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Weighty threat

Obesity our biggest public health challenge, AMA declares, p3

INSIDE

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Obesity overtaking smoking as biggest health threat

Obesity is overtaking smoking as the biggest preventable health threat, the AMA has warned, issuing a call for a sugar tax and controls on junk food ads as part of a broad national strategy.

The nation's peak medical group has sounded the alarm on the creeping health problem, warning that the failure to check failure to check the prevalence of overweight and obesity was condemning millions to serious and preventable health problems, and unnecessarily lumbering the nation with a multi-billion dollar health problem.

"The management of the obesity crisis in Australia is a national and economic priority," the AMA said in its *Position Statement on Obesity 2016*, noting evidence indicating that it was "overtaking smoking as the major cause of preventable death in Australia".

It is estimated that around two-thirds of adults and a quarter of children and adolescents are overweight or obese, and the AMA has recommended taxes to increase the cost of sugary drinks and junk food and a ban on marketing them to children.

Because carrying excess weight increases the chance of serious health problems – about 70 per cent of obese adults have at least one established disease or condition such as diabetes, heart disease, stroke, hypertension and musculoskeletal disorders – it was conservatively estimated to have cost the nation $8.6 billion in 2011-12, and consultants PricewaterhouseCoopers last year calculated the annual toll had reached $56.6 billion, taking into account health expenses as well as indirect costs such as reduced productivity and mobility problems.

A sizeable problem

Individuals are often blamed for problems with overweight and obesity but, while not downplaying the importance of individual choices and behaviour, the AMA said the causes were much broader than this, and required a comprehensive national strategy involving all governments, the health and food industries, employers, schools, the media, and non-government and community organisations.

Obesity overtaking smoking as biggest health threat

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It called on the Federal Government to undertake national coordination of a 'whole of society' response to obesity which included specific national goals for reducing obesity and its health effects.

Individual eating habits and levels of physical activity were influenced by a broad array of factors, the AMA said, including the health and behaviour of parents, genes, weight at birth, wealth, the social environment, the availability of healthy food and opportunities for activity.

"This is not to suggest that individuals are never responsible for their behaviour – only that an effective response to the obesity crisis will need to be as comprehensive and multi-faceted as the factors that generate and sustain it," the Position Statement said. "The available evidence does not point to any single type or set of interventions that will definitely induce [people to eat better and exercise more]."

Children and mothers first

Initially, the AMA recommended the focus should be preventing obesity early in life, starting with prevention and early intervention programs directed at pregnant mothers and continuing through infancy and childhood.

This should include efforts to improve the nutritional literacy of new and expectant mothers, as well as encouragement and support for them to solely breastfeed their babies for the first six months.

There was also strong evidence that school-based measures to encourage physical activity and improve food choices could help prevent childhood obesity.

But the AMA governments were "unique in their capacity to influence and regulate behaviour on a large scale", and should use the full range of instruments at their disposal, including taxes, fines, incentives and regulations.

A tax in time

AMA President Dr Michael Gannon said this action should take many forms.

"The AMA strongly recommends that the national strategy include a sugar tax, stronger controls on junk food advertising, improved nutritional literacy, healthy work environments, and more and better walking and cycling paths," Dr Gannon said.

> "The AMA said the Government should also consider subsidies for healthier foods, particularly in rural and remote communities where they are often more costly than less nutritious alternatives, because of the big potential health benefits"

Some form of tax on sugary food and drink has drawn considerable support from public health advocates, especially because currently junk foods and soft drinks are cheap and often less costly than more nutritious options.

Mexico has led the way in introducing a sugar tax, and the results so far suggest it can have an effect in reducing the consumption of sugary food and drinks.

A recent Australian study estimated that a tax that increased the cost of sugary drinks by 20 per cent could slash consumption by 12.6 per cnet.

The AMA said the Government should also consider subsidies for healthier foods, particularly in rural and remote communities where they are often more costly than less nutritious alternatives, because of the big potential health benefits.

For instance, it has been estimated that increasing Australian consumption of fruit and vegetables by just one serve a day could save the health system $157 million a year.

In addition, the AMA said the Government should ban ads for junk food and soft drinks directed at children, and called for improved food labelling, including upgrades to the Health Star Rating System, to make it easier for consumers to select healthier foods and drink.

ADRIAN ROLLINS

A tax on sugar works: WHO

Governments have been urged to introduce taxes and charges that push up the price of sugary drinks by at least a fifth as part of efforts to combat rising rates of obesity.

The World Health Organization has thrown its support behind sugar taxes, recommending governments act to reduce consumption of soft drinks, energy drinks, bottled juices and other sugary beverages by increasing their cost through an excise of at least 20 per cent.

"Consumption of free sugars, including products like sugary drinks, is a major factor in the global increase of people suffering from obesity and diabetes," said Dr Douglas Bettcher, Director of the WHO's Department for the Prevention of Non-communicable Diseases. "If governments tax products like sugary drinks, they can reduce suffering and save lives."

Dr Bettcher said such taxes had the additional benefit of cutting health costs and generating revenue that could be re-invested in health services.

The WHO's call echoes long-standing AMA policy backing a sugar tax as part of a range of measures to curb Australia's weight problem.

In June, AMA President Dr Michael Gannon said that although fast food companies and soft drink manufacturers should not be "demonised", it was clear that their products contributed to the obesity epidemic and steps to increase their cost, and to make healthy foods cheaper, should be taken.

"There is no doubt at all that these drinks are unhealthy, and price signals work: if you make these items more expensive you reduce consumption," Dr Gannon told Sky News. "Similarly, we should look at ways of supporting fresh foods perhaps being cheaper. So I think that [a sugar tax], as a part of a whole suite of policies, might be a good idea."

It is estimated that about two-thirds of Australian adults and a quarter of children are overweight or obese, and the high sugar content of many diets is seen as a major contributor to the problem.

According to the Australian Bureau of Statistics, Australians eat, on average, 60 grams of free sugar (monosaccharides and disaccharides added to food and drink) a day – equivalent to 14 teaspoons of white sugar. Consumption is greatest among males teenagers, at an average of 92 grams a day.

In all, around half of Australians exceed the WHO's recommendation that no more than 10 per cent of dietary energy be derived from free sugars.

The WHO said people do not need added sugar in their diet, and drinks and foods high in free sugars were a major source of unnecessary calories, particularly for children, adolescents and young adults.

The health organisation said young people, those on low incomes and those who frequently ate fast foods and sugary drinks and snacks were the most responsive to price increases, and would derive the greatest benefit from a sugar tax.

The most effective form of sugar tax was an excise set according to quantity or volume of a particular product or ingredient, rather than a sales tax based on a percentage of the retail price, the WHO said.

To encourage popular support, it recommended that revenue generated by a sugar tax be reinvested in health care and promoting healthier diets and lifestyles.

Mexico was the first country to impose a sugar tax in 2014, and recorded a 12 per cent drop in sales of sugary drinks by the end of that year, including a 17 per cent plunge in purchases by the poorest households.

Last year, annual sales of sugary drinks declined from 163 litres to 137 litres per person.

Hungary has imposed a tax on foods and drinks with high levels of sugar, salt and caffeine, and countries including the United Kingdom, South Africa and the Philippines have flagged their intention to introduce similar measures.

ADRIAN ROLLINS

Time for a junk food tax

Governments should impose junk food tax and restrict advertising of 'non-nutritious' products aimed at children, the world's peak medical association has said.

Sounding the alarm on rising rates of child obesity, the World Medical Association has called for governments to adopt measures similar to those used to curb tobacco to reduce consumption of high fat, high sugar foods and encourage healthy eating and exercise.

In a statement adopted at its General Assembly in Taipei in October, the WMA described child obesity as a "serious concern for public health" and said not enough was being done to regulate the promotion of unhealthy food to young people.

It warned that junk foods contained large amounts of added sugar, fat and salt, making them addictive, especially when combined with flavour enhancers.

The WMA lamented that the marketing and sales of such products was, in many countries, largely unregulated, including incomplete lists of ingredients and few restrictions on advertising and special promotions, particularly those aimed at children.

"TV advertisements for food and drink products with little or no nutritional value are often scheduled for broadcast hours with a large concentration on child viewers, and are intended to promote the desire to consume these products regardless of hunger," it said, adding that companies were also using social media networks and video games to target young consumers.

The Association recommended that government impose a tax on junk foods and curb their promotion and availability as part of a range of measures to reduce child obesity.

"Governments should consider imposing a tax on non-nutritious foods and sugary drinks," it said. "The advertising of non-nutritious products [should] be restricted during television programming and other forms of media that appeal to children, [and] attention should be paid to the availability close to schools of establishments selling products of poor nutritional quality."

Such initiatives should be complemented by action to improve the availability of nutritious foods and to educate parents and children about health eating.

It said doctors should guide parents and children on how to live healthy lives, and identify as early as possible signs of obesity.

ADRIAN ROLLINS

Penny pinching threatens chronic care reform

The Federal Government's landmark Health Care Homes reform is at risk of collapse because of a lack of funding, the AMA has warned.

Health Minister Sussan Ley has announced that $100 million will be provided to support the phase one trial of the reform, involving 65,000 patients and 200 medical practices in 10 regions across the country.

> "The allocations mean that patients on the lowest level of subsidy will be funded for just 16 visits to the doctor a year, rising to 48 visits a year for those deemed of highest need"

Under the Government's plans, practices will receive monthly bundled payments worth an average $1795 a year to manage patients with chronic and complex health conditions. Payments will vary from $591 for chronically ill patients who can largely self-manage their condition to $1267 for those who need more intensive care and $1795 for those with the most complex health demands.

The allocations mean that patients on the lowest level of subsidy will be funded for just 16 visits to the doctor a year, rising to 48 visits a year for those deemed of highest need.

Controversially, such patients would only be eligible for five extra Medicare-subsidised visits to the doctor for health issues that lie outside their chronic illness – a major change from the current system under which patients have uncapped access to GP care.

A spokesperson for Ms Ley told Fairfax that five-visit cap was only an "indicative figure for modelling and planning purposes", and said no patient would have their access to Medicare restricted or capped.

Ms Ley said Health Care Homes allowed for team-based, integrated care and would provide increased flexibility and coordination of services to tailor treatment to individual need.

But the details of the trial have reinforced suspicions that the Government is undertaking Health Care Homes primarily as a cost cutting exercise, and the AMA voiced concerns that if the reform was not adequately funded it could founder.

"The modelling is concerning and potentially leaves the whole program at risk of falling over because of being underfunded from the beginning," AMA Vice President Dr Tony Bartone told News Corporation.

Dr Bartone, a GP, is the AMA's representative on the Government's Health Care Home Implementation Advisory Group, which last met on 30 September.

He said that, if appropriately funded, Health Care Homes could support GPs to keep patients healthier and out of hospital, but added the Government needed the goodwill of general practitioners if its trial was to succeed.

"That goodwill will evaporate significantly if there is not the appropriate funding," he warned.

Earlier this year, AMA President Dr Michael Gannon warned that appropriate funding would be a "critical test" of the success or otherwise of the reform.

"BEACH data shows that GPs are managing more chronic disease. But they are under substantial financial pressure due to the Medicare freeze and a range of other funding cuts," Dr Gannon said.

"GPs cannot afford to deliver enhanced care to patients with no extra support. If the funding model is not right, GPs will not engage with the trial and the model will struggle to succeed."

ADRIAN ROLLINS

Whooping cough booster faces axe

The Federal Government may axe the whooping cough vaccine booster for first year high school students as it pulls plans for an Australian Schools Vaccination Register.

An immunisation expert group has been asked to review the pertussis vaccine schedule, including the need for a booster currently being administered to children in secondary school.

The Government has announced that the Australian Technical Advisory Group on Immunisation (ATAGI) has been asked to "provide advice on the clinical place and effectiveness of the pertussis vaccine schedule, including the pertussis booster currently given in the first year of high school".

Currently, it is recommended that infants receive a dose of the diphtheria-tetanus-acellular vaccine at two, four and six months of age, with further boosters at 18 months and four years. An additional booster is given between 12 and 17 years.

The review comes at a time when the number of whooping cough cases is in decline – about 16,000 cases have been notified so far this year, well down from the 22,500 infections reported in 2015.

But the decline has come not long after the country's largest-ever recorded outbreak of the disease, between 2008 and 2012, including 38,732 notified cases in 2011 alone.

The National Centre for Immunisation Research and Surveillance said whooping cough was a "challenging" disease to control because immunity waned over time, and epidemics occurred every three to four years.

The Centre said declining immunity was a factor in the last major outbreak, during which 4408 people were hospitalised, including 1832 babies. Between 2006 and 2012, 11 died from pertussis, all but one of them infants less than six months of age.

The review of the pertussis vaccination schedule coincides with the decision not to proceed with the creation of the Australian Schools Vaccination Register.

The Health Department said it had discontinued the tender process for the creation of the Register following advice about the review of the pertussis booster vaccine for secondary school students and the end, in 2018, of the catch-up varicella vaccination program for adolescents.

The Register was announced in the 2015-16 Budget as part of the No Jab No Pay policy, and was portrayed as vital in helping to controlling infectious disease outbreaks by identifying areas where vaccination coverage was low.

But Health Minister Sussan Ley said it had now been "put on hold…pending further advice from independent medical experts on the vaccination needs of adolescents".

The Health Department said it was possible that the Schools Register would only hold data on the human papilloma virus (HPV) if the pertussis booster for adolescents was axed and once the varicella catch-up vaccination program ends.

The Health Department said it was now looking at alternatives to the Schools Register, including the inclusion of such data in the whole-of-life Australian Immunisation Register which began operations on 30 September.

It is also in discussions with the Victorian Cytology Service about continuing the HPV Register in 2017.

Commonwealth Chief Medical Officer Professor Brendan Murphy was keen to assure that these changes would have "no impact on the health of adolescents because the full range of vaccination services are being delivered to the community, and will continue to do so".

The move to axe the Register has coincided with the release of Government figures showing that almost 200,000 children have had their vaccinations brought up-to-date following the introduction of the No Jab No Pay reforms.

The figures, reported in the *Sunday Herald Sun*, show that since the reforms were introduced on 1 January, 86,562 families, including 102,993 children, have been denied childcare payments, and $38 million of Family Tax Benefit A benefits have been suspended. Parents of 8896 children are still not meeting vaccination requirements.

But 183,000 children have had their vaccinations brought up-to-date as a result of the program, under which parents face losing Family Tax Benefit A and childcare payments if they let their child's immunity slip.

ADRIAN ROLLINS

Health costs rise as rebate freeze bites

Health Minister Sussan Ley has dumped on hopes of an imminent end to the Medicare rebate freeze, warning that it will not be lifted until there is an improvement in the Federal Government's finances.

Talking down the prospects of financial relief for hard-pressed medical practices any time soon, Ms Ley refused to set a date for an end to the policy, and told ABC radio's *AM* program that "we cannot lift the pause…any earlier than our financial circumstances permit".

The Minister said any decisions made about the freeze would be made in the context of Budget discussions.

"I'm a Minister who signs up to the agenda of a Government that leads Budget repair and strong, stable economic management, so I'm absolutely not walking from our responsibilities," she told Sky News. "These are decisions that are made through the MYEFO [Mid-Year Economic and Fiscal Outlook] and Budget process, and I'm not going to forecast when or what they might be."

The Government is due to release the 2016-17 MYEFO before the end of the year, most likely early December.

But the signs are not good.

The Parliamentary Budget Office has reported a further deterioration in the Government's finances, projecting that the deficit will balloon to $105.1 billion by 2018-19 – an $8.9 billion blow out from the Budget.

Ms Ley backed away from comments she made during the Federal election that she had been blocked from ending the freeze by her senior Treasury and Finance colleagues.

In May, Ms Ley told ABC radio that: "I've said to doctors I want that freeze lifted as soon as possible but I appreciate that Finance and Treasury aren't allowing me to do it just yet."

But when ABC reporter Kim Landers said to the Minister today that, "you've previously said that you've wanted to lift it, but you were blocked by Treasury," Ms Ley denied it.

"That's not what I've said. What I've said is: as a responsible Minister in a Government that needs to undertake budget repair, I recognise that we cannot lift the pause that was introduced by Labor any earlier than our financial circumstances permit," the Health Minister said.

The exchange came amid mounting warnings from the AMA and others that the rebate freeze is pushing medical practices to the financial brink, forcing many to abandon bulk billing and raising the prospect that patients will be charged up to $25 in out-of-pocket costs.

Ms Ley defended the rebate freeze as the right policy for the times, and said bulk billing rates had "never been higher".

The Minister's declaration, which is based on figures measuring the number of Medicare services performed rather than GP consults, has been disputed by those who claim that the real figure is closer to 69 per cent.

Health costs rise as rebate freeze bites

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Regardless, AMA President Dr Michael Gannon expressed disbelief the rebate freeze would still be in place by the time of the next election in late 2019.

"I would be gobsmacked if the Government took an ongoing freeze to the next election," the AMA President said following a meeting with Ms Ley earlier this year. "They got the scare of their life on health, and that was probably the policy which hurt them the most."

Ms Ley said that she wanted the freeze to end "as soon as possible", but refused to nominate an end date.

"I'm sure that others in the Cabinet and the Parliament want that day to be as soon as possible," the Minister said. "But we also recognise our responsibilities in terms of our credit rating, in terms of the national debt, in terms of, as I said, the economic circumstances that Labor left us with."

