration detention.

Queensland GP Dr Richard Kidd, who moved the urgency motion, told the AMA National Conference that it was deeply concerning that a doctor going about their normal work could be subject to a "fairly draconian invasion of their privacy, and that of their patient".

The AMA has called for the appointment of an independent panel of medical experts to inspect and report on the health care of refugees and asylum seekers being held in immigration detention.

Dr Young told *The Guardian* he was outraged by the "covert surveillance" the AFP had undertaken on him.

"These kind of laws weren't meant to be targeting doctors, they weren't meant to be targeting journalists, and those reassurances have proven to be false," he said.

The investigation was launched under section 70(1) of the Commonwealth Crimes Act, not the more controversial Border Force Act, which makes it illegal for people working within Australia's asylum seeker detention system to disclose information.

The Government has said that the Border Force Act is not designed to target doctors.

But Michael Bradley, the managing partner of Sydney law firm Marque Lawyers, said similar cases could arise.

"[Section 70(1) has been on the statute books since 1914 and is extraordinary wide," Mr Bradley wrote on The Drum website.

"The consequence is that a young man's death and the airing of a government's incompetence are resulting only in the shooting of the messengers."

MARIA HAWTHORNE

Prisoners take heavy medicine

Australian prisoners, particularly women, are taking more medications for chronic diseases and mental health conditions than people of their age in the general community, a new report shows.

The report by the Australian Institute of Health and Welfare (AIHW) shows that many prisoners have complex health conditions, and about half of all prisoners are taking medications of some kind.

Some prisoners' situations are complicated by histories of trauma, combined with underlying chronic and mental health conditions.

"Prisoners are largely considered to be in poorer health than the general community, and this is reflected by the types and quantities of medications taken," said AIHW spokesperson Mark Cooper-Stanbury.

The report found that prisoners are nine times as likely as the general community to take antipsychotics, four times as likely to take medications used to treat addictive disorders, and more than twice as likely to take antidepressants or mood stabilisers.

Among all prisoners aged 20 to 59 years, 17 per cent were taking analgesic pain killers, compared with 13 per cent of those in the general community.

Of women prisoners, 26 per cent were taking analgesics and 13 per cent taking antipsychotic medication, compared with 14 per cent and one percent respectively in the general community, while for male prisoners, 16 per cent were taking analgesics and eight per cent taking antipsychotic medication, compared with 12 per cent and one per cent respectively in the general community.

"Compared with the general community, prisoners also started taking medications for chronic conditions at younger ages," Mr Cooper-Stanbury said.

The report shows that by the time they are in their thirties, prisoners are more likely to be taking medications for high blood pressure, high cholesterol, diabetes and asthma than their non-prisoner counterparts, and by their forties they are more likely to be taking anti-inflammatories.

The reasons why prisoners are taking more prescription medications than other people in the community are complex, and may be influenced by certain aspects of the prison environment, the report found.

For example, prisoners are not allowed to keep medications in their possession for security reasons, and medications are usually given at certain times of the day, which might not suit all medication regimes.

Prisoners also don't have easy access to over-the-counter vitamin purchases and so they are mostly prescribed within the prison system.

The report highlights some of the issues raised by the AMA in its 2012 Position Statement on Health and the Criminal Justice System.

"Prisoners and juvenile detainees in Australia experience profound disadvantages in health compared to the wider community, with markedly elevated rates of mental illness, substance dependence, chronic disease and engagement in health risk behaviours," the AMA paper said.

"The prison setting provides a unique opportunity to address these physical and mental health needs."

Among the recommendations put forward by the AMA were that responsibility for the provision and management of health care in state-run prisons be allocated to state health authorities rather than corrective services or their equivalent.

"Assigning responsibility to health authorities enables prison health care to be benchmarked with wider health workforce strategies and public health standards; reduces the professional isolation of prison health care staff; and ensures security imperatives do not override health considerations."

DEBRA VERMEER

Boost for remote area nurse safety

> "Following Ms Woodford's death, an online petition was set up calling for the abolition of single nurse posts in Australia and requesting a mandate for two responders to attend all after-hours call outs in rural and remote communities"

An Aboriginal health organisation has reportedly been given $1.5 million by the Federal Government to boost the safety of health workers in eight remote indigenous South Australian communities, following the murder of nurse Gayle Woodford earlier this year.

Ms Woodford's employer, Nganampa Health Council, which operates eight clinics in South Australia's Anangu Pitjantjatjara Yankunytjatjara (APY) Lands, was given the money after an internal review and an external risk analysis of the safety of its workers, *The Australian* newspaper reported.

The Medical Director of Nganampa Health Council, Dr Paul Torzillo is reported as saying the review had led to changes to policies and procedures, including ensuring that nurses did not respond to callouts at night without being escorted by a trusted community member.

"We're doing the sort of things you'd expect us to be doing in this situation," he said. "We've re-emphasised a lot of what was already policy for us, and we've made some changes to areas of policy and we're implementing those things, especially around night calls. This will essentially involve people from the community."

Australian Medicine has sought comment from Dr Torzillo and the Health Department, but had not received a response by the time of publication.

Ms Woodford, 56, went missing from her house in the remote Aboriginal community of Fregon on March 23, while she was on-call. Her body was found four days later in a shallow grave nearby.

A local man has been charged with her murder.

Following Ms Woodford's death, an online petition was set up calling for the abolition of single nurse posts in Australia and requesting a mandate for two responders to attend all after-hours call outs in rural and remote communities. It garnered more than 130,000 supporters before being presented to the Federal Government.

In April, Federal Minister for Rural Health, Senator Fiona Nash convened a meeting of stakeholders providing nursing services in remote areas.

After the meeting she issued a statement thanking all those in attendance for their "respectful approach at this difficult time", but pointing out that many of the remote health services were independently run.

"Remote health workers face unique and difficult challenges every day, and these challenges are best understood by those on the front line," she said.

"Whilst the Federal Government funds many of these remote services, they are in fact, independently run, as they should be."

Senator Nash said she would seek to raise the matters raised at the stakeholders' meeting with her State and Territory colleagues.

The fatal attack on Ms Woodford is the latest in a series of incidents and assaults on remote area nurses. A University of South Australia study of 349 such nurses, undertaken in 2008, found almost 29 per cent had experienced physical violence, and 66 per cent had felt concerned for their safety.

The study found that there had been a drop in violence against nurses since 1995, coinciding with a reduction in the number of single nurse posts.

DEBRA VERMEER

Palliative care use almost doubles

The number of Australians using palliative care services is on the rise, with a new study showing that Medicare Benefits Schedule expenditure on such services has jumped by almost 80 per cent over the last five years.

An Australian Institute of Health and Welfare (AIHW) report found that in 2014-15, 13,000 patients received an MBS-subsidised palliative care medicine specialist service, at a cost of $5.3 million in benefits paid, which was a 79 per cent increase on the cost five years earlier.

The findings come as the community debate over euthanasia and assisted dying intensifies following the tabling of the Victorian Parliament's Legal and Social Issues Committee's report on its inquiry into end of life choices.

The committee recommended that the Victorian Government should, in certain limited circumstances, legalise assisted dying.

But Committee Chair, Edward O'Donohue, said the report also called for a greater focus on palliative care.

"The introduction of assisted dying laws should form part of a much broader reform that gives greater prominence to end-of-life care," he said.

The AIHW report, *Palliative care services in Australia 2016*, showed that palliative care hospitalisations increased by 11 per cent, from 55,983 in 2009-10 to 62,164 in 2013-14.

But they still accounted for less than one in 100 of all hospitalisations for both public and private hospitals in 2013-14.

AIHW spokesperson Tim Beard said that as the Australian population grew and people lived longer, the demand for palliative care services would increase.

"These services provide relief from pain and other distressing symptoms for people who are dying," he said.

"Such services are in increasing demand as patterns of disease at the end of life change. An increasing proportion of Australians are suffering from chronic illnesses, and people are therefore more likely to die from chronic illnesses and make use of palliative care services."

Cancer was the most common cause of palliative care hospitalisations (53 per cent), accounting for one in 25 (4 per cent) of all cancer-related hospitalisations. Of patients in hospital for palliative care treatment, about half were aged 75 years and older. Of admitted patients who died in hospital, more than 44 per cent had been a palliative care patient during their final hospitalisation period.

The report found that in 2013-14, just 17 per cent of the 728 public acute hospitals had a hospice care unit, while only eight per cent of the 286 private acute and psychiatric hospitals had hospice units.

The community debate over end-of-life care, euthanasia and assisted dying was reflected in a special policy session of the recent AMA National Conference, which featured a debate on the topic of assisted dying as part of ongoing AMA policy review.