ADRIAN ROLLINS

THE COST OF HEALTH

How AMA recommended fees compare with the frozen Medicare rebates

Medical Service	AMA Fee (2015)	AMA Fee (2016)	MBS Schedule Fee (2016)
Level B GP consult (MBS item 23)	$76.00	$78.00	$37.05
Level B OMP consult (MBS item 53)	$76.00	$78.00	$21.00
Blood test for diabetes (MBS item 66542)	$48.00	$49.00	$18.95
CT scan of the spine (MBS item 56219)	$990.00	$1,055.00	$326.20
Specialist – initial attendance (MBS item 104)	$166.00	$170.00	$85.55
Consultant Physician – initial attendance (MBS item 110)	$315.00	$325.00	$150.90
Psychiatrist attendance (MBS item 306)	$350.00	$355.00	$183.65

INFORMATION FOR MEMBERS

The Nokor Tep Women's Hospital and Tabitha Foundation

Tabitha Foundation Cambodia was founded in 1994 to help the poorest people in Cambodia with programs that focus on personal and financial development.

Founder Janne Ritskes has spearheaded the building of the Nokor Tep Women's Hospital, which is dedicated to ensuring that, "no woman in Cambodia will be denied medical treatment because of inability to pay basic fees".

The hospital is seeking to recruit a Chief Medical Officer and a Chief Hospital Administrator. These positions are unpaid but provide a unique opportunity for the successful candidates to leave a last-ing legacy in Cambodia.

Chief Medical Officer (CMO, self-funded)

Reporting to the Nokor Tep Hospital Management Board, the CMO will be responsible for the clini-cal vision of the Nokor Tep Women's Hospital and will provide oversight of all clinical programs. He/she will partner with clinical, program and administrative staff and volunteers to identify new programs, evaluate existing programs and determine which programs and clinical interventions best serve Nokor Tep patients.

The appointee will be responsible for the productivity of clinical staff and the quality of care deliv-ered by staff and volunteer medical providers.

Clinical care accounts for 10 to 30 per cent of the CMO's work duties, with administrative and su-pervisory responsibilities accounting for the remaining 70 to 90 per cent.

Chief Hospital Administrator (CHA, self-funded)

Reporting to the Nokor Tep Hospital Management Board, the CHA will be responsible for all day-to-day hospital operations. The role will include oversight of capital and operating budgets, regula-tory compliance, clinical performance, human resources management, service excellence, and other support services.

The purpose of this position is to provide leadership and to create an atmosphere that provides continuity of quality patient care in the emergent hospital environment. This is achieved by provid-ing clear direction and expectations to the clinical and office staff regarding the functional areas in which they work.

How to apply

For further information about these roles please contact tabitha.janne@online.com.kh. To apply for these roles please send your CV, along with a detailed covering letter, to secre-tary@tabithasingapore.com. In the coming months we will be recruiting for further volunteer posi-tions. If you are interested please check www.nokor-tep.net for details.

Please note that positions are to be self-funded. Expenses including travel, accommodation and living expenses estimated at USD4000 per month will need to be raised by the applicants. Appli-cants can raise funds to support their position or can work in conjunction with Rotary organisations, churches and/or community groups to support their goal.

Further information about Nokor Tep Women's Hospital

- The hospital will specialise in gynaecology and oncology services that are urgently needed to help the 90 per cent of Cambodian women who suffer from related diseases.
- The hospital will service 220 beds with capacity to serve up to 450 patients per day.
- There will be 28 consulting rooms.
- The Nokor Tep Women's Hospital will have a comprehensive teacher training program to upskill local workers.

For further information about the Nokor Tep Women's Hospital, please visit www.nokor-tep.net.

Family doctors need help to tackle domestic violence

Family doctors are more likely than police to see the results of family and domestic violence, and have a key role to play in early intervention and treatment, the AMA says in an updated Position Statement.

AMA President Dr Michael Gannon said the trusted role of the family doctor gave GPs a clear insight into the damage caused by the violence.

"Two women are killed nearly every week in Australia due to family and domestic violence," Dr Gannon said.

"The health effects of family and domestic violence in both the immediate victims and their families are devastating, and it is not only women who are the victims.

"Women experiencing domestic violence will share their experiences with their GPs more often than with any other professional group, and the health impacts persist long after the violence ceases."

Women who have experienced domestic or family violence have higher levels of mental and physical disorders, higher rates of suicide attempts, and are more likely to have an impaired quality of life than other women.

"Children who grow up witnessing and experiencing domestic violence can also be profoundly affected."

The AMA is committed to providing important information and guidance to empower doctors, particularly GPs, to provide better support for victims.

The release of the revised and updated *Position Statement on Family and Domestic Violence 2016* this week coincided with a major meeting of Commonwealth, State, and Territory ministers at the COAG *National Summit on Reducing Violence Against Women and their Children.*

It calls on all Australian governments to properly fund and resource specialised family and domestic violence support services, including housing and crisis accommodation.

"Family violence affects people of all genders, sexualities, ages, socio-economic background, and cultures," Dr Gannon said.

"And we are now also seeing increasing instances of elder abuse, with grandmothers and grandfathers, many frail and vulnerable, being subjected to violence from family members.

"Men can be victims. Women can be perpetrators. But it is clear that the overwhelming majority of people who experience such violence are women."

Stamping out family and domestic violence requires commitment and coordination from governments; support services; the related professions, especially medical, health and legal; neighbourhoods; and families – backed by adequate funding.

The Women's Electoral Lobby (WEL) backed the AMA's call for funding, saying it was disappointing that crisis services for women and children escaping violence were not on the agenda for the COAG Summit in Brisbane.

"The Summit plans to hold roundtable discussions on such topics as 'using behavioural insights to reduce domestic violence' and 'innovative uses of technology', as well as important discussions on the Family Court, Indigenous insights and experiences, and the effects of domestic violence on children, but there is nothing on the agenda about crisis services, including women's refuges," WEL said in a statement.

"WEL calls on the COAG Summit to include support for long-term, secure Commonwealth-State funding for women's crisis services in its deliberation and follow-up actions."

The AMA Position Statement on Family and Domestic Violence 2016 can be downloaded at: https://ama.com.au/media/equipping-doctors-provide-vital-and-sensitive-support-victims-family-and-domestic-violence

MARIA HAWTHORNE

AMA kicks off 2016 Safe Hours Audit

Few occupations are as susceptible to the dangers posed by fatigue as those in the medical profession. Yet dangerous work practices caused by unsafe and over-long hours, particularly in public hospitals, continue to be seen as acceptable.

The AMA has long said that fatigue and medicine do not mix, launching its Safe Hours campaign in 1999 to address the impact of fatigue on doctors and patient safety.

2016 sees the AMA conduct its fourth Safe Hours Audit, covering the period of 31 October to 6 November. These audits have been an integral part of the AMA's Safe Hours campaign since its inception.

The 2016 audit will assess the fatigue risk of salaried and junior doctor working hours, including GP registrars, and will inform future AMA advocacy and policy.

AMA President Dr Michael Gannon, who has putting his full weight behind the audit, says it has been an integral part of a strategy that has helped drive down the risks of fatigue for doctors.

The AMA Safe Hours Audit in 2011 found that 53 per cent of Australian hospital doctors were working unsafe hours – classified as high risk or significant risk – with reports of continuous unbroken shifts of up 43 hours.

While still unacceptably high, the proportion of hospital doctors working hours that put them into the significant and higher risk categories has been steadily decreasing. In 2001, 78 per cent of doctors were in this category. But 2006, that proportion had dropped to 62 per cent.

"While we have seen modest changes since our first audit in 2001, we know that there is still significant room for improvement," Dr Gannon said.

The AMA has adopted a risk-based approach to working hours, acknowledging the need to minimise the risks of fatigue but also preserve essential training opportunities and patient access to services.

Chair of the AMA Council of Public Hospital Doctors, Dr Roderick McRae, has urged all salaried doctors to go online and complete the audit.

"Safe hours should not be viewed as a junior doctor issue or an issue relevant only to certain specialties – it affects doctors across the board. I encourage salaried doctors of all levels and specialties to complete the survey," Dr McRae said.

Chair of the AMA Council of Doctors in Training, Dr John Zorbas, said, "research has shown that fatigue endangers patient safety and can have a real impact on the health and wellbeing of doctors. This audit will provide evidence of whether or not past improvements have been sustained."

Doctors who complete the online audit will be able to access an instant risk assessment report, which provides an analysis of the fatigue risks of their roster.

The de-identified results of the online survey will be published in a nationwide safe hours report, including a comparison with previous years.

The AMA Safe Hours Audit goes live from 31 October 2016 and can be found at www.safehours.ama.com.au. The audit takes around 10 minutes to complete.

Anyone who completes the audit will be able to access an instant risk assessment report, which provides an analysis of the fatigue risks of their roster.

- **Doctors who complete the survey will be able to access an instant risk assessment report, which shows an analysis of the fatigue risks of their roster.**
- **State and territory AMA offices will be readily available to give members advice on the risks of their rosters as well as take up individual complaints on behalf of members.**
- **The AMA Safe Hours Audit goes live from 31 October 2016 and can be found at www.safehours.ama.com.au. The audit takes around 10 minutes to complete, and any published data will be de-identified.**
- **Participants will have until 7 December 2016 to complete the audit.**

Seriously ill asylum seekers denied adequate care: AMA

The AMA has raised concerns that many asylum seekers and refugees detained on Nauru and Manus Island are being denied appropriate and timely health care for serious health problems.

The peak medical profession organisation has told a Senate inquiry that asylum seekers reportedly suffering serious illnesses or injuries including heart problems, head trauma, post-traumatic stress disorder and possible bowel cancer are receiving care below-standard care, putting their health at risk.

In a lengthy submission to the Senate Legal and Constitutional Affairs Committee, the AMA said it had been contacted by numerous asylum seekers and their advocates seeking help in ensuring they received adequate health care.

It provided details of the treatment of eight asylum seekers, including an elderly man hospitalised for seven months in Port Moresby with a heart condition and high blood pressure before being abruptly returned to Manus with his condition unresolved; a deeply traumatised woman exhibiting self-harm and at heightened suicide risk; a man hit over the head with a machete subsequently diagnosed with a mental illness and a man who suffered a head injury, the extent of which was undiagnosed.

Upon investigating their circumstances, the Association said it was "concerned that many asylum seekers are not receiving appropriate, timely and quality medical care".

"The AMA does not believe those detained on Manus and Nauru, either within detention facilities or within the community, are able to access a health care service of the same standard that a person in the Australian mainland would receive," it concluded.

Highlighting the secrecy and lack of transparency surrounding the operation of the detention centres, the AMA reported that in each instance it was told by the Department of Immigration and Border Protection it needed to obtain the written consent of asylum seekers for the release of their medical records before any information was provided.

It said the process of obtaining consent was "difficult and frustrating". In many cases, asylum seekers did not have access to computers and scanners and had to take a photo of a hand

In Australia's name

What AMA investigations have revealed about the medical care provide to some asylum seekers being held in offshore detention

Patient A

A 70-year-old Rohingya asylum seeker being held on Manus Island was hospitalised in Port Moresby for seven months, where he received little treatment. He was abruptly transferred back to Manus, where he waited 20 days to see a doctor. He was diagnosed with a heart condition and high blood pressure. At a meeting on 4 February, the-then AMA President Professor Brian Owler advised Australian Boarder Force Chief Medical Officer Dr John Brayley the man was likely to die without immediate treatment. Six days later Dr Brayley advised that a transfer to Australia should have been put in train the previous week. No further details about his location or treatment are available.

Seriously ill asylum seekers denied adequate care: AMA

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written consent form which was then sent by text to the AMA. In other instances, the Association reported it was unable to obtain the required consent and the wellbeing of the asylum seeker in question was unknown.

The AMA acknowledged that the information it obtained could not be independently verified, a fact that underlined its call for independent oversight of the health care provide to asylum seekers.

Ever since the Coalition abolished the Immigration Health Advisory Group in late 2013, the AMA has called for the establishment of an independent statutory body of clinical experts to investigate and report to Parliament on the health and welfare of asylum seekers.

AMA Vice President Dr Tony Bartone told Radio New Zealand that the appointment of such a body was vital to ensure cases of the kind investigated by the AMA were not allowed to continue.

"It's not the job of the AMA to advocate on behalf of detainees who are patients in the various offshore facilities," Dr Bartone said. "There should be an appropriate pathway which by there can be a review of the care that's being given and the outcomes that are being achieved."

The AMA Vice President said the problem did not lie with the health service provider, but the strictures within which they were required to work.

"They are operating under extremely difficult circumstances, often without enough detail or enough information to ensure the appropriate management," he said. "They're working towards a set of agreed requirements and they're probably hamstrung to deviate from that, we don't know whether a request has been made and not attended to or whether it is a failing at a much earlier level."

He said such uncertainty and lack of transparency reinforced the case for a statutory body of experts to oversee the treatment asylum seekers received.

In addition to this, the AMA has called for a moratorium on asylum seeker children who had been transferred to the Australian mainland for medical treatment to be return to offshore detention, and for all children being held in offshore and onshore centres to be immediately released.

The AMA's submission to the Senate inquiry can be downloaded at: file:///C:/Users/arollins/Downloads/Sub01.pdf

ADRIAN ROLLINS

... from p14

Patient B

A 37-year-old Iranian engineer living in the community on Nauru was attacked and hit on the head with a machete. He subsequently suffered headaches, vomiting, nausea, dizziness and weakness. A CT scan conducted a month later identified a broken bone in the centre of his skull, a diagnosis subsequently changed to one of mental illness. His condition has continued to deteriorate. At last report he was on 16 medications and had lost 24 kilograms since the attack. No more information is available.

Patient C

A man being held at Manus sustained a head injury on 11 February. Twenty hours later he collapsed and lost consciousness. About 18 hours after this, he lost consciousness again. A neurosurgeon advised he needed a brain scan, MRI or at least a CT scan. The Department subsequently told the AMA the man had not been prescribed medication and "no recent health issues have arisen". The AMA said this was at odds with what it had been advised.

ADRIAN ROLLINS

Whistleblower doctors exempt from jail threat

Doctors will no longer be threatened with imprisonment for speaking out about conditions in immigration detention after the Federal Government amended its controversial Australian Border Force Act.

Immigration Department Secretary Michael Pezzullo has confirmed that provisions of the Act have been changed so that secrecy and disclosure rules that threaten whistleblowers with up to two years' imprisonment no longer apply to health professionals including doctors, nurses, psychologists, pharmacists and dentists.

> "The operation of immigration detention centres, especially those located offshore on Nauru and Manus Island, has been surrounded by controversy amid claims of assault, self-harm, child abuse and substandard living conditions and medical services"

The backdown follows outcry by the AMA and many other medical groups and individuals against the Act's secrecy provisions, including the launch of a High Court challenge by the group Doctors for Refugees and the Fitzroy Legal Service.

Doctors for Refugees President Dr Barri Phatafod told the *Guardian* the decision was a "huge win for doctors and recognition that our code of ethics is paramount".

The provisions make it a criminal offence for those contracted to provide services to the Department of Immigration and Border Protection to record or disclose information obtained in the course of their work. The penalty is up to two years' imprisonment.

The operation of immigration detention centres, especially those located offshore on Nauru and Manus Island, has been surrounded by controversy amid claims of assault, self-harm, child abuse and substandard living conditions and medical services.

Groups including Amnesty International have condemned the detention regime, claiming it is causing enormous harm to the wellbeing of asylum seekers and refugees, particularly children.

The AMA has for several years called for the establishment of an independent medical panel empowered to investigate and report on detention centre conditions directly to Parliament.

Doctors have protested that the secrecy provisions in the ABF Act conflict with their ethical duties and their obligations under the Medical Board of Australia's Code of Conduct, most particularly their paramount obligation to the health of their patients.

These concerns have been magnified by a number of cases in which, it is claimed, authorities have sought to intervene in or override clinical advice on the transfer of detainees in need of medical attention, including the death of Omid Masoumali, who was medically evacuated to Australia from Nauru more than 24 hours after setting himself alight.

The Government denied the intention of the law was to prevent doctors from speaking up on behalf of their patients, and earlier this year Immigration Minister Peter Dutton said he thought it unlikely that health practitioners would be prosecuted under the Act.

But it was revealed that Dr Peter Young, who oversaw the mental health care of detainees for three years, was the subject of Australian Federal Police investigation, including access to his electronic communications and at its most recent National Conference, the AMA passed an urgency motion asking the Federal Council to "look into the matter" of AFP surveillance of doctors.

Dr Young told the *Guardian* the Government made the amendment because it wanted to avoid legal scrutiny of its policy.

"It's a big backdown from the Government, and they've made it because they didn't want to go to court, they knew they were going to lose, and they didn't want their planning and policies discoverable in an open court. That's what it's about," he said.

ADRIAN ROLLINS

Upsurge in doctors under billing scrutiny

A doctor has been ordered to repay Medicare rebates worth almost $1.14 million as part of an upsurge in cases of over-billing being investigated by health authorities.

The Professional Services Review has reported a near doubling of the number of cases referred to it by the Health Department as the conduct of medical practitioners, particularly in the preparation of chronic disease management plans and those working in large practices, comes under increased scrutiny.

In its 2015-16 annual report, the PSR said it had received 80 referrals from the Department, a 29 per cent jump from the previous year and an 82 per cent surge from 2013-14.

Of 49 investigations completed last year, 24 resulted in no further action being taken, while 18 were resolved with a negotiated agreement including the repayment of $1.63 million and the partial disqualification of 12 practitioners.

But in seven instances doctors were reprimanded and ordered to repay Medicare benefits worth between $48,380 and $1.138 million. In one instance, a doctor was disqualified from practising for three months.

In all, doctors were ordered to reimburse Medicare almost $4.6 million.

While the vast majority of the 85,000 practitioners providing Medicare reimbursed services are considered to be doing the right thing, the PSR reported several instances of high billing, including a GP who provided 20,000 services in a single year, as well as almost 600 GP Management Plans, 400 Team Care Arrangements and more than 1000 item 2713 mental health services – each of which has a minimum 20-minute time requirement.

A chronic problem

The agency, which is asked to investigate cases that the Health Department cannot resolve or explain, said the use of Chronic Disease Management (CDM) and Health Assessment items was of particular concern.

“Many practitioners who provide high numbers of these services use computer-generated templates; a plan may have minimal content specific to the patient for whom the plan has been prepared,” it said. “Plans sometimes have very generic health advice of the most minimal nature, and sometimes irrelevant to any condition listed in the patient’s clinical record.”

The PSR said that in other instances some GPs were preparing GP Management Plans every 12 months, and reviewing them every three months, without even consulting the patient.

“In some cases, there was little evidence that patients were aware that they had a GP Management Plan, and the precise regularity of reviews every three months…appeared contrived to maximise income rather than being based on clinical assessment.”

The PSR raised concern about the operation of larger medical practices where GPs are engaged as independent contractors who pay the operator a service fee. It said that under current arrangements individual practitioners were held solely accountable for inappropriate billing and the reimbursement of rebates – practice owners retained their share of Medicare rebates.

Local knowledge

The agency warned that overseas-trained doctors were more susceptible to breaching Medicare rules than their local counterparts, accounting for almost 54 per cent of cases referred to it last financial year.

In one instance, it found an “older English graduate…engaged in particularly egregious use” of CDM items, claiming the MBS items 721 and 723 more than 400 times in 12 months, at $240 a time.

Three other international medical graduates were found to have breached the so-called 80/20 rule, which meant they billed 80 or more GP attendance items on 20 or more days in the year. Typically, this would mean providing between 17,000 and 20,000 services attracting a gross rebate of between $800,000 and $1 million.

In all, five practitioners were investigated by the PSR for breaching the 80/20 rule, while a further 15 were identified to have provided more the 60 attendances on more than 100 days.

Upsurge in doctors under billing scrutiny

... from p17

In mitigation, many explained that they worked very long hours, they knew their patients well so could serve them quickly, that the practice was under-staffed or that they were unaware of the 80/20 rule.

Round-the-clock

The PSR flagged that while some doctors were billing CDM items inappropriately, others had come under suspicion over their provision of urgent after-hours care.

It said that although those referred for investigation had generally satisfied the definition of providing after-hours care, their interpretation of what constituted the need for urgent care was dubious.

"Examination of clinical records has shown that some practitioners have billed these items for medical conditions such as an uncomplicated rash, reissuing prescriptions for...regular medication and for routine completion of medication charts in residential aged care facilities," the PSR said, adding that the differenced in fee between urgent and non-urgent after-hours MBS items was substantial enough to have a significant financial impact on Medicare.

The agency warned that the Government's review of the MBS and Medicare compliance measures was likely to include ways to use the billing system to "better detect and define possible inappropriate practice".

The Federal Government has begun work on upgrading the Medicare payments system, inviting private sector upgrade proposals, though it has insisted the system and the information it collects will remain completely in public hands.

ADRIAN ROLLINS

Curtin medical school set to add to training pressure

Curtin University's controversial medical school has received formal accreditation in the face of widespread criticism from the medical profession.

Curtin has announced the first intake of 60 students into its five-year full-time undergraduate Bachelor of Medicine after the Australian Medical Council gave its approval to the program.

Curtin's Dean of Medicine Professor William Hart said there had been strong interest in the program, which he claimed would "go a long way to addressing the critical shortage of doctors, especially in rural, remote and outer-suburb locations".

Professor Hart said the university had received more than 1500 applications for the first 60 places, and the institution aimed to expand the program to 120 positions a year – 110 domestic students and 10 international – by 2022.

The university and the Federal Government have pushed ahead with the school in the face of fierce criticism from the Federal and West Australian AMA and the Australian Medical Students' Association.

Rather than more medical school places, the AMA said that what both Western Australia and the country as a whole needed was more training places for medical graduates.

There has been an explosion in the number of medical school places and medical graduates in the past decade, from around 1500 in 2004 to 3736 last year.

But this growth has not been matched by an increase in the prevocational and vocational training places medical graduates need to become fully-qualified doctors.

A report by the now-disbanded Health Workforce Australia warned that, on current trends, the mismatch between graduate numbers and training places would begin to emerge next year and reach a shortfall of 1011 places by 2030.

Rather than opening more medical schools, AMA President Dr Michael Gannon has argued the Government should be increasing its spending on medical training, or risk wasting much of the investment made in increasing the number of medical school places.

Last year, while still AMA WA President, Dr Gannon condemned the decision to open the Curtin medical school, arguing it would do nothing to increase the number of GPs working in rural areas and could put patients at risk.

"Medical student numbers are already at an all-time high in WA and this announcement will put incredible pressure on the health system which will almost certainly impact negatively on patient care across the board," Dr Gannon said at the time.

ADRIAN ROLLINS

INFORMATION FOR MEMBERS

Helping you claim MBS items for children with disabilities

The education guide for the Better Start for Children with Disability initiative has been updated to make claiming easier.

The education guide outlines Medicare Benefits Schedule (MBS) items available under the initiative for the early diagnosis and treatment of eligible children with a disability.

It now includes a diagram with MBS items you can claim, and the requirements for referrals, treatment, management plans and reporting.

The guide adds to other Medicare Benefits Schedule education for health professionals resources to help you understand claiming requirements.

Next steps:

- read the Medicare items for Better Start for Children with Disability initiative education guide;
- read about the Better Start for Children with Disability initiative on the Department of Health website;
- read more news for health professionals; and
- subscribe to news for health professionals to get regular updates directly to your inbox.

The guide can be viewed at: link https://www.humanservices.gov.au/health-professionals/subjects/education-services-health-professionals

Department of Human Services

Big pathology to get massive windfall at expense of patients, doctors

The AMA has warned that Federal Government proposals to cap pathology collection centre rents will likely drive up patient out-of-pocket costs and could force some medical practices out of business.

In a strongly worded letter, AMA President Dr Michael Gannon has appealed to the Small Business and Family Enterprise Ombudsman, Kate Carnell, to intervene and help try to convince the Government to drop its plan.

Dr Gannon said the proposal, announced during the Federal election, to change provisions in the Health Insurance Act would allow the two major pathology companies that dominate the market to unilaterally cut the rents they paid to medical practices for co-located collection centres (ACCs), delivering a big financial blow to small business already reeling under the effects of the Medicare rebate freeze.

"The proposed changes fundamentally alter the intent of the existing law…by imposing a blunt cap on the commercial rents that GPs and other specialists can receive for co-located ACCs," the AMA President said. "It delivers two major listed companies with an unwarranted and unfair advantage…estimated to save [them] between $100 million and $150 million per annum."

Under the deal, which was sprung on the medical profession without warning, the Government has promised to bring down rents in exchange for a promise from pathology companies that they will sustain bulk billing rates despite the loss of the bulk billing incentive.

Government Minister Senator Fiona Nash told the Estimates hearing the pathology industry had indicated "it is going to keep the bulk billing levels at its rates [and] we are taking it in good faith that that is exactly what they meant, and we expect they will do that".

The terms of the agreement were laid out in a Senate Estimates hearing by Health Department Deputy Secretary Andrew Stuart, who said the "nature of the deal between the Government and Pathology Australia is to work to bring rents down to a more reasonable level and, at the same time or in some relationship to that, to continue with the Government's proposal to remove the bulk billing incentive".

ACC rents have risen strongly since their deregulation in 2010, and there have been fears of a nexus between leases and the number of pathology tests a practice orders.

But the Health Department has reported in several different forums that it has not detected any such link.

Dr Gannon said, instead, that the rapid increase in ACC rents had been driven by competition for market share between the two big pathology companies.

He warned that the Government's proposed changes would have "a big impact" on medical practices.

"Medical practices are [already] feeling the impact of the current MBS indexation freeze, and policy changes like this will simply have a further negative impact on their cash flow and on practice viability," he said. "For those practices that have used this source of rental income to help keep them viable during the current extended freeze, it may it may mean higher costs to patients or simply selling their business."

Many, the AMA President said, had made decisions about hiring staff and purchasing equipment based on anticipated revenue streams from ACC rents, and the policy would put their finances under strain.

Dr Gannon said it was unlikely the Government comprehended the full impact of the "poorly targeted" policy when announcing it, including the massive windfall it would deliver to the big pathology providers and the hefty financial blow it would deliver to many medical practices.

Bearing out his concern, Mr Stuart admitted to the Senate committee that the Department had not modelled the likely effect of the pathology rents cap on general practices, particularly when combined with the Medicare rebate freeze.

The senior health official, who made pointed reference to the fact the deal was "a Government negotiation, not a departmental negotiation", said details of the arrangement, especially regarding its implementation, were still being finalised.

First Assistant Secretary Maria Jolly told the committee that one of the major unresolved issues was the definition of market value - as it has been for the current ACC arrangement.

She said how the new arrangement would be introduced was also yet to be determined, including how existing leases would be treated, and how the new deal would relate to the current regime governing prohibited practices.

ADRIAN ROLLINS

Pharmacies in push to provide more services

Pharmacists are trying to encroach further into GP territory while seeking to fend off competition from private hospital group Ramsay Health Care over its plans to open mega-pharmacies.

The Victorian Government recently became the latest jurisdiction to allow registered pharmacists to administer flu shots and whooping cough vaccinations to adults in approved pharmacies, leading the Pharmaceutical Society of Australia (PSA) to trumpet a new partnership with La Trobe University in Bendigo to offer vaccination training to pharmacy students.

"Over the past 12 months, PSA has trained more than 2300 pharmacists around the country ... to deliver high-quality immunisation services and to provide a major public health boost in local communities," the PSA said.

Pharmacy groups Terry White and Chemmart, which recently merged, have appealed to the Federal Government to allow pharmacists to deliver more vaccinations and write repeat prescriptions for common medicines that now require patients to go to their GP.

"Dispensing medicines and providing meaningful pharmacy services is not 'ordinary commerce' and the current system needs to be enhanced, not destroyed," the groups wrote in a submission to the review of pharmacy remuneration and regulation.

"The role Australia's network of accredited community pharmacies plays in providing health care services should be recognised, and the road blocks to their health care role should be removed."

But the pharmacists are keen to put up road blocks to non-pharmacists moving into their arena.

Following reports that Ramsay had taken a lease on a 300 square metre space in a Melbourne CBD building, where it plans to open a mega pharmacy early next year, the Pharmacy Guild issued a terse reminder that "community pharmacies must be owned by registered pharmacists".

Ramsay has 200 pharmacies across its network of private hospitals in Australia, Asia, and Europe, and 22 retail pharmacies in Australia.

The Guild acknowledged that Ramsay's broadening into retail pharmacy was part of the ongoing competitive landscape, but said regulatory requirements around pharmacy ownership must be complied with.

"Australians have made very clear that they want their health system to put patients before profits," Guild National President, George Tambassis, said in a statement.

"That is why it is critical that community pharmacies continue to be owned and controlled by practising professional pharmacists rather than big corporates which, by law, must put their shareholders first.

"The Pharmacy Guild will work with governments and regulators around Australia to ensure that pharmacist-only, pharmacy ownership laws are maintained, enforced and, if necessary, strengthened so that their clear public intent is not undermined."

MARIA HAWTHORNE

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

Gene tests on 'don't do' list

Medical experts have taken aim at 'direct to consumer' genetic testing services amid concerns that they are causing unnecessary expense and alarm.

Medical experts have warned that patients should not initiate genetic tests on their own, particularly for coeliac disease and for the genes MTHFR and APOE, which are, respectively, associated with levels of folate and susceptibility to Alzheimer's disease.

The Gastroenterological Society of Australia has recommended against genetic tests for coeliac disease because the relevant gene is present in about a third of the population and "a positive result does not make coeliac disease a certainty".

Similarly, Human Genetics Society of Australasia Clinical Professor Jack Goldblatt said variants of the MTHFR gene were "very common in the general population [and] having a variant in the gene does not generally cause health problems".

Additionally, Professor Goldblatt said that although the APOE gene was considered a risk factor for Alzheimer's, "having a test only shows a probability, so people undertaking [the test] can also risk being falsely reassured".

"Unnecessary genetic testing can lead to further unnecessary investigations, worry, ethical, social and legal issues," he said. "In particular, we caution people to not initiate testing on their own. Genetic tests are best performed in a clinical setting with the provision of personalised genetic counselling and professional interpretation of test results."

The recommendations are among 20 made by the Gastroenterological Society of Australia (GESA), the Royal Australian and New Zealand College of Radiologists (RANZCR), the Human Genetics Society of Australasia and the Australasian Chapter of Sexual Health Medicine, as part of program being coordinating by the Choosing Wisely Australia campaign to improve the use of medical tests and treatments.

The advice includes cautioning women against self-medicating for thrush, improved use of radiation therapy to treat cancer, and careful use of colonoscopies.

Professor Anne Duggan from GESA said colonoscopies had a "small but not insignificant risk of complications", and those undertaken for surveillance placed "a significant burden on endoscopy services".

Professor Duggan said surveillance colonoscopies should be targeted "at those most likely to benefit, at the minimum frequency required to provide adequate protection against the development of cancer".

The RANZCR said radiation treatment was "a powerful weapon" in the treatment of cancer, and half of those diagnosed with the disease would undergo radiation therapy.

But the College advised that such treatment should be provided within clinical decision-making guidelines, "where they exist".

In particular, it has recommended sparing use of radiation to treat prostate cancer.

Dean of the College's Faculty of Radiation Oncology, Dr Dion Forstner, radiation oncology might not be immediately required where prostate cancer is diagnosed.

"Patients with prostate cancer have options including radiation therapy and surgery, as well as monitoring without therapy in some cases," Dr Forstner said.

The College also advised that while whole-breast radiation therapy decreased the local recurrence of breast cancer and improved survival rates, recent research had shown that shorter four-week courses of therapy could be equally effective "in specific patient populations". It said patients and doctors should review such options.

The Chapter of Sexual Health Medicine made several recommendations, including advising against tests including herpes serology and ureaplasma in asymptomatic patients, and the use of serological tests to screen for chlamydia, because of frequent inaccuracy and the possibility of false-positive results.

In addition, it flagged concerns about the treatment of thrush.

Chapter President Dr Graham Neilsen said it was concerning that many women with recurrent and persistent yeast infections self-administered treatment, or were prescribed topical and oral anti-fungal treatments.

Dr Neilsen said it was important that patients had "good conversations" with clinicians about appropriate care.

"It is important to rule out other causes...such as genital herpes or bacterial vaginosis, so that other infection are not left untreated," he said. "As well as the importance of ruling out other causes before commencing anti-fungal agents, inappropriate use of antifungal drugs can lead to increased fungal resistance."

The 20 recommendations are the latest instalment in an ongoing program, coordinated by Choosing Wisely, in which 23 medical colleges and societies are working to improve the use of tests and treatments based on the latest evidence.

The process is separate from the Federal Government's MBS Review, which is examining all 5000 items on the Medicare Benefits Schedule.

ADRIAN ROLLINS

Use as recommended....

What Gastroenterological Society of Australia (GESA), the Royal Australian and New Zealand College of Radiologists (RANZCR), the Human Genetics Society of Australasia and the Australasian Chapter of Sexual Health Medicine have advised:

1. **Do not repeat colonoscopies more often than recommended by the NHMRC;**
2. **Do not undertake faecal occult testing for patients with rectal bleeding;**
3. **Attempt to reduce or cease long-term proton pump inhibitor medication;**
4. **Do not conduct coeliac gene test to screen for coeliac disease;**
5. **Wait more than three years to conduct a follow-up endoscopy on Barrett's Oesophagus patients with two consecutive findings of no dysplasia;**
6. **Don't use brain MRIs for routine surveillance of asymptomatic neurofibromatosis type 1;**
7. **Use targeted next generation sequencing in preference to sequential testing for heterogeneous genetic disorders;**
8. **Don't undertake tests for MTHR and APOE genes;**
9. **Do not conduct carrier state testing for rare excessive disorders where a partner has a family history;**
10. **No genetic testing where there are clinical diagnostic criteria and no reproductive or predictive implications;**
11. **Consider shorter treatment options rather than whole-breast radiation therapy;**
12. **Consider active surveillance rather than radiation therapy for low-risk prostate cancer;**
13. **Extended fractionation schemes should not be used routinely for bone metastases;**
14. **Don't routinely add whole-brain radiation therapy to radiosurgery for limited brain tumours;**
15. **Don't routinely used extensive loco-regional therapy for most cancers;**
16. **No herpes serology tests without clear clinical indication;**
17. **Don't screen for chlamydia using serological tests;**
18. **In cases of recurrent thrush, avoid using anti-fungal agents without a clinical assessment;**
19. **Do not test for ureaplasma in asymptomatic patients;**
20. **Reconsider nucleic acid amplification testing for gonorrhoea in patients at low risk.**

Insurers in crosshairs as complaints soar

The consumer watchdog has lashed private health insurers over an explosion in complaints over arbitrary policy changes that are costing many patients thousands of dollars in unexpected medical charges.

In its annual report to the Senate on the private health insurance industry, the Australian Competition and Consumer Commission has attacked the health funds for failing to adequately inform policyholders about changes to policy cover and benefits, causing many to face shock medical fees while others delay or forgo treatment.

There has been an across-the-board upsurge in complaints to the Private Health Insurance Ombudsman (PHIO), jumping by 24 per cent in 2014-15 – the second successive year of significant increase.

Much of this has been driven by a dramatic rise in complaints about changes to policies and benefits, which were up 290 per cent in 2014-15 to be the fastest-growing source of customer discontent.

The ACCC said this was a result of both the increasing frequency with which insurers were altering the cover and benefits they provided, and the inadequate way they sought to inform their policyholders.

"The private health insurance industry continues to be characterised by imperfect information and complexity, particularly around how the industry communicates with consumers about changes to their...benefits," the ACCC told the Senate.

The regulator earlier this year launched Federal Court action against Medibank Private alleging the insurer engaged in unconscionable conduct and making false representations over changes to gap cover arrangements, and is making the practice a focus of its work in the year ahead. The insurer rejects the claims.

Insurers, under pressure to limit the scale of premium increases, are increasingly turning to exclusions and benefit changes to hold down costs.