The session, moderated by ABC presenter Tony Jones, brought together a panel of doctors, ethicists and lawyers with a range of views on whether doctors should be involved in assisted dying.

AMA President Dr Michael Gannon, who initiated the policy review as Chair of the AMA Ethics and Medico-legal Committee, said the National Conference session would, along with 3500 responses to an AMA member survey, be used to help inform the AMA Federal Council's deliberations on the issue.

DEBRA VERMEER

Antibiotic use almost as common as the cold

Almost 40 per cent of patients who see their doctor because of a cold or flu expect to be prescribed antibiotics, highlighting concerns about the heavy and inappropriate use of antibiotics in Australia.

As health experts internationally warn about the threat of rising antibiotic resistance, the National Prescribing Service has reported that Australians are heavier antimicrobial users than the British, Canadians, Swedes, Danes, Norwegians and Dutch, often because of misconceptions about their use.

> "An NPS Medicinewise survey of 1000 Australian adults found that 38 per cent who saw their doctor because they or their child had a cold expected to be prescribed antibiotics …"

An NPS Medicinewise survey of 1000 Australian adults found that 38 per cent who saw their doctor because they or their child had a cold expected to be prescribed antibiotics, despite the fact that they are ineffective against viral infections.

Significantly, 17 per cent believed that taking antibiotics would help them get over their cold or flu more quickly.

"One misconception…that needs to be overcome is the mistaken belief that antibiotics help you get over a cold or flu more quickly: they don't," NPS Medicinewise Chief Executive Officer Dr Lynn Weekes said. "Colds, flu and most coughs are caused by viruses. Antibiotics only work on infections caused by bacteria, not those caused by viruses."

The survey findings were complemented by a separate report, based on data from 182 medical practices, which found that up to 50 per cent of patients with a cold or upper respiratory tract infection were prescribed an antibiotic when it was not needed, including 90 per cent of patients diagnosed with acute bronchitis.

Dr Weekes said the rate at which antibiotics were being prescribed inappropriately for upper respiratory tract infections was coming down, but "as health professionals we cannot become complacent",

The AMA has urged doctors to only prescribe antibiotics when clinically appropriate, such as when the benefits to the patient are likely to be substantial, as recommended by clinical guidelines and pathologists, and to ensure that they are of the appropriate dose and duration.

The Association added that it was important for patients to understand that not only were antibiotics ineffective against colds and the flu, but should be used in accordance with instruction when prescribed.

The misuse of antibiotics has emerged as a major global health threat.

The World Health Organisation late last year warned that the planet was heading for a "post-antibiotic era" in which common infections and medical procedures could once again become deadly.

"The rise of antibiotic resistance is a global crisis," WHO Director-General Dr Margaret Chan said. "Antimicrobial resistance is on the rise in every region of the world."

The problem is being fuelled by the fact that in many parts of the world antibiotics are cheap and readily available – in the past year 44 per cent of Russians had obtained them without prescription and 5 per cent of Chinese had ordered them through the internet – and they are being used to treat not only viral infections in humans, but in many countries they are also being given to farm animals to speed their growth.

The WHO said multidrug-resistant tuberculosis infected 480,000 people in 2013 and has spread to 100 countries, antimicrobial-resistant malaria is spreading through the Mekong delta, and there are "high proportions of antibiotic resistance in bacteria that cause common infections (such as urinary tract infections, pneumonia, bloodstream infections) in all regions of the world".

Dr Weekes said individuals can do their bit to help stem the spread of antibiotic resistance by managing ordinary colds and flu without antibiotics.

"For Australians that do come down with a cold or flu this winter, we are urging them not to ask for antibiotics, and to let their doctor know that they only want antibiotics if they are truly necessary," she said.

ADRIAN ROLLINS

Registry could transform prostate cancer outcomes

The outcomes for men undergoing treatment for prostate cancer are expected to improve significantly following the establishment of what is claimed to be the world's largest national prostate cancer registry.

The Prostate Cancer Outcomes Registry has been set up to provide a comprehensive insight into the quality of life for men after they are diagnosed and treated for prostate cancer.

The registry, which covers Australia and New Zealand, will include a record of both of the treatment men receive, and feedback from patients as to their experiences following treatment.

Registry Chair, Professor David Roder, said that collecting patient feedback alongside clinical data would give clinicians important information in selecting treatment options and appropriate support services.

"The Registry is a practical means of improving men's lives following a diagnosis of prostate cancer," Professor Roder said. "It will help clinicians provide more support to their patient by taking into account the personal impact of treatment options on men's lives."

Around 120,000 men currently live with prostate cancer, and about 18,000 new cases are diagnosed each year – making it the most commonly diagnosed cancer among men.

Treatment for prostate cancer have debilitating side effects, including incontinence, sexual and intimacy issues, and psychological distress.

Urological Society of Australia and New Zealand President Professor Mark Frydenberg said the registry presented the first time clinicians would have the opportunity to review treatment and outcomes from the perspective of the patient, and would provide valuable insights that would improve care.

"This means that all men, no matter where they are from – regional towns or major capital cities – will have the best possible chance of surviving and thriving after a prostate cancer diagnosis," Professor Frydenberg said.

The registry is being funded through money raised by the Movember Foundation.

ADRIAN ROLLINS

Doctors – honest and trustworthy

Australians consider doctors to be among the most trustworthy and honest professional groups in the country, affirming a status they have held for decades.

The medical profession's reputation improved in the latest Roy Morgan Image of Professions survey, which measured a 2 percentage point increase in approval to 86 per cent – putting doctors in equal second position with pharmacists, and just behind nurses, who have held the top spot for the past 22 years.

Doctors have ranked in the top five since the survey started in 1976.

Also in the top 10 were dentists, teachers, judges, engineers and police.

Car salesmen were once again rated the least ethical profession – a dubious honour that they have held for more than 30 years.

The survey results show that the actions of a few rogue doctors found to be overcharging or rorting the Medicare system have failed to tarnish the medical profession's reputation, and underline the authority of doctors and the AMA when speaking out on health policy, particularly as it affects the health of patients.

KIRSTY WATERFORD

Consumers warned on complementary medicines

Consumers have been warned to take care if using complementary medicines, particularly if buying them online, after an international documentary linked supplements with liver damage and deaths in the United States.

The joint investigation by the *New York Times* and the PBS *Frontline* program raised a host of questions about the quality and safety of vitamins and dietary supplements, including whether they contained the correct ingredients and whether they contained more than the daily allowance of substances.

The report examined an outbreak of liver problems in Hawaii in 2013, which was later linked to a diet and workout supplement called OxyElite Pro.

The supplement was supposed to use a compound called aegeline, a component of the Bael tree which has been used by naturopaths for centuries, usually safely.

However, the OxyElite Pro manufacturers did not use Bael tree extract, but a form of aegeline made by a Chinese drug company.

The US Food and Drug Administration (FDA) has linked OxyElite to more than 70 cases of liver damage, including the death of a mother of seven.

In Western Australia, a man lost his liver after a protein powder with green tea extract and a supplement containing garcinia cambogia.

NPS MedicineWise CEO Dr Lynn Weekes said the program highlighted the need for care when taking supplements.

"Although complementary medicines can have benefits, they can still have side effects, interactions, and cause allergic reactions, and they also undergo less testing in general compared to other types of medicines," Dr Weekes said.

"Finding good information on the internet can be tricky, as there are thousands of websites providing information about complementary medicines, but you need to keep in mind that many of these are designed to sell products, and the information they provide is often not reliable.

"There are also potential pitfalls and risks when it comes to buying complementary medicines online. There's no certainty that something you buy from an overseas website has been manufactured to Australian standards, and even a product with the same brand name as an Australian product may have completely different active ingredients.

"Essentially, if it seems too good to be true, it probably is."

Supplements purchased online, especially from international suppliers, are not subject to Therapeutic Goods Administration regulations, giving consumers no guarantee about their safety or effectiveness.

MARIA HAWTHORNE

AMA Members recognised in Queen's Birthday Honours

Dr Hannah Krause (second from left) with professor Judith Goh (second from right), Queensland urogynaecologist, and fiscular patients at a clinic in Western Uganda in 2015

More than 20 AMA Members from across the nation were recognised in this year's Queen's Birthday Honours list for service to medicine and the community.

Brisbane urogynaecologist Dr Hannah Krause was made an Officer (AO) in the General Division of the Order of Australia for her distinguished service to medicine in the field of urology and gynaecology, particularly through surgical assistance to women in developing countries throughout Asia and Africa.