According to the PHIO, such changes typically involved the exclusion or reduction of services from existing hospital cover, and the alteration of insurer rules, provider arrangements, and the lowering or general treatment and dental benefits.

A breakdown of complaints provided by the PHIO shows most in the past three years have related to changes to the cover and benefits provided for IVF, gastric banding, psychiatric and spinal treatments.

The ACCC said one insurer admitted more than 500,000 of its policyholders were affected by benefit changes in 2014 alone, and in the same year another removed more than 200 medical benefit items from its schedules.

There has been a deterioration in the quality and comprehensiveness of cover. In 2006, 68 per cent of hospital policies provided full cover. By last year, that had dropped to 47 per cent. Over the same period, the proportion of such policies with an excess or co-payment soared from 58 to 82 per cent.

The impact on patients is to land them with unexpected fees and charges for health care or to cause them to cancel or delay treatment, including seeking care in the public health system.

The ACCC is highly critical of the way some funds seek to communicate these changes to their members.

"There are a range of poor practices around how some insurers notify customers of changes to their private health insurance benefits, and these practices are contributing to consumer harm such as increased bill shock, inadequate insurance coverage, lost switching opportunities and limited access to health care," it said.

These ranged from presenting information poorly and overwhelming consumers with confusing or unclear announcements to failing to inform policyholders about some benefit changes at all.

The problems, in the ACCC's view, have been compounded by the increasing number and complexity of policies on offer. As at mid-2015 there were around 46,500 products offered by 34 insurers, including 18, 535 hospital-only policies, 9646 general treatment-only policies, and 18,273 combined offerings.

"This complexity makes it harder for consumers to understand and respond effectively when insurers change their benefits, and makes consideration of reforms to improve benefit change notifications even more important," the watchdog said.

It said the evidence suggested the young, the elderly, the chronically ill, those undergoing treatment and non-English speakers were the most likely to suffer the consequences of the industry's poor practices.

The ACCC has put the industry on notice to reforms its ways at the same time as it faces scrutiny from the Federal Government, which has undertaken a review of the industry over perceptions of a steady decline in the value of its product.

Alarmed by the erosion of private health cover, Health Minister Sussan Ley has announced changes to the prices insurers are charged for prostheses as part of efforts to hold down costs and help limit the size of annual premium increases.

ADRIAN ROLLINS

INFORMATION FOR MEMBERS

Specialty Training Pathways Guide – AMA Career Advice Service

With more than 64 different medical specialties to choose from in Australia, making the decision to specialise in one can seem daunting.

AMA members now have access to a new resource – one designed to assist in making decisions about which specialty pathway to follow. We know that concerns about length of training, cost of training and work-life balance are important factors in making these decisions, and information on the new site will help here too.

The absence of a comparative and definitive guide was raised by our doctors in training and medical students.

Responding to this need from our doctors in training and medical students, the AMA Career Advice Service has developed a comprehensive guide to the specialties and sub-specialities which can be trained for in Australia. The Guide will be updated annually to reflect changes made by the Colleges, and the 2017 update will be uploaded shortly.

The web-based Guide allows AMA members to compare up to five specialty training options at one time.

Information on the new website includes:

- the college responsible for the training;
- an overview of the specialty;
- entry, application requirements and key dates for applications;
- cost and duration of training;
- number of positions nationally and the number of Fellows; and
- gender breakdown of trainees and Fellows.

The major specialities are there as well as some of the lesser known ones – in all, more than 64 specialities are available for comparison and contrasting.

For example, general practice, general surgery – and all the surgical sub-specialities, paediatrics, pathology – and its sub specialities, medical administration, oncology, obstetrics and gynaecology, immunology and allergic medicine, addiction medicine, neurology, dermatology and many, many more.

To find out more, visit www.ama.com.au/careers/pathway

This new addition to the Career Advice Service enhances the services already available which include one-on-one career coaching, CV templates and guides, interview skills “tips” and, of course, a rich source of information available on the Career Advice Hub: www.ama.com.au/careers

For further information and/or assistance, feel free to call the AMA Career Advisers: Annette Lane and Christine Brill – 1300 133 665 or email: careers@ama.com.au

Please note current information within the guide relates to 2016 requirements. Information will be updated to reflect 2017 requirements soon.

Let the AMA’s specialty training pathways guide help inform your career decisions.

Breast cancer – best practice statement released

Cancer Australia has released a landmark Statement on best practice in breast cancer, to give evidence-based, practical guidance to professionals working with breast cancer patients.

The Statement was developed in consultation with medical colleges and cancer organisations, with the aim of eliminating unwarranted variations in breast cancer care for women across Australia.

It highlights key appropriate and inappropriate breast cancer practices, and provides health providers, patients and policymakers with the evidence supporting effective and best practice care, to deliver value to the patient and the health system.

It is appropriate to:

- Offer genetic counselling to women with a high familial risk at or about the time that they are diagnosed with breast cancer, with a view to genetic testing to inform decision-making about treatment;
- Ensure optimal fixation of breast cancer specimens for accurate pathological examination and biomarker assessment;
- Consider and discuss fertility and family planning with premenopausal women before they undergo breast cancer treatment;
- Offer a choice of either breast-conserving surgery followed by radiotherapy, or a mastectomy to patients diagnosed with early breast cancer, as these treatments are equally effective in terms of survival;
- Offer a shorter, more intense course of radiotherapy (hypofractionated radiotherapy) as an alternative to conventional radiotherapy for patients with early breast cancer who are aged 50 years and over, have a cancer at an early pathological stage, and have undergone breast-conserving surgery with clear surgical margins;
- Offer patients with early breast cancer the opportunity for their follow-up care to be shared between a primary care physician and a specialist, to provide more accessible, whole-person care;
- Offer palliative care early in the management of patients with symptomatic, metastatic breast cancer to improve system control and quality of life; and
- Consider the pre-operative use of chemotherapy or hormonal therapy, informed by hormone and HER2 receptor status, for all patients where these therapies are clinically indicated.

It is not appropriate to:

- Confirm or exclude a diagnosis of breast cancer without undertaking the triple test, which involves taking a patient history and clinical breast examination, imaging tests, and biopsy;
- Offer a sentinel node biopsy to patients diagnosed with ductal carcinoma in situ (DCIS) who are having breast conserving surgery, unless clinically indicated;
- Perform a mastectomy without first discussing with the patient the options of immediate or delayed breast reconstruction; or
- Perform intensive testing (full blood count, biochemistry, or tumour markers) or imaging (chest X-ray, PET, CT, ad radionuclide bone scans) as part of standard follow-up of patients who have been treated for early breast cancer and who are not experiencing symptoms.

Royal College of Pathologists of Australia (RCPA) Fellow, Professor Sandra O'Toole, who was a member of the working group that developed the Statement, said the process was exhaustive and evidence-based.

"As a group, we chose to focus on areas with the capacity to improve existing practice, rather than those that were already being effectively implemented," Professor O'Toole said.

The Statement can be viewed at www.canceraustralia.gov.au/statement.

MARIA HAWTHORNE

Cancer myth recycled in abortion debate

Claims that abortion is linked to breast cancer have been rubbished as irresponsible and without foundation by AMA Vice President Dr Tony Bartone.

The Australian Christian Lobby is spruiking a film, Hush, which purports to show research demonstrating that abortion is linked to breast cancer and is being screened as a fundraiser for the Women's Forum Australia group.

On its website, Women's Forum Australia declares that it "challenges the rhetoric of 'choice' promoted by an abortion industry that has a vested interest in promoting abortion as a procedure without repercussion".

But Dr Bartone told *The Sydney Morning Herald* that there was "no evidence that abortion is in any way linked to the development or onset of breast cancer".

Instead, he raised concerns about how the claim could affect women either with breast cancer or contemplating an abortion.

"A patient suffering from breast cancer has enormous challenges to deal with, and they certainly don't need this kind of misinformation adding to their already overwhelming worries," Dr Bartone said. "Also, patients making informed decisions about terminations do not need to be subjected to this kind of misinformation, which can only create significant and unnecessary further stress when they already have so many concerns to deal with."

The issue has arisen amid renewed calls for the reform of abortion laws in Queensland and New South Wales to remove the legal uncertainty hanging over the procedure in both states.

ADRIAN ROLLINS

INFORMATION FOR MEMBERS

FUNDING GRANTS FOR WOMEN'S LEADERSHIP DEVELOPMENT

In 2016 Women & Leadership Australia is administering a national initiative to support the development of female leaders across the health sector.

From September 21st 2016 the initiative will provide women in the health sector with grants for leadership development. More specifically, grant applications are open for women at three levels. Please click on the preferred program link for details. The deadline for expressing your interest for this funding in your sector ends on December 15th.

1. **Senior management and executive level women leaders** can apply for $8,000 part-scholarships to undertake the Advanced Leadership Program
2. **Mid-level female managers** and leaders can apply for $4,000 part-scholarships to undertake the Executive Ready Program
3. **Aspiring talent and emerging women managers** can apply for $3,000 part-scholarships to undertake the Accelerated Leadership Performance Program.

Expressions of Interest

Attached to this email is the Expression of Interest form or can be downloaded here.

Should you wish to discuss the initiative in more detail please contact Ian Johnson at the office of the National Industry Scholarship Program, Women and Leadership Australia on

03 9270 9016 or via ijohnson@wla.edu.au.

Medibank puts away the fags for good

The nation's largest health insurer has dumped the last of its shares in tobacco, but has no plans to extend its investment ban to include fossil fuels, alcohol or gambling.

Medibank Private Chief Executive Craig Drummond announced the company had completed a multi-year sell-off of its tobacco stocks, and was instead pumping $170 million into a tobacco-free trust operated by State Street Global Advisers.

Mr Drummond told the *Australian Financial Review* that Medibank had made the change at the prompting of director and former Queensland Premier Anna Bligh and oncologists and anti-tobacco stocks campaigner Bronwyn King.

"Our stakeholders expect us to be promoting better health and, given that approximately 15,000 Australians die each year from the effects of tobacco, we don't see that it's consistent to have tobacco-related securities in our investment portfolio," he told the AFR.

Medibank is the foundational investor in the State Street trust, which also excludes investment in armaments including cluster bombs, landmines, chemical and biological weapons and depleted uranium.

But Mr Drummond said the insurer had no plans to increase its range of banned investments to include fossil fuel, alcohol or gambling.

He said that while such products could be safe when used in moderation, tobacco caused harm even in small doses.

ADRIAN ROLLINS

INFORMATION FOR MEMBERS

1 NOVEMBER 2016 – AMA LIST OF MEDICAL SERVICES AND FEES

The 1 November 2016 edition of the AMA Fees List will soon be available in hard copy and electronic formats.

The hard copy book is for AMA members in private practice or with rights of private practice, and salaried members who have requested a book. Dispatch of the book will commence on 14th October 2016.

The AMA Fees List is available in the following electronic formats:

- **PDF** of the hard copy book
- **CSV** file for importing into practice software
- **Online database** where members can search for individual or groups of items and download the latest updates and electronic files.

PDF and CSV versions of the AMA Fees List will be available to all members via the Members Only area of the AMA website http://www.ama.com.au/resources/fees-list from 21st October 2016. The Fees List Online Database will be updated on 1st November 2016.

Access the Fees List via the AMA website

To access the AMA Fees List online, simply go to the AMA homepage and logon by clicking on the symbol icon the right corner of the blue task bar and entering your AMA username and password. Once logged in, on the right hand side of the page, click on 'Access the AMA Fees List'. From here you will find all electronic formats of the Fees List.

Access the AMA Fees List Online Database

The AMA Fees List Online Database is an easy-to-use online version of the AMA Fees List. To access the database follow the steps above or go to: https://ama.com.au/article/ama-fees-list-online

AMA Fees Indexation Calculator

Also available to members is the AMA Fees Indexation Calculator, this allows you to calculate your own fee increase based on your individual cost profile. To access the AMA Fees Indexation Calculator, follow these steps:

1) From the home page hover over **Resources** at the top of the page. A drop down box will appear. Under this, select **Fees List**.
2) Select AMA Fees Indexation Calculator (Members Only).

Members who do not currently have a username and password should email their name, address and AMA member services number to **memberservices@ama.com.au** requesting a username and password.

Financial members with rights to private practice will automatically receive the book. If you are a salaried member and would like a copy, please contact the AMA on 02 6270 5400 or email feeslist@ama.com.au.

Driving our way to better health

Driverless cars will have a revolutionary impact on public health by virtually eliminating road accidents, slashing vehicle emissions, reducing social isolation and encouraging active transport, according to a leading health researcher.

Issuing a call for public health advocates to get behind the emerging technology, Professor Simone Pettigrew of the Faculty of Health Sciences at Curtin University said autonomous vehicles would make road transport far safer, saving hundreds of lives and billions of dollars each year.

> "Trials of driverless cars have begun on public roads in the United States and Britain, and there has already been one recorded fatality when a Tesla Model S in autopilot mode failed to brake when a truck crossed the highway in front of it"

Professor Pettigrew said around 1200 Australians were killed in motor vehicle accidents each year (almost 960 people have been killed on the nation's roads so far this year), while a further 34,000 were hospitalised, costing the country $16 billion.

She said that 93 per cent of crashes were caused by human error such as speeding, running red lights or being distracted, and putting vehicles under the control of computers equipped with 360-degree sensors and split-second reaction times would virtually eliminate the chances of a crash occurring.

Trials of driverless cars have begun on public roads in the United States and Britain, and there has already been one recorded fatality when a Tesla Model S in autopilot mode failed to brake when a truck crossed the highway in front of it. A man in the car died in the crash. The company said both the car and the driver failed to detect the truck "against a brightly lit sky".

Despite the accident, plans to test driverless cars on Australian roads are proceeding in South Australia, Queensland and Western Australia, and mining giant Rio Tinto already uses a fleet of autonomous trucks to haul iron ore at its Pilbara mines.

The technology has enormous financial backing.

Car makers Toyota, General Motors and Ford are investing billions of dollars into driverless car research in the next five years, and tech giants Google and Apple have joined Tesla in the race to develop autonomous vehicles and systems.

But regulators are cautious about letting the technology loose on the open roads, and many are uneasy about entrusting the safety of themselves and other road users to computers. One of the oft-raised concerns is how an autonomous vehicle might respond when faced with split-second decisions, such as the choice of either crashing into a tree or a child.

Professor Pettigrew scoffed at such concerns.

She said human drivers, with all their fallibilities, were already entrusted to make such decisions and driverless cars were, if anything, more trustworthy because of the technology they were equipped with.

"Autonomous vehicles are fitted with 360 degree sensors that are monitored constantly, so the chance of them detecting a child running onto the road is much, much greater than a human who has a more limited field of vision and slower reaction times," she said.

Professor Pettigrew added that the safety of autonomous cars would increase over time because the lessons learned from any crashes involving a driverless car would be shared across all such vehicles.

In addition to slashing the road toll, the professor said driverless cars would help reduce greenhouse gas emissions because most were likely to derive most of their propulsion from electricity, and computer control would make them much more energy efficient than cars driven by humans.

Driverless cars would also make it far easier for the elderly and the disabled to get around, improving their access to health care and other services and reducing their social isolation, she said.

While autonomous vehicle technology is developing rapidly, advocates are uncertain how quickly it will be adopted.

But there are estimates that by 2040 around 75 per cent of all cars in the United States will be driverless, and Professor Pettigrew said she expected their use in Australia would be almost universal within the next 50 years.

But, because the benefits of the technology in reduced deaths and trauma was so large, she said health professionals should actively lobby for their adoption as early as possible.

"Because of these huge benefits, the more of us pushing the message the better," Professor Pettigrew said.

ADRIAN ROLLINS

Modest health bill growth belies 'unsustainable' claims

Federal Government complaints about unsustainable growth in health spending have been undermined by figures showing its health bill is growing little faster than the pace of inflation.

Australian Institute of Health and Welfare figures show Commonwealth health spending increased by 2.4 per cent to $66.2 billion in 2014-15, compared with a 2.3 per cent rise in underlying inflation over the same period.

> "The figures demonstrate that increasingly the burden of health funding is falling onto the shoulders of patients, either directly through rising out-of-pocket costs or indirectly via rising private health insurance premiums"

State and Territory government spending was even weaker, contracting by 0.4 per cent to $42 billion – the first such decline in a decade.

The results undermine the Government's case for swingeing cuts in the health budget, which have been based on assertions that public spending on hospitals, GPs and other health services has been out of control.

The AIHW's *Health expenditure Australian 2014-15 report* shows, instead, that Federal Government spending has slowed sharply in recent years. 2014-15 was the third year in a row where expenditure growth was below the annual average of 4 per cent.

The figures demonstrate that increasingly the burden of health funding is falling onto the shoulders of patients, either directly through rising out-of-pocket costs or indirectly via rising private health insurance premiums.

Between 2004-05 and 2014-15, the Commonwealth's share of the nation's health bill slipped from 43.9 to 41 per cent. Over the same period, the states' and territories' share increased from 24 to 26 per cent, for individuals it went from 17.4 to 17.7 per cent and for health funds, from 7.7 to 8.7 per cent.

The cost-shifting was particularly stark in the three years to 2014-15, when a 1.3 percentage point jump in the health insurer's share coincided with a 2 percentage point plunge in the Federal Government's share.

The AIHW said this was driven by changes in the Government's private health insurance rebates that had the effect of cutting its contribution, with insurers (and, more particularly, policyholders) picking up the tab. The development casts attempts to blame the surge in premiums on doctor fees or procedure costs in a different light.

Partly the shift in the Federal Government's share can be explained by changes in revenue. The Commonwealth's tax take has been hammered by the global financial crisis and the wind-down of the mining boom, and shrank by 1.5 per cent in 2014-15. By contrast, State and Territory tax collections have been growing at an above-average pace for the past decade. This has meant that while health has been grabbing a greater share of tax revenue at the Federal Government level, at the State and Territory level it has been shrinking.

Overall, the nation's spending on health increased by 2.8 per cent in 2014-15 to $161.6 billion – well down from the 10-year average growth rate of 4.6 per cent.

However, because of the slowdown in the broader economy, health expenditure as a proportion of GDP actually increased 0.2 of a percentage point to reach 10 per cent of total output for the first time.

This is higher than the developed country median of around 9.1 per cent, but is comparable with countries including New Zealand, Canada, the United Kingdom and Finland, and far below the United States, where health expenditure accounts for 16.6 per cent of GDP.

Per person, Australia spends $6657 on health – ranked 10th highest among OECD countries but well below the US ($13,266), Switzerland ($9977) and Norway ($8940).

ADRIAN ROLLINS

Australians shedding their hard drinking image

Drinks sales are forecast to decline as growing numbers of Australians cut back on their consumption or quit altogether, in a sign that higher excises and lock-out laws are helping to curb the nation's drinking problem.

Industry analyst IBISWorld expects per capita alcohol consumption, which has already dropped to a 50-year low, will continue to decline until at least the middle of the next decade as people heed health messages and respond to higher prices, drink-driving laws and other measures by reducing their intake.

The analyst predicts that by 2024 consumption will drop to 8.54 litres per person, a fall of almost 20 per cent from the start of this decade.

"We're seeing increasing health consciousness among the under 30s, while at the other end of the market people are also drinking less," IBISWorld senior analyst Andrew Ledovshkik told *The Australian Financial Review*.

The analysis echoes the findings of an Australian Institute of Health and Welfare report showing that consumption is declining, with 22 per cent reporting they had abstained from drinking in 2013 (up from 17 per cent in 2004), and the proportion who have never had a full drink reaching 14 per cent.

Even rates of risky drinking are declining.

The AIHW reported an 11 per cent drop in the rate of Australians drinking at risky levels on a single occasion (from 2950 to 2640 per 10,000 people), and 13 per cent drop who indulge in risky drinking over a lifetime, from 2080 to 1820 per 10,000.

The declines have paralleled changes to the cost and availability of alcohol.

The excise on beer and spirits is indexed twice a year and for some beverages has reached $81.21 per litre of alcohol. Wine is treated differently and is subject to a so-called equalisation tax currently set at 29 per cent of its wholesale value. Public health advocates are critical of the arrangement and argue that alcohol should be taxed at a minimum unit price that applies regardless of the beverage.

Several State governments, most notably New South Wales and Queensland, have also acted to restrict outlet trading hours and impose lock-outs in response to alcohol-fuelled assaults and murders.

The Institute said the results suggested that strategies including increasing the price of alcohol, restricting trading hours and

reducing the density of outlets "can have positive outcomes in reducing the overall consumption levels of alcohol".

Aside from making alcohol more expensive and difficult to get, there are signs that younger people are less inclined to drink to the same extent as older generations.

In the United States, a survey of 67,000 youths and adults conducted by the Abuse and Mental Health Services Administration found that just 9.6 per cent of adolescents aged between 12 and 17 years reported drinking alcohol in 2015, down from 17.6 per cent in 2002.

The question is whether others drugs are being used as a substitute for alcohol.

In the US, there has been a slight drop in heroin use, but prescription drug use and abuse is high. It is estimated that about 19 million Americans aged 12 years or older misused prescription drugs, mainly painkillers, in the previous year.

In Australia, about 3.3 per cent of those 14 years or older have used analgesics for non-medical purposes in the previous 12 months, 10 per cent have used cannabis, 2.1 per cent have used cocaine and methamphetamine, 2.5 per cent have used ecstasy, 1.3 per cent have used hallucinogens and 0.1 per cent have used heroin.

But even with the decline in its consumption, alcohol remains a major health problem. It was the leading cause of disease burden for the under 45s in 2011, and alcohol use disorders accounted for 1.5 per cent of the total burden of disease that year.

ADRIAN ROLLINS

Young mother stillbirth puzzle

The rate of stillbirths and neonatal deaths among young mothers is increasing even as perinatal mortality rates among older mothers is in decline, puzzling researchers.

The first study of its kind into national perinatal mortality, covering the period from pregnancy through to the first four weeks of life, found that the overall rate had remained steady in the past 20 years at around 9.9 deaths for every 1000 pregnancies.

But this result disguised conflicting trends, including elevated rates of stillbirth and neonatal deaths among mothers under age 20 and older than 40 years.

And, while the odds of a baby surviving the first four weeks of life improved - as shown by an 18 per cent decline in neonatal deaths between 1993 and 2012 - over the same period the rate of stillbirths climbed 13 per cent to the extent that they accounted for about three-quarters of perinatal deaths between 2011 and 2012.

Researchers from the University of New South Wales' National Perinatal Epidemiology and Statistics Unit and the Australian Institute of Health and Welfare found that characteristics including where a mother lived, her socioeconomic status, her weight, whether or not she smoked and her ethnic background all influenced perinatal mortality.

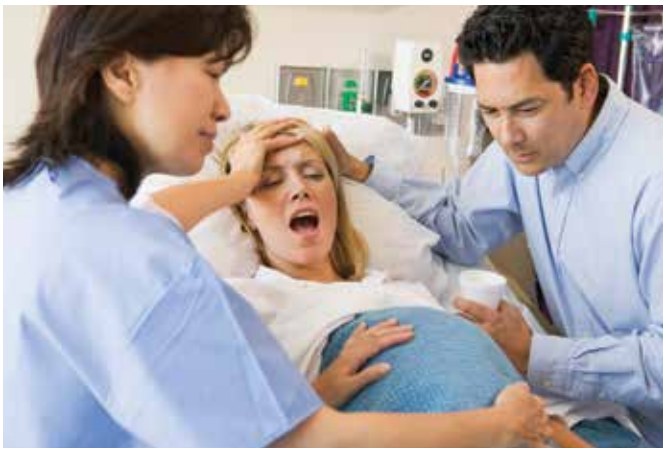
In general, mothers aged between 25 and 39 years who lived in a city, did not smoke, were of normal weight and reasonably well-off were the least likely to experience stillbirth or neonatal death. The stillbirth rate among mother 30 to 34 years was just 6 per 1000 births.

But among Indigenous mothers the perinatal death rate (17.1 per 1000 pregnancies) was virtually double that of non-Indigenous women (9.6), while among smokers it was 13.3 1 per 1000 pregnancies, compared with 8.9 among non-smokers, and perinatal mortality increased among babies of obese and underweight mothers.

Another significant variable was age, which was linked to factors including maternal health, previous pregnancies and births, and the development of congenital abnormalities.

Such abnormalities were found to be the leading case of stillbirths, accounting for 26.3 per cent of them in 2011 and 2012, as well as a third of all neonatal deaths.

The researchers said the fact that the risk of congenital abnormalities increased in older mothers (above 45 years of age), combined with the greater chance that they were suffering other health problems such as hypertension and diabetes, helped explained higher rates of perinatal mortality (17.1 per 1000 pregnancies) in this age group.



But they were uncertain what the above-average (13.9 per 1000 pregnancies) perinatal mortality rate among mothers younger than 20 years.

"The reason the perinatal mortality rate was higher among younger mothers is uncertain," their report, *Perinatal deaths in Australia, 1993-2012*, said. "It could be due to a number of factors including higher rates of smoking, inadequate antenatal care and gynaecological immaturity."

In a sign that efforts to improve Indigenous health were having an effect, the report found that although the perinatal death rate for Indigenous babies was high, it was coming down, dropping by 20 per cent in the past 20 years, including a 16 per cent fall in stillbirths and an even sharper 30 per cent plunge in the neonatal birth rate.

The researchers also identified interesting differences by ethnicity.

Mothers who were born in China or Europe had the lowest rates of stillbirth (5.1 per 1000 births) and perinatal mortality (6.8 and 6.9 deaths per 1000 births). The highest perinatal mortality rates were among women from Africa (13.5) and the South Pacific (13.6).

According to the study, whether or not a mother had previously given birth might be a factor, though they cautioned that other changes including advancing maternal age and changes in socioeconomic status may be influential.

Overall, the chance of a stillbirth or neonatal death fell if a mother had had one previous child, but gradually increased the more they had after that.

ADRIAN ROLLINS

Hips and knees going strong, 15 years on

Hip and knee replacements carried out in the year Sydney hosted the Summer Olympics are proving as enduring as Cathy Freeman's gold medal race.

A 15-year assessment of performance data has found that more than nine in 10 hip and knee replacements carried out in 2000 are still going strong.

The Australian Orthopaedic Association (AOA) has revealed that 92 per cent of all total hip and 92.3 per cent of all total knee replacement devices implanted in patients in 2000 have not required revision.

"While there have been significant advances in surgical procedures and prosthesis development, the 15-year performance data underlines the fact that, for many decades, hip and knee replacement surgeries have consistently been two of the most popular and successful surgeries performed in Australia," AOA President Andreas Loefler said.

The figures are reported in the AOA National Joint Replacement Registry annual report.

The report shows that orthopaedic surgeons are performing almost 300 hip, knee, or shoulder replacements every day across Australia, while the proportion of revision surgeries being carried out has dropped to all-time lows.

In the 12 months to December 2015, the proportion of revision hip procedures reported to the Registry declined to 9.6 per cent, from a high of 12.9 per cent in 2003, while knee revisions dropped to 7.4 per cent from a peak of 8.8 per cent in 2004.

"These are significant results when you consider the number of replacement surgeries being performed in Australia continues to rise year on year," Dr Loefler said.

A total of 107,740 hip, knee, and shoulder replacement surgeries were performed in 310 hospitals throughout Australia in 2015 – the equivalent of 8,978 a month, 2,072 a week, or 295 a day.

This is the first year that outcomes for shoulder surgery has been included in the annual report.

"In recent years, there has been substantial improvement in technology regarding shoulder replacements – most significantly,

the reverse total shoulder replacement," Dr Loefler said.

"The Registry has been able to establish that the performance of this technology has been very satisfactory, and provides an alternative option to standard shoulder replacement.

"As a result, shoulder replacement surgery has increased by 88.5 per cent since 2008."

The report is available at https://aoanjrr.sahmri.com/documents/10180/275066/Hip%2C%20Knee%20%26%20Shoulder%20Arthroplasty.

MARIA HAWTHORNE

Women overlook the biggest killer

Women may list breast cancer as their major health concern, but new research suggests they are more likely to die from cardiovascular disease.

Long regarded as a health issue for middle-aged men, CVD – with its contribution to dementia, diabetes, and kidney failure – is the biigest killer of Australian women, researchers at the Mary Mackillop Institute for Health Research say.

Urgent investment is needed for female-specific awareness campaigns, guidelines, and prevention programs, the researchers say.

"The large majority of Australian women are still under the impression that heart disease and stroke are male diseases," Professor Simon Stewart from the Australian Catholic University said.

"This is simply not true and, without urgent education, more Australian women are at risk of falling victim to this killer, particularly with their current, high cardiovascular-risk lifestyles.

"Increased obesity rates mean that all forms of CVD are becoming increasingly common in younger women.

"With nearly one in three Australian women aged 18 and over considered insufficiently active, and one in five reporting no exercise at all, the likelihood of these young women developing CVD in the longer-term is frighteningly high."

The *Hidden Hearts: Cardiovascular Risk and Disease in Australian Women* report finds CVD, including heart attack and stroke, and associated diseases such as diabetes and kidney failure, contribute to the deaths of at least 31,000 Australian women every year – significantly more than the 12,000 deaths attributed to the most common forms of cancer.

But low awareness of the risks leads women to ignore the warning signs. More than 3,000 Australian women each year suffer a sudden and fatal cardiac event without reaching hospital.

"CVD and its consequences are highly preventable – these are avoidable diseases with extraordinary personal and financial burdens," Professor Stewart said.

"With $3 billion spent on CVD-related hospital care for women every year, it's vital that the public health system stops being complacent, and prioritises this critical health issue."

The *Hidden Hearts* report recommends investment in awareness campaigns, gender-specific guidelines and prevention programs, and targeted research to combat the current and future burden of CVD among Australian women.

The report is available at http://mmihr.acu.edu.au/wp-content/uploads/sites/2/2016/09/Hidden-Hearts.pdf.

MARIA HAWTHORNE

Revalidation: what's the problem?

The AMA has been working with the Medical Board of Australia to develop a suitable approach to revalidation. Australia has an extremely high standard of health care and the last thing the Australian health care system needs is to introduce layers of bureaucracy that don't actually improve the patient journey or make it safer. The AMA was very glad to see that the Board is not proposing a UK-style model.

One of the issues the Board appears to be grappling with is to clearly identify the problem that such a process would be set up to address, given that only a small proportion of doctors are the subject of formal complaints from patients or colleagues.

A discussion paper on options for revalidation, issued by the Medical Board, proposes that doctors undertake a 'strengthened' CPD program. This would include peer review of a doctors' performance. The plan could mean a review of doctor's medical records, and peer discussion of critical incidents and requirements to get feedback from multiple sources including medical colleagues, health practitioners and patients.

Simultaneously, there would be a 'proactive' screening process to identify and assess doctors who may be performing poorly and potentially pose a risk to patients. Under the Board's proposals, doctors deemed at risk would be formally assessed via a variety of methods. Doctors who were found to be underperforming through the Board's proactive screening program would be offered support and mediation to get them back on track.

The AMA would like the Board to outline the problem it wishes to address, and the proposed solutions, in greater detail.

Unfortunately, there is currently not enough detail in the Board's interim report to come to any conclusion about this. Likewise, the report notes that the costs of the proposed additional CPD and the system to identify and manage poor performance are unknown.

Of some comfort is that the report recommends guiding principles that should apply to all potential approaches:

- smarter not harder: strengthened CPD should increase effectiveness but not require more time and resources;
- integration: all recommended approaches should be integrated with, and draw upon, existing systems and avoid duplication of effort; and
- relevant, practical and proportionate: all recommended improvements should be relevant to the Australian healthcare environment, feasible and practical to implement and proportionate to public risk.

The Board's next steps are to finalise engagement and collaboration in 2016 and recommend an approach to pilot in 2017.

Consultations close on 30 November. You can have your say in a number of ways via the Board's consultation webpage http://www.medicalboard.gov.au/News/Current-Consultations.aspx

JODETTE KOTZ

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

Coalition rent pledge followed fallout on pathology centres, *The Australian*, 2 November 2016

AMA President Dr Michal Gannon said that the proposed changes deliver two major listed companies with an unwarranted and unfair advantage during lease negotiations with small businesses. He argued that rents for co-located collection centres had grown due to competition between pathology companies for market share, not the actions of GP clinics who had negotiated in good faith.

Doctors in risky shifts, *The Daily Telegraph*, 31 October 2016

Doctors remain vulnerable to dangerously long shifts, putting themselves and patients at risk. The AMA has launched an audit of doctors' work hours to track changes.

$100 to see your doctor, *The Daily Telegraph*, 24 October 2016

AMA Vice president Dr Tony Bartone said the longer the Medicare rebate freeze lasts the more GPs in corporate clinics, in rural and remote areas, will have to look to their ability to deliver bulk billing solutions or whether they can bulk bill everybody, or even pensioners.

Feel sick? You must have seen the doctor, *Daily Telegraph*, 19 October 2016

The AMA recommended a hike in GP fees. Dr Gannon said every year the Government approves health insurance premium rises three times the inflation rate but won't increase the Medicare rebate at all. He said it is next to impossible to practice high quality medicine when you aren't properly funded.

Elderly get power to choose treatment, *Sunday Telegraph,* 16 October 2016

Dr Gannon said end of life care was a pressing issue and the AMA would observe the discussion with interest. He said that we can do better on end of life care and do better on the stewardship of resources but that does not include the denial of basic care.

Anti-jab seminars 'sad, disappointing', *Weekend West,* 15 October 2016

Dr Gannon said parents should be wary of vaccination scaremongering. He said he would refer patients to the Science of Immunisation booklet rather than information from "zealots they pass on the way out of Coles".

Vaccine campaign targets wealthy, *The Australian*, 11 October 2016

Launching an updated booklet on the science of vaccination, Dr Gannon said that while immunisation rates were up generally in Australia, some areas still had rates as low as 86 per cent.

Millions caught in health records breach, *The Saturday Paper Melbourne*, 8 October 2016

Dr Gannon said he had written to the Health Minister outlining a list of ongoing concerns. He said while the Medicare freeze was not the only issue in the health system it was a speed bump to general engagement. He highlighted the winding back of bulk billing incentives for radiology and pathology, and the pre-election deal struck with big pathology companies to force GPs to cap rents they charge for co-located pathology collection centre.

RADIO

Dr Gannon, ABC North Queensland, 1 November

Dr Gannon said that there was limited scope for medical marijuana and that doctors have set protocols and procedures to follow before they prescribe the drug.

Dr Bartone, 3AW Melbourne, 30 October

The AMA launched an audit of doctor's working hours. Dr Bartone said previous audits found 53 per cent of hospital doctors were working unsafe hours.

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.

... from page 36

Dr Gannon, 6PR Perth, 24 October

Dr Gannon said that the public hospital system desperately needed a boost to reduce surgery waiting times. He urged the Government to invest in more training positions for medical graduates, saying the Government could do a lot better when it comes to uninsured patients.

Dr Bartone, 774 ABC, 19 October

Dr Bartone said at this time every year the AMA gave advice to its members about what their fees should be. He said doctors have to look at their input cost and what it costs to provide care.

Dr Bartone, 6PR Perth, 19 October 2016

The AMA released its list of medical fees for 2017 to guide the community on their consultation fees. Dr Bartone said that there could be more expenses to patients if the Medicare rebate freeze remained frozen.

Dr Gannon, 2MCE Orange, 7 October 2016

The AMA called on the Federal Government to scrap proposed plans to impose tighter rules on pathology collection centre rental agreements in exchange for pathology companies dropping their high-profile campaign against bulk billing policies.