Dr Krause has been a specialist at Queen Elizabeth II Jubilee Hospital since 2006, and is a visiting specialist at Greenslopes Private Hospital.

She has also been a volunteer specialist at fistula camps and units in Uganda, Guinea, Ghana, Sierra Leone, Liberia, the Democratic Republic of Congo, Ethiopia, Cambodia and Bangladesh since1995.

A dozen AMA Members were made Members (AM) in the General Division:

- Professor Daniel Cass from the University of Sydney and Westmead Children's Hospital, for significant service to paediatric medicine as a surgeon, academic and researcher, and to child accident prevention and trauma care;
- Professor Lynne Cohen from Edith Cowen University, for significant service to tertiary education, particularly in the field of psychology, and to the community;
- Western Australian rheumatologist Dr Jack Edelman, for significant service to community health, particularly to people with arthritis and osteoporosis, and to medicine;
- Eye Centre co-founder Dr Peter Heiner, for significant service to medicine as an ophthalmologist, to medical education and eye health research, and to professional organisations;
- Associate Professor John King from Royal Melbourne Hospital, for significant service to medicine as a neurologist, to medical education, to multiple sclerosis research, and to professional organisations;
- South Australian GP Dr William Lawson, for significant service to medicine as a general practitioner, to medical heritage and professional organisations, and to the community;

- Dr Iain Murray from Curtin University, for significant service to people who are blind or have low vision, and to education in the field of assistive technology as an academic and researcher;
- Medical broadcaster Dr John D'Arcy O'Donnell, for significant service to community health and education through a range of broadcast media roles, and to medicine as a general practitioner;
- Austin Health Weight Control Clinic founder Professor Joseph Proietto, for significant service to medicine in the field of endocrinology, particularly obesity and diabetes research, and as a clinician, educator and mentor;
- Professor Avni Sali from the National Institute of Integrative Medicine, for significant service to integrative medicine as an educator, clinician and researcher, and to professional education; and
- Dr John Skipper from Royal Adelaide Hospital, for significant service to medicine in the field of gynaecology as an advocate of women's health and the early detection of cervical cancer.

A further 10 members were awarded the Medal (OAM) of the Order of Australia in the General Division:

- Victorian GP and palliative care physician Dr David Brumley, for service to medicine as a GP, and to palliative care;
- Associate Professor Brett Courtenay from St Vincent's Clinic, for service to orthopaedic medicine, and to medical education;
- Victorian GP Dr Bernard Crimmins, for service to medicine, and to men's health awareness;
- Dr Hannes Gebauer from Fremantle Hospital, for service to medicine as a dermatologist, and to hockey;
- Dr Robyn Napier, for service to professional medical associations, including the AMA, AMA NSW, Medical Council of NSW, and MDA National;
- Rural NSW GP Dr David Sevier, for service to medicine as a general practitioner;
- Melbourne rheumatologist and medical historian Dr Richard Travers, for service to medical history, to medicine, and to the community;
- Sydney psychiatrist Dr Gerrit Westerink, for service to medicine, particularly in the field of psychiatry;
- Rural NSW GP and VMO Dr Judith White, for service to the community of Lithgow; and
- Dr David Wilkinson from Royal Adelaide Hospital, for service to hyperbaric medicine.

The AMA congratulates them all on their recognition and thanks them for their service to the health of the nation.

MARIA HAWTHORNE

INFORMATION FOR MEMBERS

AMA CAREER ADVICE SERVICE AND RESOURCE HUB (ama.com.au/careers)

You may have heard about, or seen, the recently newly-launched AMA Career Advice Service and Resource Hub. The website content has recently undergone a major makeover and you are invited to visit the website to see for yourself what is available to assist you in your career or career progression.

With pages providing enhanced and expanded information to those wanting to study medicine, doctors in training and international medical students and graduates, as well as new pages on caring for yourself and global health opportunities, as examples, with better and easier access to AMA practical resources, the site provides a more comprehensive suite of resources than ever before. With further enhancements coming over the months ahead which will include advice on preparing for independent practice, and strategies for transitioning from clinical practice to retirement or non-clinical roles, and the specialist training pathway guide, the site and the complementary one-on-one advice service, adds real value to your membership.

The service offers through the Career Adviser, (careers@ama.com.au) Christine Brill, who has had 32 years working for the AMA and with the profession; advice on resume building (with a model template), addressing selection criteria and cover letter advice as well as tips and tricks on preparing for interviews - which we know are daunting for most. The service aims to ensure that AMA members get their applications noticed and perform well at interview - giving them the edge in an increasingly competitive training and employment environment. As well as this Federal resource, AMA Victoria offers an advice service to Victorian doctors and AMA NSW offers a service to its members.

This site is not just for our doctors in training, but there is a strong emphasis on this cohort of the profession at this time. New pages include global health opportunities, life after graduation, looking after yourself and your finances – with further resources to be added to these pages in the coming months.

The site provides for easy access to AMA resources for the profession; such as the GP toolkit, AMA media statements and its position on a range of issues of concern to the profession – particularly related to student numbers, training places and access, the value of general practice and funding of public hospitals.

AMA backs Indigenous health push

Achieving health equality for Aboriginal and Torres Strait Islander people is a priority for the AMA.

On 9 June 2016, the AMA joined some of Australia's most influential Indigenous organisations to co-sign the *Redfern Statement*, which called on all major political parties make Aboriginal and Torres Strait Islander affairs a key priority.

With Aboriginal and Torres Strait Islander policy being on the sidelines of the Federal Election campaign, the AMA has supported peak Indigenous groups in demanding that Indigenous issues receive immediate attention and action.

This is the first time that such a united call has been put to all political leaders.

The Redfern Statement calls on the next Federal Government to meaningfully address the disadvantage experienced by Aboriginal and Torres Strait Islander people by reversing cuts to the Indigenous affairs portfolio, and reinvest in health, justice, early childhood and disability services, as well as services to prevent violence.

With Aboriginal and Torres Strait Islander people experiencing stubbornly higher levels of chronic disease and dying much younger than their non-Indigenous peers, it is imperative that adequately resourced and culturally appropriate services are available and readily accessible for Indigenous Australians.

Over recent decades, there has been some progress in improving Indigenous health and life expectancy, but there is still much more to be done. While there has been some success in reducing childhood mortality and smoking rates, high levels of chronic disease among Aboriginal and Torres Strait Islander people continue to be a major concern.

The AMA and other signatories to the Redfern Statement said it was not acceptable that Indigenous people did not have the same level of good health that is enjoyed by the broader Australian population.

The authors of the Redfern Statement said that the decades-long churn of governments, policies and promises in Indigenous affairs has been a significant impediment to improving health and life outcomes for Aboriginal and Torres Strait Islander peoples.

The AMA, along with many others working in Indigenous health, has been campaigning for long-term funding and commitments from government to improve the health and wellbeing of Aboriginal and Torres Strait Islander people, and has committed to continuing its advocacy to help achieve this goal.

With more than 200,000 Australians supporting action to close the gap, the AMA said it was evident that the public wanted the Government to work in partnership with Aboriginal and Torres Strait Islander peoples and their representatives to meet the challenge of improving the health and life expectancy of Indigenous people.

"The next Federal Government has an unprecedented opportunity to work closely with Indigenous people and meaningfully address Aboriginal and Torres Strait Islander disadvantage," the AMA said. "The AMA urges the next incoming Government to ramp up its ambition to achieve health equality for Aboriginal and Torres Strait Islander people and take further steps in building on existing platforms."

The Redfern Statement at a Glance

The Statement calls on the next Federal Government to:

- Restore the $534m cut from the Indigenous Affairs Portfolio by the 2014 Budget.
- Commit to better and ongoing engagement with Aboriginal and Torres Strait Islander peoples through their representative national peaks.
- Recommit to Closing the Gap by:
  - > setting targets to reduce rates of family violence, incarceration and out-of-home care and increase access to disability support services; and
  - > securing national funding agreements to drive the implementation of national strategies.
- Commit to working with Aboriginal and Torres Strait Islander leaders to establish a Department of Aboriginal and Torres Strait Islander Affairs in the future
- Commit to address the unfinished business of reconciliation.

Cutting edge diabetes knowledge available to all

> "NPS MedicineWise … is designed to assist health professionals to balance patient and medicine factors when choosing the best glucose-lowering medication for their patients"

Health professionals will have access to the latest evidence-based information about medications for type 2 diabetes through an initiative developed by the national prescribing service, NPS MedicineWise.