Dr Gannon said Minister Ley needed to give GPs and other medical facilities a fair chance.

TELEVISION

Dr Bartone, Sky News, 30 October

Many Australian doctors are working unsafe hours in public hospitals. Dr Bartone said better rostering practices and adequate opportunity to sleep between shifts were needed. He said fatigue can potentially impact focus and may lead to a quality of care issue.

Dr Bartone, Channel 7, 19 October

The AMA released its annual fees book, saying that patients should expect fees to rise unless the Government reconsiders its freeze on the Medicare rebate. Dr Bartone said that every day of the Medicare rebate freeze is another day patients pay more for medical services.

Dr Gannon, ABC News, 9 October 2016

Dr Gannon spoke about changes in medical terminology, saying the work 'risk' would no longer be used to describe an unborn baby's chances of having Down syndrome.

INFORMATION FOR MEMBERS

Food Standards Australia New Zealand – Board nominations

AMA members are invited to nominate for the Board of Food Standards Australia New Zealand.

FASNZ has invited the AMA to provide nominees for the consumer, science and/or public health positions on the GSANZ Board.

Nominees must have relevant expertise: good knowledge of consumer rights and consumer affairs policy for the consumer position; expertise in one or more of public health, food science, food allergy, nutrition, medical science, microbiology, food safety and biotechnology in the case of the public health/science position.

Nominations must be received by 30 November.

For more information, including selection criteria, please contact AMA Secretary General Anne Trimmer at ama@ama.com

Your AMA Federal Council at work

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

Name	Position on council	Committee meeting name	Date
Dr Tony Bartone	Vice President	Health Care Home Implementation Advisory Group	30/09/2016
		MBS Review After Hours Working Group	17/10/2016

INFORMATION FOR MEMBERS

AMA Indigenous Peoples Medical Scholarship 2017

Applications for the AMA Indigenous Peoples Medical Scholarship 2017 are now open.

The Scholarship, open to Aboriginal and Torres Strait Islander people currently studying medicine, is worth $10,000 a year, and is provided for a full course of study.

The Scholarship commences no earlier than the second year of the recipient's medical degree.

To receive the Scholarship, the recipient must be enrolled at an Australian medical school at the time of application, and have successfully completed the first year of a medical degree (though first-year students can apply before completing the first year).

In awarding the Scholarship, preference will be given to applicants who do not already hold any other substantial scholarship. Applicants must be someone who is of Aboriginal or Torres Strait Islander descent, or who identifies as an Australian Aboriginal or Torres Strait Islander, and is accepted as such by the community in which he or she lives or has lived. Applicants will be asked to provide a letter from an Aboriginal and/or Torres Strait Islander community organisation supporting their claim.

The Scholarship will be awarded on the recommendation of an advisory committee appointed by the AMA's Indigenous Health Taskforce. Selection will be based on:

- academic performance;
- reports from referees familiar with applicant's work regarding their suitability for a career in medicine; and
- a statement provided by the applicant describing his or her aspirations, purpose in studying medicine, and the uses to which he or she hopes to put his or her medical training.

Each applicant will be asked to provide a curriculum vitae (maximum two pages) including employment history, the contact details of two referees, and a transcript of academic results.

The Scholarship will be awarded for a full course of study, subject to review at the end of each year.

If a Scholarship holder's performance in any semester is unsatisfactory in the opinion of the head of the medical faculty or institution, further payments under the Scholarship may be withheld or suspended.

The value of the Scholarship in 2017 will be $10,000 per annum, paid in a lump sum.

Please note that it is the responsibility of applicants to seek advice from Centrelink on how the Scholarship payment may affect ABSTUDY or any other government payment.

Applications close 31 January 2017.

The Application Form can be downloaded at:

https://ama.com.au/system/tdf/documents/Application%20Form_0.pdf?file=1&type=node&id=45143

Information on previous recipients can be found at https://ama.com.au/advocacy/indigenous-peoples-medical-scholarship

The Indigenous Peoples' Medical Scholarship Trust Fund was established in 1994 with a contribution from the Australian Government. The Trust is administered by the Australian Medical Association.

The Australian Medical Association would like to acknowledge the contributions of the Reuben Pelerman Benevolent Foundation and also the late Beryl Jamieson's wishes for donations towards the Indigenous Peoples' Medical Scholarship.

AMA in action

At the beginning of last month AMA President Dr Michael Gannon co-launched the Academy of Science's booklet *The Science of Immunisation* with Minister for Health Sussan Ley in Canberra. The launch was a big draw card for media.

The President and Vice President Dr Tony Bartone spent much of October month attending a series of AMA Committee meetings including the AMA Council of General Practice, the Council of Doctors in Training, the Council of Rural Doctors, and the Taskforce on Indigenous Health. The President also attended the RANZCOG Conference and managed to squeeze in a quick visit to Taiwan to attend the World Medical Association's General Assembly.

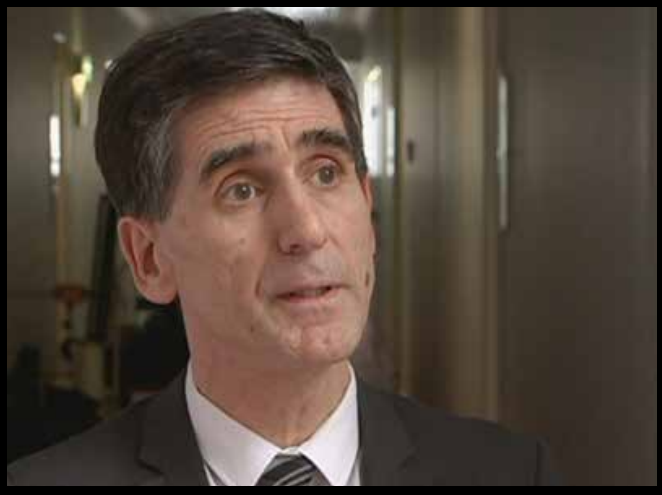
The AMA Board met in Canberra and, between their many commitments, the President and Vice President still found time to conduct numerous media interviews.

KIRSTY WATERFORD

AMA Board meeting late last month at AMA House, Canberra

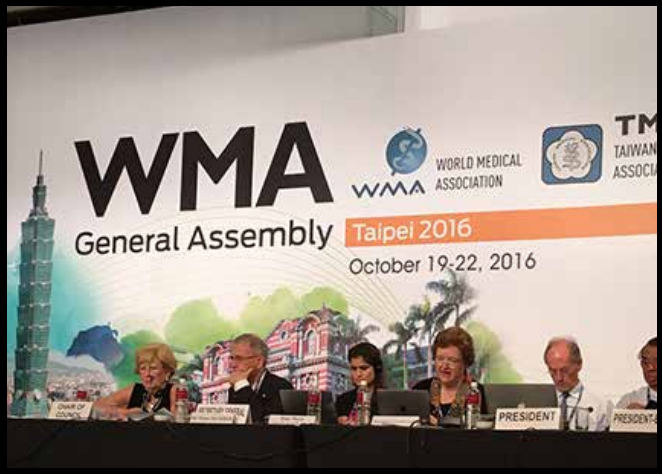
AMA Council of General Practice meeting in Canberra

AMA Council of Rural Doctors meet in Melbourne

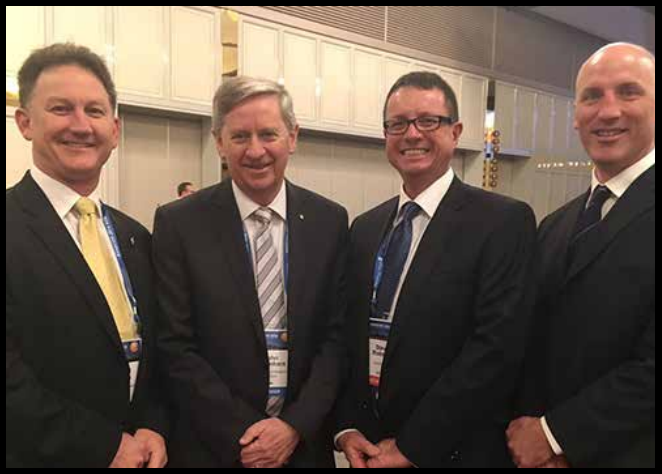


Dr Bartone interviewed by ABC News regarding asylum seeker health

Dr Gannon speaking at the Science of Immunisation launch

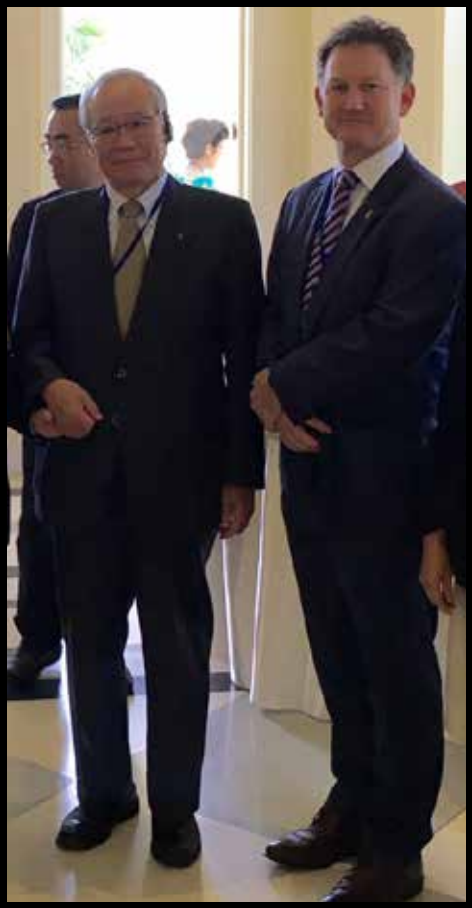


World Medical Association General Assembly in Taiwan

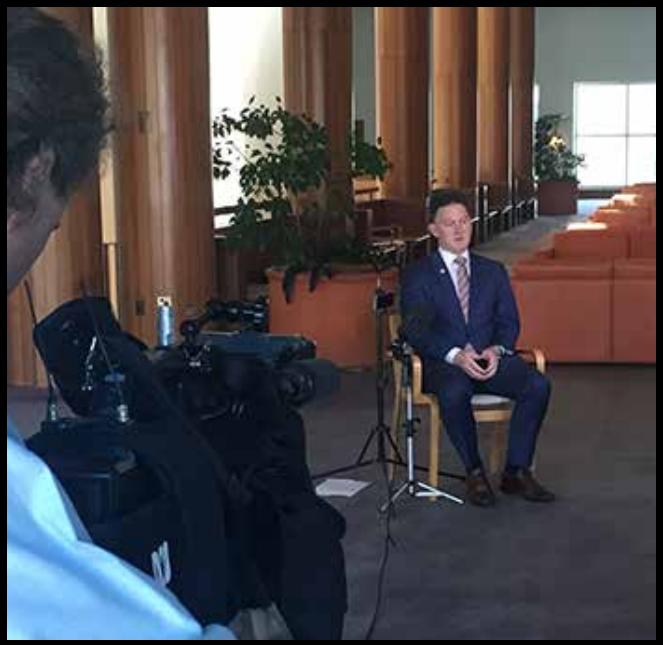


Dr Gannon with collegues at the RANZCOG Conference

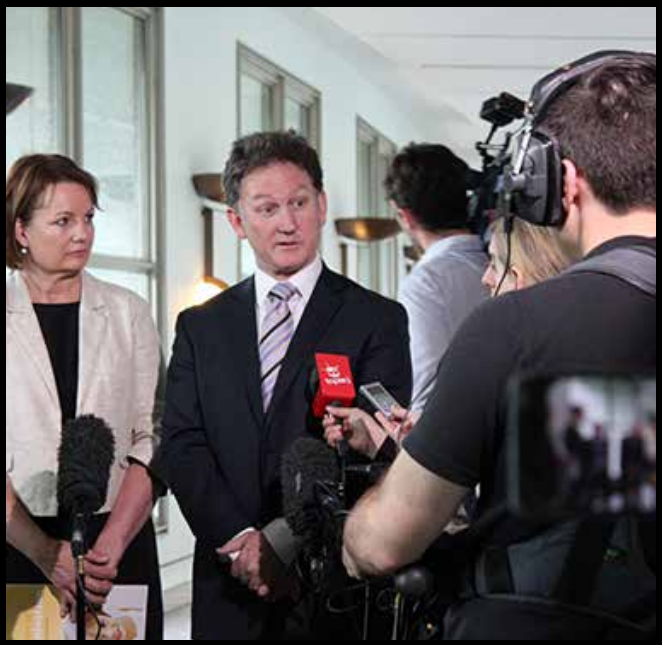
Council of Doctors in Training meeting in Canberra



WMA President-Elect Dr Yoshitake Yokokura from Fukuoka, with Dr Gannon



Dr Gannon being interviewed on Lateline



Dr Gannon with Health Minister Sussan Ley at the launch of the Australian Academy of Science's *Science of Immunisation* booklet

Exciting, enriching, rewarding: working in Indigenous outreach clinics

BY DR ALEXANDER SAXBY, ROYAL PRINCE ALFRED HOSPITAL AND SYDNEY UNIVERSITY

From the moment the plane's wheels leave the runway at Bankstown I begin to smile. I know I am with friends. I know I am going to a very special part of Australia that relatively few get the opportunity to visit. I know I am going to spend two busy but rewarding days, hopefully making a difference to a couple of communities which have become very dear to me over the last two years.

For me, quite simply, it is a breath of fresh air.

We all lead hectic lives in the city, where we can become overwhelmed and enveloped by our clinical commitments, operating, teaching, lecturing, researching and so on.

My trips to Brewarrina and Bourke every couple of months are a reminder for me of what is really important. Making a difference to people who really need our help and really appreciate it.

Since 2014, I have been very privileged to be the ear, nose and throat (ENT) surgeon on a team that travels out to the communities of Brewarrina and Bourke. Our entourage includes an endocrinologist, a social worker and myself as the ENT surgeon. But our small plane always accommodates additional team members which, depending on circumstances, might include students, registrars, allied health practitioners or others whom we feel could benefit the project. The program is coordinated through the University of Sydney's Poche Centre for Indigenous Health, which was established in 2008 following the generous philanthropic actions of Greg and Kay Poche, who have gifted more than $50 million to Aboriginal Health in the last decade.

Brewarrina is a small community of about 1100 residents lying approximately 800 kilometres north-west of Sydney.

It has a very rich Aboriginal history and is home to one of the oldest man-made structures in the world, the Brewarrina Fish Traps, which are a beautiful reminder of the location's important cultural significance. Dating back 40,000 years, this collection of rock pools has been used for thousands of years to catch the fish of the mighty Barwon River.

Exciting, enriching, rewarding: working in Indigenous outreach clinics

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We land on the small strip of tarmac just outside of the town and are met by the fantastic team of the Brewarrina Aboriginal Medical Service. Our clinic runs for the greater part of the day, where I will see a wide diversity of ENT conditions.

There are many challenges in treating patients from remote communities, not least the huge travel distances involved should surgical intervention be required.

> "A key aspect of the Poche model is that the same physicians are used on each trip, improving trust and rapport with patients in order to achieve better continuity of care – something we feel is crucial for the success of outreach programs like this"

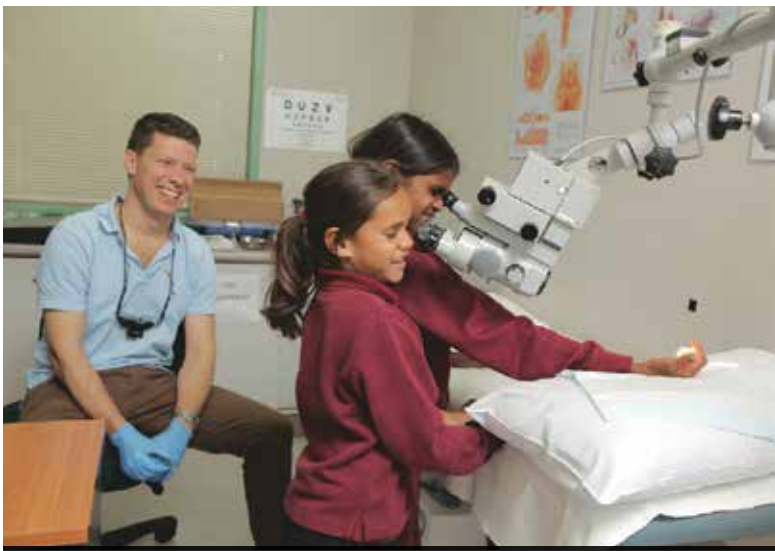
Sydney is about 12 hours' drive from Brewarrina. Families will then often need to stay in the city for a prolonged period in case of any complications, which poses accommodation difficulties and keeps patients away from their communities. Follow up is possible at the next outreach clinic, but that may not be for a number of weeks.

A key aspect of the Poche model is that the same physicians are used on each trip, improving trust and rapport with patients in order to achieve better continuity of care – something we feel is crucial for the success of outreach programs like this.

A wonderful feature of every trip is the dinner held on the night between the two days of the clinic. Poche realised that this represents a wonderful opportunity to bring all of the carers involved together. The dinners are attended by the local GP, nurses, care workers, hospital administrators, pilots and anyone else involved with making the trips a success.

In the winter we will sit around a roaring fire under the stars and exchange stories and ideas.

This is one of the most enjoyable and, I am sure, beneficial parts of every trip. It brings the local and visiting teams closer together and promotes communication and comradery which we believe translates into a better standard of care for all involved.



Dr Alexander Saxby with young patients at the Brewarrina Aboriginal Medical Service

Outreach clinics like this are one way to overcome the geographic isolation of these communities, enabling access to specialist services like otolaryngology.

Telemedicine, mobile hearing screening buses, Australian Hearing rural centres and, most importantly, the local team of nurses, general practitioners and community health workers, are other critical features in providing the care required.

One problem is that such clinics are often independent, run either by philanthropic organisations such as Poche or individuals who generously give their time, but with little knowledge of what other outreach programs are in existence.

This is something the Poche Centre is actively trying to rectify in an upcoming audit project commencing this month. The O.P.E.N. Survey (Outreach Programs for ENT services in NSW) has been set up with the collaboration of Aboriginal medical services, researchers and doctors from the University of Sydney and UNSW and the AMA. It intends to map all of the current outreach ENT programs taking place in NSW to better understand where gaps in coverage exist, and to better coordinate provision of services to these rural communities.

Exciting, enriching, rewarding: working in Indigenous outreach clinics

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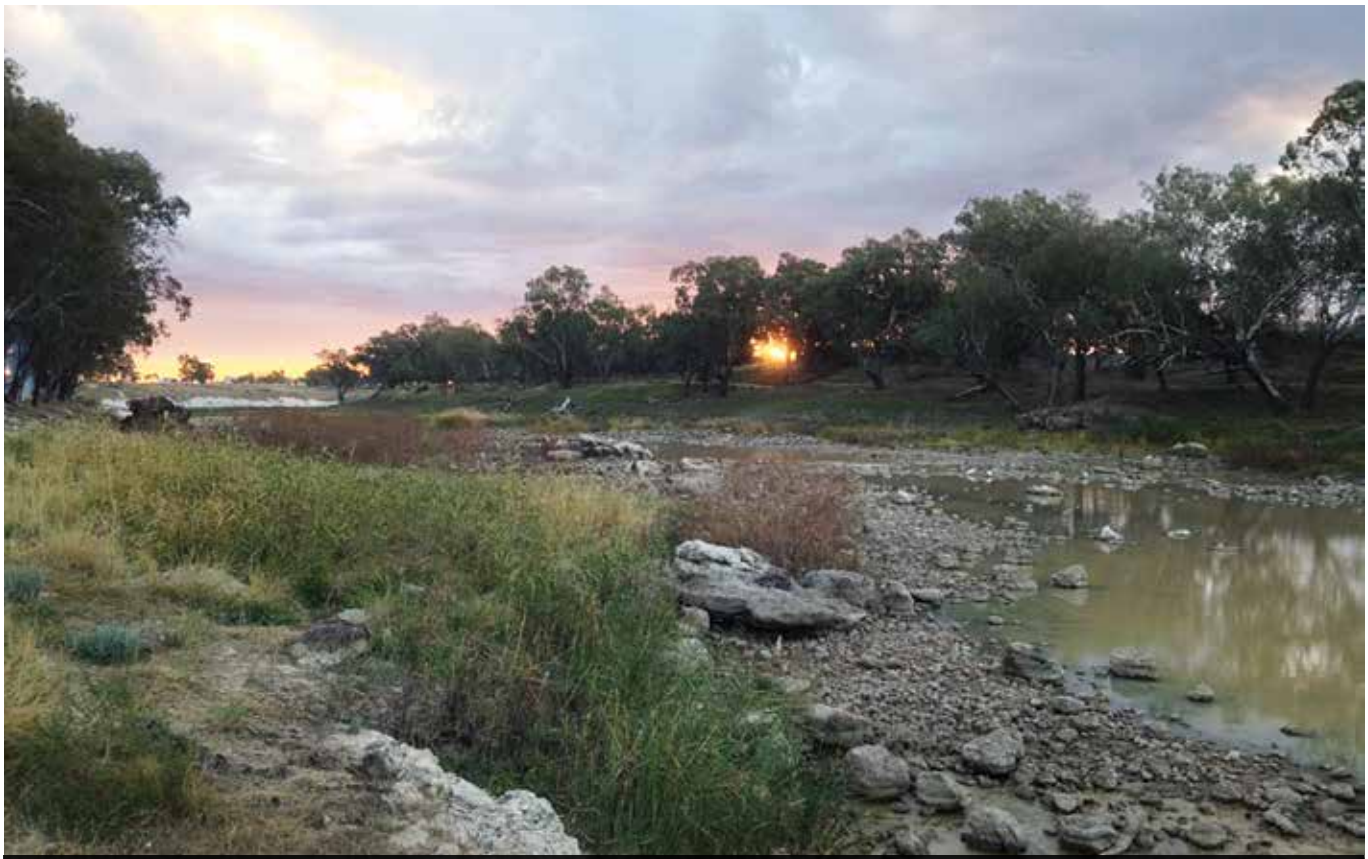

The Brewarrina Fish Traps, one of the oldest man made structures on earth

Ear health statistics show incredible discrepancies between Indigenous and non-Indigenous Australians. Approximately 10 per cent of Indigenous children experience ear problems, compared with just 3 per cent of the non-Indigenous population. Indigenous children are twice as likely to experience otitis media as their counterparts.

The impact of this increased ear disease and hearing impairment is huge, and can affect language development, education, social interaction and employment, with far reaching implications for more complex social dynamics such as contact with the criminal justice system, so treating such issues early and effectively is crucial in redressing the balance for these remote and rural communities.

I would highly recommend anyone who is contemplating becoming involved in an outreach program, whatever your medical discipline, to jump at the opportunity.

The rewards for you are just as big as for the community you will be helping.

It is incredibly fulfilling, exciting and interesting and, thanks to the efforts of groups like the Poche Centre, we really can make a difference for the future.

An ABC News story on the Outreach Clinic was broadcast last month and can be viewed at: https://youtu.be/clImNdmiiRQ

For more information about the Poche Centre for Indigenous Health, go to:

http://sydney.edu.au/medicine/poche/index.php

Health on the hill

POLITICAL NEWS FROM THE NATION'S CAPITAL

Ley 'expects' health funds to pass on prostheses price cuts

Health Minister Sussan Ley has raised expectations of a slowdown in the growth of private health insurance premiums after announcing a multimillion dollar cut in the cost of common medical implants.

As insurers finalise their proposed premium increases for 2017, Ms Ley has approved changes in the pricing of 2440 prostheses including pacemakers, intraocular lens' and artificial hips and knees that she said would save health funds $86 million in the first year and $394 million over five years.

The Minister is pressuring insurers to pass on the savings to their members in lower premiums.

"I expect that every dollar of the $86 million finds its way to the bottom line to reduce the cost of next year's premium," she told reporters. "I expect if insurers take $86 million out of the cost they pay the hospital that will immediately transfer to lower premium increases for patients and consumers."

But the Minister refused to specify by how much she expected premiums to fall, and demurred when asked to detail what processes were in place to ensure insurers passed the cuts on to policyholders.

Her reluctance was seized upon by Labor. Shadow Health Minister Catherine King said that while steps to improve health insurance affordability were welcome, "there is no guarantee whatsoever that these cuts will be passed on to consumers".

But in evidence to a Senate Estimates hearing, senior Health Department officials said the move would put downward pressure on premiums and expected it would result in "a lesser increase than there would otherwise have been".

Earlier this year Ms Ley initiated a review of the way the Government sets the price of prostheses amid complaints by insurers that they were being charged grossly inflated prices compared with those billed to public hospitals.

Health funds claimed that up to $800 million could be saved by bringing prostheses costs in private hospitals in line with those paid in the public sector. For example, a public hospital in WA is charged $1200 for a coronary stent that costs $3450 in the private system.

The claimed savings have been disputed by private hospitals and medical device manufacturers, and the Medical Technology Association of Australia told *The Australian* the cuts announced by the Minister would result in job losses, increased out-of-pocket expenses for patients and cost shifting to other parts of the private health sector.

Ms Ley, under pressure over mounting patient disaffection with the relentless rise of insurance premiums – which have been growing by around 6 per cent a year – has prioritised reform of the Prostheses List as a way to rein in the cost of private health cover and slow the drift of policyholders to cheaper but much less comprehensive policies riddled with multiple exclusions.

In February, she appointed Professor Lloyd Sansom to head a working group looking at medical device pricing, including the operation of the Prostheses List, which was created in 1985 to set out the maximum benefit insurers should pay for medical implants and devices.

Health on the hill

POLITICAL NEWS FROM THE NATION'S CAPITAL

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Since 2001, there have been a number of regulatory reforms that have resulted in a significant increase in prices.

The Australian has reported that the cuts announced by the Minister are based on advice from the Sansom review, which highlighted how the regulated prices of cardiac devices, intraocular lens systems, hips and knees were "significantly higher, in many cases, than market prices based on available domestic and international data".

"These categories are considered appropriate for initial consideration for benefit reduction because they have large volumes and benefits paid, with relatively high levels of competition among prostheses sponsors," it said.

The AMA said it supported a "robust and transparent process" for prosthetic pricing, and backed the use of price referencing in review charges on Prostheses List.

But it urged the Government to make sure that any changes did not have the unintended consequence of reducing the range of prostheses available to privately insured patients.

The Association said it would be vigilant in ensuring that Government reforms and health fund initiatives did not encroach on the freedom of medical practitioners to make decisions in the best interests of their patients.

It called for Prostheses List reforms that emphasised the importance of clinician choice, reduce prices and were devised taking into account possible implications for the cost of rehabilitation.

ADRIAN ROLLINS

States to feel heat on doctor shopping

The states are under pressure to detail how they will act on doctor shopping when they report on progress in implementing a national real-time prescription monitoring system at a meeting of the country's health ministers next month.

More than three years after the Commonwealth, states and territories agreed on a framework for tracking the dispensing of controlled drugs including painkillers and tranquilisers, frustration is mounting that a reporting system is yet to be enacted.

Attempting to inject fresh momentum, Federal Health Minister Sussan Ley last month secured a commitment from the states and territories to report on their progress in implementing the scheme to an Australian Health Ministers' Advisory Council meeting scheduled for December.

At last month's COAG Health Council meeting, the State and Territory ministers agreed to "further progress a national real-time prescription monitoring system that alerts doctors and pharmacists to people who are abusing prescription drugs by doctor or pharmacy shopping".

The importance of the issue has been underlined by figures showing in 2013 almost 5 per cent of Australians admitted to misusing pharmaceuticals, up from 4.2 per cent in 2010.

Painkillers are the most commonly abused medication. Among adults, 3.3 per cent admitted using them for non-medical purposes, and of these half were using prescribed analgesics.

The scale of the problem is large. The number of opioid prescriptions subsidised through the Pharmaceutical Benefits Scheme jumped from 2.4 million to 7 million in the 15 years to 2007, and between 1997 and 2012 the supply of oxycodone increased 22-fold and fentanyl, 46-fold.

Abuse of such drugs has become the most common cause for people seeking drug and alcohol treatment. A Victorian drug and alcohol counselling service has reported that it receives almost three times as many calls regarding prescription opioids as it does heroin.

Seeking to crack down on doctor and pharmacy shopping, the Federal Government in 2012 finalised the Electronic Recording and Reporting of Controlled Drugs System.

But so far, only Tasmania has rolled it out in their State.

ADRIAN ROLLINS

Health on the hill

POLITICAL NEWS FROM THE NATION'S CAPITAL

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Doctor accreditation under review

Health economist Professor Michael Woods will look at ways to encourage collaboration between the health professions as part of a review of accreditation systems.

The Independent Review has been commissioned by the Australian Health Ministers' Advisory Council to examine the effectiveness of the accreditation system "to ensure that the educational programs provide a sustainable registered health profession workforce that is flexible and responsive to the changing health needs of the Australian community".

Among his terms of reference, Professor Woods, who is Professor of Health Economics at the University of Technology Sydney, has been asked to report on the cost effectiveness of the accreditation regime, as well as options to streamline the process and "opportunities for increasing consistency and collaboration across professions".

The review is being conducted at a sensitive time.

The AMA has been in discussion with several professional groups including the Pharmacy Society of Australia about ways to improve coordination and collaboration, and has backed the incorporation of non-prescribing pharmacists as part of a GP-led primary health care team.

But a number of groups, most notably in pharmacy and chiropractic, have earned the AMA's ire over attempts to encroach on the medical profession's field of practice and expertise, driven by concerns that it might put patients at risk of harm.

These concerns have been underlined by a direction from the nation's health ministers, meeting at COAG Health Council last month, for the Chiropractors Board of Australia and Australian Health Practitioner Regulation Agency to provide them with "evidence of any treatments provided by chiropractors that are not appropriately within the chiropractic scope of practice and may be harmful to patients".

The ministers asked the agencies to advise on "potential regulatory responses".

Professor Woods is due to complete his review by the end of 2017.

ADRIAN ROLLINS

Cancer register bill passes with amendments

The new National Cancer Screening Register will begin in May 2017 after legislation passed federal Parliament – with amendments after the AMA and other groups raised concerns about privacy.

The new Register will replace eight separate State and Territory cervical cancer screening registers and the paper-based national bowel cancer screening system, allowing more timely and efficient notification and follow-up.

"Cervical and bowel cancers are largely preventable with regular screenings," Health Minister Sussan Ley said.

"The Australian Government remains committed to saving lives through more efficient screening processes and co-ordination, and the new national register is an important part of this process."

The draft Bill was amended to strengthen the privacy provisions in the Bill. The contractor will be forced to notify the Australian Information Commissioner and Health Department Secretary of any breaches of data.

The changes came after the AMA, the Australian Information Commissioner, and other health groups raised concerns about the potential for privacy breaches, and called for highly rigorous and ethical safeguards.

The AMA also criticised the lack of transparency around the process for awarding the contract to Telstra Health.

"The awarding of such a contract to an entity that has hitherto had no direct role in establishing or operating a register of this kind sets a challenging and potentially troublesome precedent," the AMA submission to the Senate inquiry into the legislation said.

Health on the hill

POLITICAL NEWS FROM THE NATION'S CAPITAL

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"The AMA therefore would welcome a detailed explanation and assurance from the Department of Health, as well as independent privacy and data experts, that the entity awarded the contract has the capacity to deliver it as contracted, and that every assurance can be given as to how sensitive health and medical data will be stored, how any potential breaches will be addressed, and what arrangements are to be put in place to manage the transition of nine separate cancer screening registers into a single National Cancer Screening Register.

"Given the potential commercial value of the data contained in the register, the AMA would be more comfortable with it being operated by government, a tertiary institution, or not-for-profit entity that has little interest in how the data in the register might otherwise be used.

"This would go a long way to allaying concerns about the secondary use of data for commercial reasons."

Labor also criticised the Government's decision to sign the contract with Telstra before legislation had been presented to parliament.

"Labor has said from the outset that we support the National Cancer Screening Register, but given the volume of sensitive health information at hand, it is critical to get it right," Labor health spokeswoman Catherine King said.

"The passing of this legislation does not lessen the fact that Australians are still owed a clear explanation about why, only days before calling the election, the Turnbull Government rushed to sign a contract with Telstra."

Labor tried but failed to amend the bill further to mandate that the Register be run only by a Government agency or a not-for-profit body, to ensure consumers are notified of data breaches, and to impose more severe penalties for data breaches.

MARIA HAWTHORNE

'Obsolete' Medicare system to be replaced

The Federal Government has commenced work on replacing the ageing Medicare, health and aged care payments system in a move welcomed by the AMA.

Health Minister Sussan Ley and Human Services Minister Alan Tudge have announced that the process of identifying a new system to supplant the current 30-year-old structure has commenced.

"Australia's existing health and aged care payments system is 30 years old and is now obsolete," the Ministers said. "A process has commenced to identify solutions for this new payments system, which will be based on existing commercial technology."

But, seeking to prevent a repeat of Labor's damaging election campaign claim that such a move amounted to the privatisation of Medicare, the Ministers insisted the Government would retain ownership and control.

"The new system will support the Australian Government continuing to own, operate and deliver Medicare, PBS, aged care and related veterans' payments into the future," they said.

AMA President Dr Michael Gannon said the Government's move amounted to a modernisation rather than privatisation.

"The AMA made it very clear during the election campaign that replacing the backroom payment system for Medicare does not equate to the privatisation of Medicare," Dr Gannon said. "The current payment system is 30 years old. It is clunky and inefficient. Its many faults create inefficiency and inconvenience for doctors and patients."

The AMA President said medical practices had taken on much of the work of processing Medicare payments on behalf of the Government, costing them considerable time and effort.

The Government has promised to consult "extensively" with health providers and stakeholders in determining the final design of the new system.

Dr Gannon said such consultation was vital.

Health on the hill

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"It is critical the AMA is closely involved in the design of the new system to ensure it meets the needs of doctors and patients," he said, adding that medical practices must be properly supported to incorporate and implement the new system for the benefit of patients.

Consultations on the new system are due to be finalised in January 2017.

ADRIAN ROLLINS

Mental health groups urged to boycott new plan

A prominent mental health advocate has blasted the Government's draft Fifth National Mental Health Plan as "rubbish", and called on mental health groups to boycott the consultation process.

The plan was released for consultation on 20 October, with Health Minister Sussan Ley describing it as "an important document" that was "focused on actions that will genuinely make a difference for consumers and carers".

"The Fifth Plan contains seven priority areas, which have been identified for action in close collaboration with the mental health sector," Ms Ley said in a statement.

But Professor John Mendoza, the former head of the Mental Health Council of Australia, said the plan would simply continue funding late-term intervention at the expense of prevention and early intervention.

Professor Mendoza called on colleagues at an international mental health conference in Brisbane that the consultation process should be boycotted.

"The plan does not reflect the Prime Minister's commitment at the election 'to leave no stone unturned when it comes to mental health'," Professor Mendoza told *The Australian*, adding that the plan was "mealy-mouthed rubbish" designed by bureaucrats with no institutional knowledge.

"The plan does not take us one step further in relation to the Government's announcements last November when it responded to the National Mental Health Commission report and it strongly endorsed the national commission's recommendations."

Professor Mendoza said that Prime Minister Malcolm Turnbull had used the words "we need to really embrace innovation, we have to focus on the mental wealth of the nation".