In an initiative aimed at making it easier for doctors and other health workers to keep abreast of advances in diabetes treatment and develop individually tailored management schemes, NPS MedicineWise has released the 'Type 2 diabetes: what's next after metformin?' program, focussed on keeping professionals up to date with the latest evidence on second- and third-line medicines for lowering blood glucose, and is designed to assist health professionals to balance patient and medicine factors when choosing the best glucose-lowering medication for their patients.

Dr Jeannie Yoo, medical adviser for NPS MedicineWise, said that new medications for type 2 diabetes were constantly being introduced, and it was important that health professionals had access to the latest information so they could select the most appropriate medication for their patients.

"With over one million Australians living with type 2 diabetes, and the number of people undiagnosed with type 2 diabetes also on the rise, it's critical for health professionals to stay up to date with current approaches to managing the condition," Dr Yoo said.

The first resource in the education campaign – an edition of *Medicinewise News* on type 2 diabetes – was distributed early last month. It includes updated information on current medicine options, particularly when considering add-on oral glucose-lowering medicines to metaformin, and discusses how to individualise therapy according to medicine and patient characteristics.

Dr Yoo said that while they were specifically hoping to improve use of second and third therapies, strategies for improving adherence to the typical first-line therapy metformin is also an important focus of the educational program.

"Despite high prescribing rates from GPs in line with guidelines, we know there are high levels of non-adherence to metformin, and would like to encourage health professionals to consider not just medicine, but individual patient factors to try and improve adherence," Dr Yoo said.

"Ultimately we hope that though health professionals being better informed about medicine choices, we can help people with type 2 diabetes achieve improved glycaemic control, reduce associated long term complications and minimise medicine related adverse effects."

Almost 850,000 Australians surveyed in 2011-12 reported that they had type 2 diabetes, but experts believe the number is likely to be much larger.

The Australian Institute of Health and Welfare said the figure was likely to be an underestimate, with estimates that up to 1 per cent of adults may be unaware they have type 2 diabetes.

Diabetes is a significant cause of hospital admissions – about 45,000 of hospitalisations in 2013-14 involved diabetes as the principal diagnosis, and diabetes was listed as a co-existing condition affecting patient management in an additional 884,337 cases.

The NPS MedicineWise program also includes free educational visits and CPD activities. For more information visit - www.nps.org.au/news-diabetes-2016

KIRSTY WATERFORD

AMA in the news

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

PRINT/ONLINE

Doctors suffer for e-health records, *Adelaide Advertiser*, 15 June 2016

AMA has called for a moratorium on changes that will penalise general practices thousands of dollars if they do not upload patient health summaries to the My Health Record system. Doctors could charge patients a new fee to recover the $60,000 they stand to lose annually if they refuse to use the Federal Government's new electronic system, which could spell the end of bulk billing.

Doctors' boss to limit calls for cash, *The Australian*, 8 June 2016

AMA President, Dr Michael Gannon, believes he has to be mindful of the budget deficits and not ask for "more, more, more" funding for public hospitals. Dr Gannon said the freeze on GP rebates, in particular, was the "number one issue" for the AMA.

TV show a catalyst for research prize, *psnews.com.au*, 2 June 2016

Professor Emily Banks , a researcher at The Australian National University (ANU) was recognised with a Medical Journal of Australia research prize for a study that focused on whether an episode of the ABC television show Catalyst led to a drop in the number of Australians taking heart attack medication. Professor Banks and her colleagues, including lead author, Andrea Schaffer from the University of Sydney, Sallie-Anne Pearson and Timothy Dobbins from the University of NSW and Nicholas Buckley from the University of Sydney, were presented with their prize and plaque at the AMA's 2016 National Conference in Canberra.

GP visits could rise $25, warns AMA chief, *Courier Mail*, 30 May 2016

Doctors could start charging patients an extra $25 a visit, AMA President, Dr Michael Gannon, warned. "Unravelling the (Medicare) freeze is so important. The AMA will continue that campaign. But that's the start of a bigger conversation." Dr Gannon said.

Dr Michael Gannon named new Australian Medical Association president, *The Sydney Morning Herald*, 29 May 2016

Western Australian obstetrician and gynaecologist Dr Michael Gannon pledged to work "constructively" with whichever party formed government, shortly after he won the Association's election at its national conference in Canberra on Sunday. Victorian GP and former president of the Association's Victorian branch, Dr Tony Bartone, was voted Vice President. Dr Gannon and Dr Bartone will each serve two-year terms.

New concussion guidelines for children welcomed by local sporting teams, *The Age*, 29 May 2016

The Australian Medical Association and the Australian Institute of Sport released a statement recommending children aged under 18 who suffer concussion should not return to the sporting field until at least two weeks after their symptoms have cleared. The voluntary guidelines came out of a joint project between the AMA and AIS, which saw the creation of a government-funded website, resources and warnings for parents, coaches and sports administrators to be more cautious when allowing children with head injuries back on to the sporting field.

NT wins AMA Dirty Ashtray award, *SBS News (online)*. 27 May 2016

The Northern Territory Government has been awarded the AMA's Dirty Ashtray Award, ranking it last in the nation for efforts to reduce smoking. The AMA said the NT needed to ban smoking at all pubs, clubs and dining areas and eliminate exemptions for high roller rooms at casinos. On the plus side, the NT was the first jurisdiction to implement a comprehensive prison smoking ban.

RADIO

Dr Gannon, 2UE Sydney, 20 June 2016

AMA President Dr Michael Gannon spoke about out-of-pocket costs for surgery. Dr Gannon said that doctors have a right to charge reasonable fees, but that no one can reasonably justify bills of $20,000 or $30,000 for an afternoon's work.

Dr Michael Gannon, 2UE Sydney, 15 June 2016

The Australian Medical Association says the Federal Government's My Health Record system needs more work before it can deliver improvements to patient care. Dr Michael Gannon, AMA President, says it's not fair to penalise doctors if the system is not up to scratch.

Dr Michael Gannon, 720 ABC Perth, 8 June 2016

Dr Michael Gannon opened up about his childhood, his early career experiences, and his motivations and aspirations in a wide-ranging interview.

Australian Medical Association, 5CC, 7 June 2016

Rural doctors called on the major political parties to get behind a 'rural rescue package' jointly proposed by the Rural Doctors Association of Australia and the Australian Medical Association.

The package aims to attract more doctors with the advanced medical skills needed by country communities to rural practice.

Dr Michael Gannon, 2HD, 1 June 2016

Dr Michael Gannon, newly elected President of the Australian Medical Association, said being elected was a tremendous honour, adding that he was looking forward to working for his colleagues. Dr Gannon urged the Federal Government to lift the freeze on the Medicare rebate, claiming it was going to have a big impact on those that the use the services of GPs.

Dr Michael Gannon, Radio National, 30 May 2016

Dr Gannon, the new President of the AMA, said the Association opposes the Medicare freeze but there is room for consultation in other areas of health policy. He said the AMA will continue to pressure all political parties to have the rebate freeze scrapped.

TELEVISION

Dr Gannon, Channel 10, 3 June 2016

Dr Gannon said the AMA wanted a national prescription tracking system to crack down on medicine abuse at a time when Australia's prescription drugs abuse rates have been reported the second highest in the world.

Dr Michael Gannon, Sky News Live, 1 June 2016

Dr Gannon, newly elected AMA President, said GPs are at breaking point and their ability to provide quality services is limited at the current level of Government funding. He added that investments in general practice provided a lot of benefits, including helping keep patients out of hospital emergency departments.

Dr Michael Gannon, ABC News 24, 29 May 2016

Dr Michael Gannon, incoming AMA President, vowed to continue to campaign against the freeze on Medicare rebates.

INFORMATION FOR MEMBERS

AMA Fee List Update – 1 July 2016

The AMA List of Medical Services and Fees (AMA List) will be updated on the 1 July 2016 to amend existing items and include new items. These items are provided in the Summary of Changes for 1 July 2016, which will be available from the Members Only area of the AMA website at https://ama.com.au/article/1-november-2015-31-october-2016-current

The updated AMA Fees List Online will be available from http://feeslist.ama.com.au. Members can view, print or download individual items or groups of items to suit their needs. The comma delimited (CSV) ASCII format (complete AMA List) is available for free download from the Members Only area of the AMA Website (www.ama.com.au). To access this part of the website, simply login by entering your username and password located at the top right hand side of the screen and follow these steps:

1) Once you have entered your login details, from the home page hover over **Resources** at the top of the page.
2) A drop down box will appear. Under this, select **Fees List**.
3) Select first option, **AMA List of Medical Services and Fees – 1 July 2016.**
4) Download either or both the CSV (for importing into practice software) and **Summary of Changes** (for viewing) detailing new, amended or deleted items in the AMA List.

If you do not have Internet access please contact us on (02) 6270 5400 for a copy of the changes.

The problem with 'record high' bulk billing rates

BY EDWIN KRUYS, SUNSHINE COAST GP AND AUTHOR OF DOCTOR'S BAG MEDICAL BLOG: HTTPS://DOCTORSBAG.NET

According to government data, bulk billing rates are at an all-time high: around 85 per cent of GP services are bulk billed.

This figure is often used to justify the lack of investment in general practice, including the freeze on Medicare rebates patients get back after a visit to their family doctor.

Why is this figure so high?

Not surprisingly, the issue is more complex than politicians want us to believe.

According to the Government it is a matter of supply and demand. In other words, they claim that GPs will not be able to introduce a fee because their patients would go to a bulk billing practice down the road.

This argument, as well as the Government's focus on record high bulk billing figures, is misleading and doesn't tell the whole story.

The truth about bulk billing rates

The reality is that we don't exactly know why bulk billing levels are high.

There are several possible explanations, such as:

- GPs have been billing compassionately to provide access to all their patients;
- GPs have been absorbing the costs of the government's freeze on patient Medicare rebates;
- doctors have increased their services to compensate for the low Medicare rebates; and
- as a result of the ageing population, more people are bulk billed.

The explanation given by the Government, that market forces are the reason GPs bulk bill, does not do justice to the work of GPs around the country.

Besides, as a result of Government policies, out-of-pocket expenses for patients have been rising over the years.

Why out-of-pocket costs go up

GPs are genuinely concerned about their patients first and foremost and, no matter what politicians say, GPs have been bulk billing a large proportion of their services because they know that many patients would not seek medical care if they had to pay a fee of $15-20 per visit.

Unfortunately the Government has indicated it will not further index Medicare patient rebates and, as result of the Government's long-term Medicare freeze, practices across Australia will be forced to introduce fees.

This was the whole idea behind the government's original co-payment plan and the reason the Medicare freeze has been dubbed a 'co-payment by stealth'.

The short-term 'savings' created by the Medicare freeze will likely result in more health problems due to delayed GP visits, and drive up costs in the longer term. A typical case of a penny wise and pound foolish approach.

Downward spiral

What if practices don't introduce a fee? A bare-bone, high-turnover model is one way bulk billing practices can sustain themselves: doctors may decide to see seven to eight patients per hour, instead of four to five.

The question is, of course: how safe is this, and how long can they keep doing this?

High bulk billing rates, yes – but is this the health care system we want for Australia?

The bulk billing statistics tell us what percentage of services is bulk billed, not patients.

We also know that Australians already pay more out-of-pocket for their care than many other countries, which creates barriers to visiting a family doctor.

These figures are rising, so clearly the bulk billing statistics only tell part of the story.

Instead of looking at bulk billing rates as a measure of success, we should be carefully monitoring the out-of-pocket health expenses in Australia.

GP leaders have warned that we're facing a downward spiral – which is a risk for the nation's health and leads to higher overall costs.

Even if the freeze on Medicare patient rebates is reversed – which is an absolute must – we're not out of the woods. We need well-resourced, sustainable primary care funding models that support high quality care for our patients and are easy to implement at grassroots level.

Research

Morphine use increases pain severity, doubles duration

Morphine can more than double the duration of pain and amplify its severity in the long term, according to new international research on its effects as a painkiller.

But the study team, which included researchers from Colorado, South Australia and China, has also discovered how to switch off this pain-amplifying mechanism, offering hope for millions of pain sufferers world wide.

Author of the study and University of Adelaide Research associate Dr Peter Grace said the results, published in the

journal Proceedings of the National Academy of Sciences (PNAS), further questioned the use of opioid-based painkillers and treatments.

“Prior studies have looked at the effect morphine has on pain sensitivity short term, but in this study we looked at the weeks and months after morphine use,” Dr Grace said.

“What we found is that the opioid painkiller activates spinal immune cells, causing a further inflammatory response.”

“The pain is effectively transitioned to a chronic state, making the pain itself both more severe and longer lasting.”

The research team found that rats with chronic nerve pain that had been treated with morphine for just five days experienced prolonged pain sensitivity than their control group counterparts.

“This extended period of chronic pain has followed from just five days of treatment with morphine, which in itself is very significant,” Dr Grace said.

The study was led by Professor Linda Watkins at the University of Colorado Boulder.

Chronic pain affects 10 per cent of the world’s population, about 60 million people, with estimates of closer to 20-25 per cent in some countries.

Dr Grace, who is also a Research Assistant Professor with the University of Colorado Boulder, said the study had huge implications for the treatment of pain worldwide.

“Our results add weight to the growing body of science suggesting that treatment with opioids such as morphine may in fact be a contributor to people’s chronic pain,” Dr Grace said.

“It means we need a more sophisticated approach because what we found is that opioid pain killers such as morphine activates spinal immune cells, causing further inflammatory response.”

The research team discovered a way of switching off this pain-amplifying mechanism using a new technology known as Designer Receptor Exclusively Activated by Designer Drugs (DREADD).

By using DREADD, researchers were able to isolate the spinal immune cells and prove their involvement in this response to opiate use.

“Importantly, we’ve also been able to block the two main receptors involved in this immune response, including Toll-

Like receptor 4 (TLR4) and another one called P2X7R, which have both been separately indicated in chronic pain before,” Dr Grace said.

“By blocking these receptors, we’re preventing the immune response from kicking in, enabling the painkilling benefits of morphine to be delivered without resulting in further chronic pain.”

Dr Grace said chronic pain sufferers could take opiate-based medicine as well as the receptor-blocking drug to reduce likelihood of long-term effects.

“It means they would need to take two drugs instead of one – they would still be able to use morphine or other opiate-based drugs as well as the additional drug.”

Research

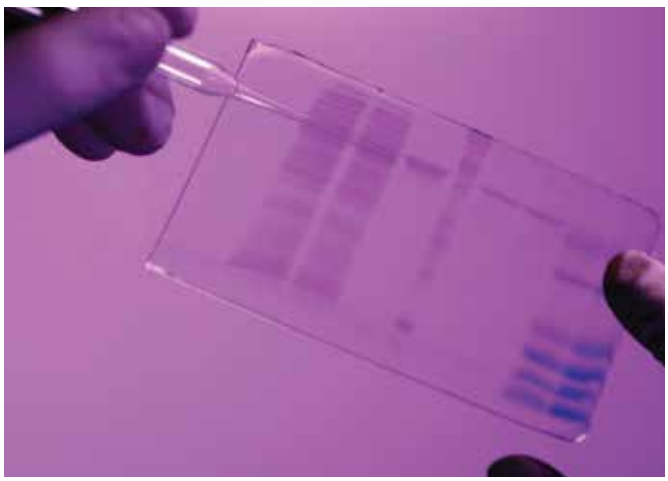
... from p25

Novel drugs are currently undergoing testing and are not expected to be on the market for 10 years.

Dr Grace said the team would like to further investigate how broad the receptor-blocking drug was and whether it had similar effects for other opiate-based drugs such as oxycodone and fentanyl, and for other types of chronic pain including low back pain.

ALANNAH JAMES, THE LEAD SOUTH AUSTRALIA

Gene discovery sparks hope for type 2 diabetes cure



Researchers have identified the gene they believe is responsible for the onset of type 2 diabetes, sparking hope for treatments to prevent and possibly reverse the progressive condition.

The researchers from Flinders University in South Australia collaborated with international research teams from the United States, Sweden and the United Kingdom to narrow down the possible field of 5000 candidate genes to one, known as RCAN1.

Study leader and Flinders University cell physiologist Professor Damien Keating said a cross-referencing approach using genes from individuals with Down syndrome was crucial to the result.

Professor Keating said people with Down syndrome were prone to a range of health disorders, including diabetes, resulting from the overexpression of particular genes because Down syndrome occurred when people had an extra copy of chromosome 21.

“Many individuals with Down syndrome experience lower insulin secretion, mitochondrial dysfunction and increased oxidative stress in the insulin-producing beta cells of the pancreas, which are all conditions that also appear in people with type 2 diabetes,” Professor Keating said.

To identify genes duplicated in Down syndrome that contribute to problems with insulin secretion, scientists screened the genes of four mouse models of the disorder – two had high blood sugar and two did not, with the variation enabling a short-list of 38 implicated genes to be identified.

The scientists then narrowed down the list by comparing it to genes overexpressed in beta cells from humans with type 2 diabetes.

“The comparison identified a single gene, RCAN1, which, when we overexpress it in mice, causes them to have abnormal mitochondria in their beta cells, produce less cellular energy and secrete less insulin in the presence of high glucose,” Professor Keating says.

According to the World Health Organisation, the number of people with diabetes in 2014 was 422 million, up from 108 million in 1980. In 2012, an estimated 1.5 million deaths were directly caused by diabetes and another 2.2 million deaths were attributable to high blood glucose.

Type 2 diabetes, which accounts for the majority of diabetes ases, is a progressive condition in which the body becomes resistant to the normal effects of insulin and/or gradually loses the capacity to produce enough insulin in the pancreas. The cause of type 2 diabetes is unknown.

“Given that we’ve identified this gene as important for reducing insulin secretion in type 2 diabetes, we are now at a stage where we have a series of drugs that target RCAN1 and we are now going to test to find whether these drugs can improve insulation secretion in type 2 diabetes,” Prof Keating said.

“We don’t understand what changes in our pancreas or in our insulin secreting beta cells to cause that transition from just being insulin resistant and having metabolic syndrome to transitioning to full-blown type 2 diabetes.

“RCAN1, this gene we identified, is certainly a candidate now for that.”

Research

Prof Keating said none of the available treatments for type 2 diabetes targeted the primary cause of the condition.

“All the drugs out there simply alleviate the symptoms,” he said.

“So we have to test these drugs that we have because we feel like that may be able to go straight to the cause of the reduced insulin secretion that causes Type 2 diabetes ... prevent it and possibly reverse it.”

The results of the study led by Prof Keating have been published in the international journal PLOS *Genetics*.

ANDREW SPENCE, THE LEAD SOUTH AUSTRALIA

Study finds 5:2 diet is useful weapon in fight against diabetes

A POPULAR diet is proving to be effective for improving the health of people with type 2 diabetes.

In a pilot trial conducted by the University of South Australia, use of the 5:2 diet resulted in a significant reduction of blood glucose level and weight loss.

In the three-month trial involving 35 people, participants reduced their haemoglobin A1C (HbA1c) by an average of 0.6 per cent and also reduced their bodyweight by 6-7kg.

The results have prompted a larger year-long study to begin in the coming months, which aims to involve 100 participants.

University of South Australia PhD candidate Sharayah Carter said there had been a lot of research to support the new diet, but none that looked into its potential benefit for people with type 2 diabetes mellitus (T2DM).

“One of the major struggles with weight loss is people’s ability to stick to a daily-restricted calorie diet,” she said.

“On top of that, people with T2DM have medication to consider. A person with diabetes is not going to be able to take the same amount of medication on those two days because they’re not eating enough food to support that medication.

“What we found was that two days of severe energy restriction basically achieves similar results to a daily restriction diet.”

The UniSA trial was the first of its kind and tested the effects of a two-day intermittent energy restriction (IER) diet with 5-days of habitual eating for people with T2DM. This was compared to a daily restricted diet.

The results showed that while the IER diet has less of an impact on lifestyle and medication, both diets achieved similar reductions on weight and in haemoglobin A1C levels.

The standard calorie restriction diet consisted of 1200 calories a day for women and 1500 calories for men. All participants were asked to walk an extra 2000 steps per day to increase their level of exercise.

People who are obese are up to 80 times more likely to develop type 2 diabetes than those with a Body Mass Index (BMI) of 22. Weight loss can help control and possibly halt the disease.

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Type 2 diabetes, which accounts for the majority of diabetes cases, is a progressive condition in which the body becomes resistant to the normal effects of insulin and/or gradually loses the capacity to produce enough insulin in the pancreas. The cause of type 2 diabetes is unknown.

“IER uses short periods of severe energy restriction – 500 calories for women and 600 calories for men - followed by periods of habitual eating to achieve similar health improvements as daily dieting but unlike some IER diets, does not require non-fasting days to involve restricted dieting,” Carter said.

Research

... from p27

"We achieved a 0.6 per cent drop in HbA1c in both groups which was a significant drop in that time frame and importantly all our participants who were on medication reduced their dosages which is important for both the individual and the health budget.

"Essentially you are achieving the same total energy restriction after seven days by following the two-day restriction and getting the same results."

The study was conducted in collaboration with the Sansom Institute for Health Research. It is a consortium of leading researchers with the aim of intervening early to prevent illness, improve health systems and services, creating more effective therapies and advancing health equality.

CALEB RADFORD, THE LEAD SOUTH AUSTRALIA

Malnourished dads linked to underdeveloped kids

Malnourished fathers could avoid passing on poor health to their children by taking vitamin supplements and antioxidants before conceiving.

Researchers from the University of Adelaide in South Australia conducted a laboratory study using under-nourished male mice and found a direct correlation between the health of the offspring and the father's health at the time of conception.

University of Adelaide researcher Nicole McPherson said previous studies had looked at the affect of malnutrition in mothers but new evidence suggests that paternal influences could play a more direct role.

"Malnutrition is a serious issue and affects hundreds of millions of people around the world," she said.

"The biggest issue is that people dismiss men's health and it's impact on the health of their children, whether that is under-nutrition or over-nutrition.

"However, we now know that the parents' health at the moment of conception is incredibly important. What we're seeing from our research is that some form of dietary supplementation may also benefit fathers-to-be."

There are about 2 billion people in the world who suffer from various forms of malnutrition. About 2.6 million children die from malnutrition each year, which accounts for a third of child deaths globally.

Under-nutrition is considered to be the number one risk to health worldwide and accounts for 11 per cent of the global burden of disease.

The research study found that the offspring of malnourished male mice were born underdeveloped and showed evidence of abnormal gene expression and metabolic markers.

These offspring were prone to health conditions including increased risk of non-communicable diseases, cardiovascular disease and type 2 diabetes, mirroring the situation for human children born in the developing world.

Researchers responded by altering the diet of the male mice to include additional zinc, folate, iron and other vitamin supplements.

This resulted in improved fertility rates, healthier children and normal metabolic markers.

"A father's health at the time of conception is really important – their particular dietary quality and nutrient sufficiency," Dr McPherson said.

"We hope that these findings could eventually be translated into interventions, to help reduce the health burden of under-nutrition to the world."

"This is however a laboratory study and we still need to do more research."

The study titled Paternal under-nutrition programs metabolic syndrome in offspring which can be reversed by antioxidant/vitamin food fortification in fathers has been published in the Nature journal *Scientific Reports*.

CALEB RADFORD, THE LEAD SOUTH AUSTRALIA

Antidepressants could be dangerous for kids

Most antidepressants don't work in the treatment of depression in children and adolescents, and could even be dangerous, a new study has shown.

The study, published in *The Lancet*, looked at the treatment of Major Depressive Disorder, one of the most common mental disorders in children and adolescents.

It reviewed studies of 14 of the most commonly prescribed antidepressants and found only one, fluoxetine, was more effective than a placebo at relieving depression in children and teenagers.

Research

Lead study author, Dr Andrea Cipriani, of Oxford University, told The Lancet podcast that about 3 per cent of primary school aged children have the condition, and 6 per cent of high school aged adolescents.

“Another important thing to bear in mind is that Major Depressive Disorder in children and adolescents, compared with Major Depressive Disorder in adults, not only is it still underdiagnosed and under-treated, but also it tends to present in a different way,” he said.

“Depressive symptoms in children and adolescents are rather undifferentiated. You notice more irritability, aggressive behaviour, problems at school, and the consequences of depressive episodes in children and adolescents are dramatic because they include impairment in their social functioning but also an increased risk of suicidal ideation and attempts.”

The study was a systematic review and meta-analysis of the existing literature, which identified 34 randomised controlled trials involving 5260 participants with a mean age of between nine and 18 years, and 14 antidepressant treatments.

Researchers focused on two primary outcomes of antidepressant treatments – efficacy, (or change in depressive symptoms), and tolerability (whether treatment was discontinued due to adverse events).

They found that only fluoxetine was more effective than the placebo, and also rated better in terms of tolerability.

Patients given three drugs in particular - imipramine, venlafaxine and duloxetine - had more discontinuations due to adverse events than those given the placebo. Compared with placebos and five other antidepressant medications, venlafaxine was found to increase the risk of suicidal thoughts and attempts.

Dr Cipriani said the study’s results back up existing international guidelines which say that the starting point for childhood or adolescent depression should be psychological treatment, rather than antidepressants.

“International guidelines suggest to start with non-pharmacological interventions – psychological intervention - for children and adolescents with major depression,” he said.

“The reason being twofold – one is because of the evidence. We have some evidence that some of the psychological interventions like cognitive behavioural therapy, interpersonal therapy may work for these patients, and at the same time the recent meta data analysis showed that these are two interventions that might work.

“But, also, with children and adolescents, we are talking about a developing brain. We are always very cautious when prescribing medications because we don’t really know the potential implications long-term for the developing brain.”

Dr Cipriani said the next step for researchers would be to carry out a natural meta-analysis comparing pharmacological versus non pharmacological treatment, in order to have a proper ranking of treatments for young people with depression.

“However if we look at the evidence now, psychological treatment should be the front line treatment,” he said.

DEBRA VERMEER

Cancer mortality rates

The number of people dying from cancer is projected to grow, but experts predict overall cancer mortality rates will decline as the medical profession gets better at detecting and treating the life-threatening illness and dangerous behaviours like smoking and heavy drinking decline.

In an upbeat assessment of the outlook for one of the nation’s most common killers, the Australian Institute of Health and Welfare (AIHW) has used past trends in cancer deaths and mortality rates to develop projections for the next 10 years.

The Institute said that the mortality rate for all cancers combined has generally decreased over time, from 199 deaths per 100,000 in 1968 to 166 per 100,000 in 2013. AIHW said that the overall decrease is influenced by changes in both total cancer incidence and total cancer survival.

Research

... from p29

The report did not go into reasons for the decline, but initiatives including cancer screening programs, advances in diagnosis and treatment, and changes in diet and lifestyle, including a big decline in the prevalence of smoking and heavy drinking are considered to have made an important contribution.

Though cancer is a diverse group of diseases, each with its own specific risk factors, progression, treatment and prognosis, the Institute said the data pointed to a decreasing trend in cancer mortality overall.

The AIHW has projected that if current trends continue, by the middle of next decade the male mortality rate from all cancers combined will decline from 208 to 180 per 100,000 males. Nonetheless, because of population growth, the number of men dying from cancer will increase, from 25,643 l 2014, to a projected 31,555 deaths in 2025.

For women, the mortality rate from all cancers will decline from 133 to 120 deaths per 100,000 over the same period, and the AIHW predicts 24,159 women will die from cancer in 2025 – up from 19,644 in 2014, due to population growth.

The AIHW report can be found at http://www.aihw.gov.au/cancer/mortality-trends-projections/

KIRSTY WATERFORD

Parents don't know how much painkiller is safe for kids

Many parents do not know safe doses of over-the-counter paracetamol products for their children, underlining concerns that large numbers of youngsters are being exposed to potential drug overdoses and other harmful outcomes.

University of Wollongong researchers have found that one in four parents do not know the recommended daily dose for paracetamol, and one in three are unaware that liver toxicity could result from an overdose of the painkiller.

Lead researcher Associate Professor Judy Mullan said the lack of knowledge among parents regarding the appropriate uses of paracetamol could leave children susceptible to potential adverse drug events.

NPS MedicineWise Medical Advisor Dr Andrew Boyden said that it is important, especially for parents, to understand that all medicines come with risks as well as benefits.

"Small mistakes can cause big problems in little bodies, so parents and carers need to know how to give medicines to children safely," Dr Boyden said.

The study, involving 174 people, found that 26.4 per cent did not know the recommended maximum daily dose for children's paracetamol, 37.4 per cent did not know that an overdose could cause liver toxicity, and 46 per cent were unsure how many days in a row the recommended dose could be given safely.

Participants in the study were mostly female (93 per cent), well educated (86 per cent), with a mean age of 36 years.

A/Professor Mullan said the findings showed that much more needed to be done to educate parents about the safe use of paracetamol in children.

"Some strategies to address knowledge gaps could include improving health professional/consumer communication, improving product packaging labelling, and improving media coverage about the potential adverse effects associated with incorrect dosage," she suggested.

Dr Boyden said that knowing how to accurately measure and administer medicines to children would help to avoid accidental overdosing or underdosing.

"Some ways to be medicinewise when children are involved include reading the medicine label and packaging, knowing the child's weight, measuring liquid medicines accurately, keeping track of medicines given, and asking questions if you're unsure about anything," Dr Boyden said.

The paper was presented at the National Medicines Symposium. Read more at http://ro.uow.edu.au/smhpapers/3765/

KIRSTY WATERFORD

Life expectancy up, but Africa still behind – WHO

A new report has highlighted the disturbing extent of health inequality across the globe, showing that while life expectancy has risen at its fastest rate since the 1960s, sub-Saharan Africa still lags the rest of the world by a considerable margin.

The World Health Organisation (WHO) figures show that global life expectancy increased by five years between 2000 and 2015 – the fastest increase since the 1960s.

The African region had the strongest growth, up by 9.4 years, driven by improvements in child survival, malaria control and access to retrovirals for HIV treatment.

The increase has narrowed the gap between African life expectancy and European life expectancy by 4.9 years since 2000.

But even so, a child born in Africa in 2015 can only expect to live to the age of 60, compared with the global average of 71.4 years.

A child born in Sierra Leone has a life expectancy of just 50.1 years, more than 33 years less than a child born in Switzerland (83.4). An Australian (82.8 years) can look forward to three more decades than an Angolan (52.4 years).

"The world has made great strides in reducing the needless suffering and premature deaths that arise from preventable and treatable disease," WHO Director-General Dr Margaret Chan said.

"But the gains have been uneven. Supporting countries to move towards universal health coverage based on strong primary care is the best thing we can do to make sure no-one is left behind."

The *World Health Statistics: Monitoring Health for the SDGs* report shows that the declines in life expectancy experienced in the 1990s, caused by the AIDS epidemic in Africa and the impact of the collapse of the Soviet Union on eastern Europe, have been reversed.

"The global average increase in life expectancy at birth since 2000 exceeds the overall average rate of life expectancy increase achieved by the best performing countries over the past century," WHO said.

"The world as a whole is catching up with those countries, and improvements in outcomes for all major causes of death have contributed to these huge gains."

WHO said it was worth considering a proposal to measure premature mortality – deaths before the age of 70 – as it was more sensitive to interventions.

"There were an estimated 30 million deaths under age 70 in 2015 and, if the Sustainable Development Goals (SDG) mortality targets had been achieved in 2015, this would have been reduced to 19 million deaths," the report said.

"This represents a 36 per cent reduction (almost 11 million averted premature deaths) – close to the proposed 40 per cent target."

Had those deaths been averted, five million people would not have died from infectious diseases, malnutrition, and child and maternal mortality. A further five million would not have lost their lives to non-communicable diseases, and 900,000 people would not have died from injuries.

The report found that Japan topped the life expectancy list, at 83.7 years, and Sierra Leone was the lowest (50.1).

Healthy life expectancy, a measure of the number of years of good health a 2015 newborn can expect, stands at 63.1 years globally – 64.6 years for women and 61.5 for men.

On average, women (73.8 years) live longer than men (69.1 years) in every country of the world. Scandinavian countries had the lowest male-female gaps (Iceland 3.0 years, Sweden 3.4) while some former Soviet countries were among the highest (Russia 11.6 years, Ukraine 9.8 years).

The full report can be found on the WHO website at http://www.who.int/gho/publications/world_health_statistics/2016/en/

MARIA HAWTHORNE

Seeing Europe the hard way

BY ADRIAN ROLLINS, *AUSTRALIAN MEDICINE* EDITOR

This is the easy bit: descending from one of the dozens of epic Pyrenean summits

It used to be that when winter hit hard in Australia, those who could afford it would fly to Europe to bask in the Mediterranean sunshine, visit a museum or two, eat great food, imbibe stunning wines and generally lap up the warmth.

But the days there are many travellers making their way to Europe for whom rest and relaxation is the last thing on their mind.

With a bicycle in their luggage, and months of hard training in their legs, they are making pilgrimages to the fabled climbs of the Alps, the Pyrenees, and the Dolomites.

This time last year, I was among their number.

It was with more than a little trepidation that, to mark my impending fiftieth year on the planet, I signed up for the Haute Route Triple Crown, a cyclosportive that would involve cycling 2700kms through the Pyrenees, the Alps and the Dolomites in just 23 days - climbing more than 60,000 metres in the process.

With some reason, the organisers of the Haute Route bill it as the highest and toughest cyclosportive in the world.

Taking the anxiety level up a few notches, there was a daily cut-off time – miss the cut, and you were out of the running to be an officially recognised finisher. Translated, that meant: no bad days.

For a rank amateur such as myself, it was the closest I would ever get to experiencing the life of a pro cyclist.

For three weeks, the only thing I had to concentrate on each day was hauling myself and my bike over some of Europe's biggest mountains, and make sure I was in good enough shape to do it all again the following day.

In many ways, it felt like the cycling equivalent of the rock star lifestyle, except with completely shattered legs, an inability to stay awake after about 9pm, no sex and no enjoyable drugs (ibuprofen doesn't count).

The original plan had been to just ride the Pyrenees. But my wife argued, with compelling logic, that if I was going to fly around to

the other side of the world to ride my bike, I should do the whole thing. I didn't do the sums, but on a dollar per kilometre count, it seemed to make sense.

All I had to do was convince my legs (and my bum, back, neck, arms and even hands) that it was a good idea as well.

After 12 months of intense training (and endless fussing about gear and nutrition), I made it to the start line in Anglet, a small French port on the Atlantic coast just up the road from Biarritz on 15 August to begin the biggest cycling – nay, sporting – adventure of my life.

The Haute Route is organised like a full Grand Tour (not surprising, since it is planned and run by many of the same people responsible for Tour de France). Every morning there is a grand depart from the middle of town, there are motorcycle escorts and outriders, there are time limits, feeding zones, Mavic support vans and a legion of volunteers who patrol every village and intersection the ride goes through.

Zipping through little mountainside hamlets lined with clapping locals, hurtling across village squares and through cross roads, all without barely having to touch the brakes, was exhilarating.

So too were the views. To actually ride up cols I had only ever seen in late-night broadcasts of the Le Tour and the Giro was unforgettable – particularly so because I probably took about three times as long as the slowest pro.

The Haute Route took us up and over many of the iconic climbs – the Tourmalet; Hautacam; Izoard; the highest mountain pass in the Alps, Col de la Bonnette; the Col de la Croix de Fer; the Furka Pass in the Swiss Alps; the Gavia and the Giau in the Dolomites.

All up, the 28 of us who embarked on the Triple Crown would climb 57 cols before reaching our destination in Venice on September 6.

Competing in the Haute Route for the whole three weeks is to be in a bike-infused bubble.

Mentally, there is little down time.

Virtually every waking moment is spent either working on recovering from the ride you've just finished, or preparing for the ride to come.

As my fellow Triple Crowner Howard Galloway put it, we were velo: we had morphed into cycling machines operating at a base level of consciousness whose overriding purpose was to turn pedals.

The Haute Route peleton slowly makes its way up the Col de la Croix deFer climb

There is no getting away from the fact that this is an enormous mental challenge.

Often people say they "find themselves" on such adventures. I can't say that happened for me. What I did find was that (a) Europe has a LOT of cows; (b) you have to be careful where you step in the bushes behind rest stops; and (c) you can get out of bed and onto a bike while still half asleep.

If you want to hone your capacity for doggedness and persistence, the HR Triple Crown is the perfect place to do it.

As the three weeks unfolded and the kilometres mounted, the novelty of being a bike "pro" gradually morphed into a familiar

Not smiling, grimacing ... grinding up another stunning pass through the French Alps

... from p33

rhythm – get to the end of the stage, quickly quaff some recovery drink, scoot to the hotel, book a massage, have a quick shower, get your gear ready for the next day, go to dinner and then crash.

But constant challenges and changes meant no two days were ever alike.

On some there was barely a flat spot, while on others two summits would be separated by a long valley haul where joining a bunch was essential to save much-needed energy. Occasionally, the route went along a major road, at other times along riverside bike paths.

Just about every night meant a new town and hotel. Some days finished with a transfer – including, memorably, finishing the Pyrenees ride on the outskirts of Toulouse and dashing to the nearby airport to catch a flight to Nice in time to start the Alps leg.

Then there were the constantly shifting weather patterns that meant we experienced everything from baking heat to torrential rain, fog, snow and ice (sometimes in the same day).

On top of this, each week the character of the ride changed as a new influx of cyclists descended on the event.

The Haute Route is actually comprised of three discrete week-long events, and this is what most sign up for.

For those of us doing the Triple Crown, it was almost like doing a stage race in which 90 per cent of the peleton was replenished with fresh riders at the start of every week. It meant that there was a constant cavalcade of new people to meet and be entertained by.

Aside from the spectacular scenery, tortuous climbs and demanding descents, the fact is that when you draw together 600 keen cyclists from around the world, you are bound to see some pretty unusual and amusing sights.

Like the jostling among riders huddling in the narrow doorway of what looked like an electricity substation at the summit of the Izoard in a vain attempt to shelter from a massive storm lashing down.

Or the spray of excrement that showered a bunch as it hit a 200-metre patch of road on the descent of the Tourmalet that was smeared in a layer of cow manure.

Then there was the local spotted high up on the flanks of the Tourmalet riding a recumbent which had a door-sized solar panel strapped to the top – which would have made the next 20 kilometres of descending interesting.

Alongside the weird and wonderful sights, there were the inevitable crashes as people explored – and occasionally exceeded – the limits of their ability.

Nestled in the heart of the Alps, the Col de Madeleine is a challenging climb. But the struggle up is worth it for the glorious

descent. Perfectly engineered switchbacks cut a sinuous path through the heavily forested flanks of the mountain before entering a deep and lush valley with sheer rock walls rearing up one side, and a sharp drop to a river on the other.

It feels made for fast descending.

Unfortunately, it brought several badly unstuck. As I came around one bend I flashed past a figure in blue and black lycra crouched by the side of the road clutching his right shoulder in the classic "I think I've broken my collarbone" posture, with the motorbike medic just pulling up to render assistance.

A couple more kilometres down the descent, people were swarming by the side of the road where an ambulance had stopped. A cyclist had lost it on a sweeping bend and gone over the side. He had landed in the upper braches of a large pine tree and broken his femur. The rescue crews had to winch him down.

Staying upright and healthy for the whole three weeks is a big part of the challenge, and just about all those who attempted the Triple Crown were at some stage forced to battle illness or injury.

Incredibly, just about all those who embarked on the journey in Anglet made it through to Vienna.

The Haute Route is not a race, but daily time limits mean it is not a cruise either.

There are undoubtedly tougher one-day rides on the calendar, but it is hard to dispute its claim to being the highest and toughest cyclosportive in the world.

The Haute Route – my top 10 tips

1. Sign up with an official tour operator (I used Sydney-based Will Levy and his Two Wheel Tours team, who were fantastic). You can book accommodation through the Haute Route organisers, but unless you don't mind wondering around a French ski resort for a couple of hours after finishing a nine-hour ride trying to find your hotel, only to discover the single room you booked is now also shared with two other sweaty cycling strangers, a tour company that looks after everything except the cycling is the way to go.
2. Pace yourself. Each week begins with a frenzy at the front, as adrenaline-filled riders battle for a place near the head of the peleton. Unsurprisingly, the first day is when some nasty accidents happen. Hold a little back in the first few days, and you will make up plenty of places by then end of the week.
3. Carry a rain jacket. Even if there is no rain, you can quickly get very cold on the long descents. A jacket and a bit of newspaper under the jersey can be lifesavers.
4. Don't dawdle at rest stops. It is easy to waste a lot of time at the feed stations. Top up your bottles, grab some food and keep going. You want to stay ahead of the Lantern Rouge.
5. Avoid the first rest stop of the day (where possible). The first feed station is invariably a bun fight. Carry enough food and water to get you through to the second feed station.
6. Ride smart. Do your turn in the bunch, but don't try to ride the peleton off your wheel. You will pay for it. Similarly, it's worth working hard to stay in a bunch in the long flat sections (which can sometimes be 60 kilometres long), but if you are at risk of blowing, ease off.
7. Use the bunches. Often the descents are not timed, and at the bottom cyclists will gather just before the timing mat. Pull over and wait with them until a bunch forms up. It'll save you valuable energy, and will usually get you to the end just as quickly.
8. Start at the front. In a contradiction to #2, it is smart to start towards the front on every day except the first day of the week. The top 75 riders are sent off ahead of the pack, and then it is everyone for themselves. If you start toward the front, you can settle into one of the big bunches and get a drag to the first climb of the day, then ride at your own pace.
9. Get prepared. Every night, do as much as you can to get yourself ready for the next day. The rides usually begin at 7am, which means getting up around 5.30 or so. The less you have to do (and remember) at that time of the morning, the better. Get your gear out, put on your bib number, set out the food you'll carry. Have your water bottles handy, and have your bags pretty much packed.
10. Pack your own lunch. Haute Route provides a lunch, but unless you are confident you'll be in the first hundred or so, you'll find that a lot of the nicest food is gone and you are left with a choice between boiled fish, gluggy pasta and dried out rice. At breakfast, make yourself a roll or two and stash them in your bag ready to scoff at the end.

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