"And he was stating that because it was clear to him that the economic drag on Australia now, through its focus on acute, late-intervention services rather than early intervention and prevention, means that we have hundreds of thousands of Australians who are unable to participate in work, who are unable to complete education, who are unable to sustain and maintain relationships, because they simply can't get access to the care they need," Professor Mendoza said.

"The Commission said this isn't good enough, we need fundamental reform. And the Government said that was what it was going to do.

"Now, the Fifth Plan that's been released for consultation does nothing of the sort.

"It pays no attention to the Government's reform agenda, and it certainly doesn't marry up with what either the Queensland and NSW Governments [are doing] - two different sides of politics, both of them have articulated clear plans.

"This national plan is completely devoid of any specific actions, any measures, any targets."

The seven priority areas are:

- Integrated regional planning and service delivery;
- Coordinated treatment and support for people with severe and complex mental illness;
- Suicide prevention;
- Aboriginal and Torres Strait Islander mental health and suicide prevention;
- Physical health of people living with mental health issues;
- Stigma and discrimination reduction; and
- Safety and quality in mental health care.

The Department of Health and Mental Health Australia will hold consultation meetings in all capital cities, as well as Townsville and Alice Springs, in November and December.

The final plan will be considered by the Australian Health Ministers' Advisory Council and the COAG Health Ministers' Council early next year.

MARIA HAWTHORNE

Research

New "beacon" method detects cancer recurrence

By Caleb Radford, The Lead South Australia

HealthA NEW detection method for tumour recurrence in bowel cancer patients is proving to be twice as effective as regular treatment.

Research led by gastroenterologists from Flinders University in South Australia found that a blood test, which targeted tumour-derived DNA, successfully detected recurrence in colorectal (bowel) cancer patients during remission.

Senior researcher Graeme Young said the two-gene test acted like a highly effective beacon, which was simpler, less invasive and more reliable.

"Through this study we have proven better detection but we clearly have to go on and study how it impacts patients in different environments," he said.

"While patients have routine x-rays often on an annual basis, the legions need to be a few centimetres in size in order to be detected.

"Here we are looking for simpler less-invasive ways that might tell us really early on if and when the tumour is recurring.

"If we monitor patients closely and are able to catch recurrence early enough we can still potentially cure them."

The research involved 122 cancer survivors post-surgery and found methylated BCAT1 and IKZF1 DNA in the blood of almost 70 per cent of patients with recurrence.

It also found 32.1 per cent of them tested positive for carcinoembryonic antigens (CEA). CEA monitoring is the standard test for recurrence.

There were 94 patients without clinically detectable recurrence and no significant difference in the percentage positive (the false-positive rate) for the beacon test compared to CEA.

Sensitivity estimates of the beacon test were 75 per cent and 66.7 per cent for local and distant recurrence respectively, compared with 50 per cent and 29.2 per cent for CEA.

Professor Young said the beacon test could replace CEA monitoring and the technique might be useful to assess adequacy of initial treatment in eradicating tumours.

According to the World Health Organisation there were about 8.2 million cancer related deaths in 2012 and colorectal cancer was one of those most commonly diagnosed.

Professor Young said almost half of people undergoing CRC treatment experienced recurrence in the first couple of years after diagnosis.

"An inability to detect early molecular changes consistent with underlying tumour progression can result in recurrent colorectal cancer going undetected or being discovered in the later stages of disease when clinical intervention is less likely to be effective," Professor Young said.

"We believe the two-gene test has the potential to fill an urgent and unmet clinical need, and are committed to advancing its clinical development as a new tool for improving patient outcomes."

The study will be published by the journal *Cancer Medicine* later this month.

Professor Graham will present the findings at this year's Australian Gastroenterological Week Conference in South Australia's capital Adelaide.

The conference is Australia's first multi-disciplinary symposium on colorectal cancer screening and will run from October 10 - 12.

It will also look at the impact of diet and lifestyle, whether screening can eradicate the disease and the role of GPs in tackling one of the most common cancers in the world.

Adelaide has three long-standing public universities, Flinders University, University of South Australia and the University of Adelaide, each of which are consistently rated highly in the international higher education rankings.

Fortifying bread works

The presence of iodine in women's breast milk has virtually doubled since it was made a mandatory ingredient in bread to support baby health.

An Adelaide University study has found that since adding iodine to bread became mandatory in 2009, the concentration of the essential trace element in breast milk has jumped from an average of 103 grams per 1000 litres to 187 grams – well above the required minimum of 100 grams per 1000 litres.

Iodine is vital to help support the thyroid development and function of babies, and the fortification of bread was introduced as a public health measure after a study found a re-emergence of iodine deficiency in school children.

The researchers compared samples of breastmilk from 291 mothers taken in 2006 and 2007 with samples from 653 mothers in 2012 and 2013.

Research

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The study found there had been a marked improvement in iodine levels over the period.

Before 2009, 49 per cent of women did not have the minimum required amount, equivalent to 100 grams per 1000 litres.

After iodine supplementation in baking was made mandatory, the proportion of mothers with insufficient concentrations of iodine dropped to just 13 per cent.

Lead author of the study, Dr Jo Zhou, said although it showed levels of the trace element in breast milk had increased, some mothers would still need to take additional iodine.

"Iodine supplementation may still be required in some women post-iodine fortification to reach the level that is considered adequate to meet the iodine requirement of full-term infants," Dr Zhou said.

Her advice echoes the recommendation of the National Health and Medical Research Council that pregnant and lactating women to take a supplement of 150 micrograms of iodine daily.

Dr Zhou's research is due to be published in the journal *Public Health Nutrition.*

ADRIAN ROLLINS

From detecting bombs to diagnosing dementia

By Caleb Radford, The Lead South Australia

A technique for detecting improvised explosive devices (IEDs) is being used to identify vitamins in the bloodstream linked to dementia.

The method, initially developed by University of Adelaide researchers in 2014 to determine the presence of explosive residue using light, is now being used to highlight vitamin B12 in diluted human blood, with the potential to mature into a diagnosis tool for dementia or Alzheimer's disease.

Lead investigator Georgios Tsiminis said the technique was still being modified for commercial use, but could also be used to detect a range of different molecules useful in identifying other diseases.

"We shine a light onto a blood sample that gives us a measurement of the amount of vitamin B12, which is linked to dementia," Dr Tsiminis said.

"It's a more efficient and cost-effective alternative to normal methods that could be applied to diagnosis of Alzheimer's disease.

"Our sensor is an early first step towards a point-of-care solution for measuring and tracking B12 in healthy ageing adults. This would allow doctors to monitor B12 levels and intervene as soon as B12 deficiency was detected."

The new detection technique uses optical fibre and a laser to collect the signature of certain molecules.

Light shines through a vial of diluted blood, which causes vitamin B12 molecules to vibrate.

The optical fibre collects a signature from the molecule vibrations that make up the sample and delivers it to a spectrometer.

This device then carefully analyses the signature and allows researchers to identify the molecule it corresponds to.

Dr Tsiminis said the optical measurement only took about 30 seconds after blood preparation, whereas normal vitamin B12 detection methods took almost two days.

Vitamin B12 is a highly complicated vitamin that is vital in the functioning and health of nerve tissue, brain function, and red blood cells.

The National Institutes of Health in the United States recommends that those older than 14 years consume about 2.4 micrograms (mcg) of vitamin B12 a day, pregnant women 2.6 mcg and lactating women 2.8 mcg.

Vitamin B12 can be found in most animal products but is not typically found in plant foods.

According to the World Health Organisation there are more than 47.5 million people in the world with dementia, and Alzheimer's disease contributes to between 60 and 70 per cent of cases.

"The next step has to do with showing that the sensitivity limit can be reduced but we need a wider scale study, across different blood types, to show that down the line this is something that can be applied to a wider population," Dr Tsiminis said.

"Time and cost limitations currently mean that regular and frequent B12 measurements are not being carried out.

"When you go to the doctor or the nurse, amongst the other results you get for blood, vitamin B12 could one day be included."

The research was presented at the inaugural SPIE BioPhotonics Australasia Conference in Adelaide last month.

Research

Australian researchers target diabetes, gluten intolerance

Is it too good to be true? In separate projects, Australian scientists claim to have developed non-pharmaceutical treatments for gluten intolerance and type 2 diabetes.

In the first project, Australian biopharmaceutical company Glutagen has used caricain, a naturally-derived enzyme from the papaya fruit, to improve gluten digestion.

Glutagen's lead researcher, Professor Hugh J Cornell, said clinical studies showed that the oral anti-gluten enzyme supplement, GluteGuard, was able to significantly protect people with gluten intolerance from adverse symptoms.

The tablet is enterically coated, allowing it to pass through the stomach undigested and activate in the gut. Without the coating, the tablet would dissolve in the stomach and the caricain enzyme would be inactivated by the acid environment.

"Availability of a preventive enzyme supplement like GluteGuard will likely add to the quality of life and well-being of gluten intolerant people, especially those who have difficulty in strictly adhering to a gluten-free diet," Professor Cornell said.

One in 10 Australian adults are estimated to be avoiding or limiting their consumption of wheat-based products, with gluten sensitivity blamed for a wide range of symptoms from abdominal pain and bloating to general malaise and tiredness.

In the second project, Melbourne-based nutrition specialist Omni Innovation says it has developed a pre-meal shake that reduces the spikes in blood sugar levels after a high GI meal, and improves overall glycaemic control (HbA1c) in the long-term.

GlucoControl uses a blend of proteins from whey and milk, and vegetable fibre extracts, to slow the digestion of a meal, with slower emptying of stomach contents, and slower conversion of carbohydrates to sugars.

Gastroenterologist Dr Chris Rayner, who was involved in the study, said the pre-meal drink would appeal to the broad community of people living with type 2 diabetes.

"Better control of blood glucose, as reflected not only in HbA1c but also in the rise in blood glucose after meals, helps prevent or delay the serious complications that can develop in type 2 diabetes, which include vision impairment, vascular damage, and even amputations," Dr Rayner said.

Both companies advise people to seek advice from their GP before using the products.

MARIA HAWTHORNE

Weights may help stop dementia

Hitting the weights doesn't just increase body strength, according to research, it also strengthens the mind.

A recent trial by the University of Sydney, Centre for Healthy Brain Ageing at University of NSW and University of Adelaide found that strength-based exercise led to improved brain function in adults with mild cognitive impairment (MCI).

A precursor to Alzheimer's disease, MCI is an intermediate stage between the expected cognitive decline of normal ageing and the more-serious decline of dementia. It can involve problems with memory, language, thinking and judgment that are greater than normal age-related changes.

The trial, which was part of a wider study into cognitive function and resistance training, involved 100 adults with MCI, aged between 55 and 86. They were divided into four groups:

- resistance exercise and computerised cognitive training;
- resistance exercise and a placebo computerised training;
- brain training and a placebo exercise program; and
- placebo physical exercise and placebo cognitive training.

Those doing resistance exercise were required to lift weights twice a week for six months at 80 per cent of their peak strength. As they got stronger the amount of weight they lifted was increased.

The trial found that cognition was improved significantly after resistance training, as measured by tests including the Alzheimer's disease Assessment Scale for cognition, with the benefits persisting 12 months after the supervised exercise sessions.

The cognitive training and placebo activities did not have this benefit.

The findings were reinforced when MRI scans showed an increase in the size of specific areas of the brain among those who took part in the weight training program. The brain changes were linked to the cognitive improvements noted after weight lifting.

Lead researcher Dr Yorgi Marvos from the University of Sydney said that the improvement in cognition function was related to muscle strength gains.

"The stronger people became, the greater the benefit for their brain," Dr Marvos said.

The research was published in the *Journal of American Geriatrics.*

KIRSTY WATERFORD

UK's 'stunning own goal' could feed doctor exodus

The British Government has been accused of a "stunning own goal" over its muddled plan to make the country self-sufficient in doctors by the middle of the next decade.

Just days before Prime Minister Theresa May told senior National Health Service officials there would not be any more money for public health services when the Government issues a financial update this month, Health Secretary Jeremy Hunt announced an extra 1500 home-grown doctors would be trained each year from 2018 in order to reduce the nation's reliance on international medical graduates.

> "Under the plan ... doctors would be fined £220,000 (A$352,000) if they left the NHS before completing a minimum four years of service"

Under the plan, which the Government said would cost £100 million (A$160 million) in its first two years, doctors would be fined £220,000 (A$352,000) if they left the NHS before completing a minimum four years of service.

The goal is to make the country self-sufficient in doctors by 2025.

Mr Hunt outlined the plan as a response to concerns that a shortage of medical practitioners is contributing to overwork and poor morale among NHS doctors.

Ms May also portrayed it as a way to reduce the country's reliance on practitioners from overseas to help fill workforce gaps – an issue with heightened implications given the UK's decision to cut ties with the European Union.

But, coming against the backdrop of a bitter dispute over the Government's attempts to impose new work contracts on junior doctors, the policy has been criticised by some as ham-fisted and ill-conceived.

Harrison Carter, co-Chair of the British Medical Association's medical students committee, told *The Lancet* the initiative was poorly directed and failed to address the underlying problems afflicting the UK's medical workforce.

"It's a stunning own goal by the Secretary of State [for Health]," Mr Carter said. "[The Government] needs to deal with the underlying issues causing doctors to walk away from the NHS."

A recent survey of 420 British doctors who have graduated in the past decade found that 42 per cent planned to practise overseas, because their experience of work was worse than they had expected. A further 16 per cent said they had "taken a break" from their medical career.

The results have underlined concerns that the bruising industrial battle over work contracts, which involved unprecedented strikes, has created significant ill-will and disillusionment among junior doctors, encouraging many to look elsewhere to develop their careers.

Dr John Zorbas, Chair of the AMA Council of Doctors in Training, told the *Financial Times* that there was strong interest among young UK doctors about working in Australia.

"When I speak to my overseas trained colleagues already working here, interest from UK doctors in training about working in Australia is high," Dr Zorbas said. The AMA has written to the UK Government about the [NHS] dispute, which is no doubt impacting on the morale of doctor sin training in the UK. Unfortunately, it appears the Government's agenda is more about an attack on working conditions than improving the quality of care for patients."

Mr Carter said Mr Hunt's plan to create extra training places and impose a four-year service requirement was no solution.

"This is not the way to address the crisis in morale in the profession," he said. "What they will be faced with is doctors who are disillusioned, with low morale, and who will be bound to their job, not because of desire but because of an obligation."

His concerns have been echoed by Royal College of Physicians Registrar, Andrew Goddard, who told *The Lancet* that although the extra training places was welcome, an extra 1500 graduates a year was not enough.

There is also dismay at the way the Government has sold its policy, particularly remarks by the Prime Minister regarding overseas trained doctors.

UK's 'stunning own goal' could feed doctor exodus ... from page 53

In an interview following the announcement, Ms May should doctors from overseas would stay "in the interim period until the further number of British doctors are able to be trained and come on board".

While the PM later clarified her comments to say that overseas trained doctors did not have to leave, senior figures in the profession said the remarks were damaging.

"I think it is really dangerous to start thinking that all overseas doctors are about to go home," Medical Schools Council Chief Executive Katie Petty-Saphon told *The Lancet*. "We really appreciate the work of overseas doctors...and the NHS would fall over without them. They are welcome here and they need to stay here."

Mr Carter said the Prime Minister's comment betrayed confused thinking within Government over the push to self-sufficiency in doctors.

He said if the goal was to train local doctors to take over roles currently filled by overseas trained practitioners as well as meeting the growing need for health care, the Government would need to train many more than just 1500 extra a year.

"There is no way that by 2025, with the 1500 who will come in [from] 2018, we will be anywhere near being self-sufficient," Ms Petty-Saphon said.

ADRIAN ROLLINS

Getting difficult to call Australia home

Disillusioned National Health Service doctors have been warned that they may find it difficult to get work in Australia.

Dr John Zorbas, Chair of the AMA Council of Doctors in Training, told the Financial Times that Australia's long-standing reliance on overseas trained doctors to fill gaps in the medical workforce was waning.

Dr Zorbas said the although international medical graduates (IMGs) from around the world, including the United Kingdom, had made a "critical" contribution to the medical workforce in the last 15 years, demand was easing as an increasing number of locally trained doctors were graduating.

"IMGs looking to come to Australia need to know that job opportunities are limited, often confined to short-term roles or areas of medical workforce shortage like rural locations," he said.

In the past 12 years the number of medical school graduates has more than doubled from 1500 to 3700 a year, creating intense pressure for advanced specialist training places.

As a result, the Government is considering removing a number of specialties from the Skilled Occupations List used to assess applications for permanent residency, including general practitioners, anaesthetists, intensive care specialists, gastroenterologists and obstetricians.

"We do not expect that this will have a big impact as there will still be other visa options available," Dr Zorbas said. "However, it is the first sign that we are overcoming medical workforce shortages and are less reliant on international recruitment."

He said data showed overall doctor numbers in Australia were "in balance", even though they were not evenly distributed by location or specialty.

ADRIAN ROLLINS

Worldwide shortage of health workers looms

The world is facing a projected shortfall of 18 million health workers within 15 years, predominantly in poorer countries, an international inquiry has found.

The High-Level Commission on Health Employment and Economic Growth, chaired by French President Francois Hollande and South African President Jacob Zuma, called for urgent investments globally to create new jobs in the health care sector.

> "Investing in health workers is one part of the broader objective of strengthening health systems and social protection, and essentially constitutes the first line of defence against international health crises"

"With the Ebola outbreak in West Africa, we have seen how inaction and chronic underinvestment can compromise human health, and also lead to serious economic and social impacts," the Presidents wrote in the *Working for Health and Growth – Investing in the health workforce* report.

"Investing in health workers is one part of the broader objective of strengthening health systems and social protection, and essentially constitutes the first line of defence against international health crises.

"Health workers are the cornerstone of a resilient health system. We need these 'Everyday Heroes' to meet these needs and expectations."

The Commission – supported by the World Health Organization (WHO), the International Labour Organization (ILO), and the Organisation for Economic Cooperation and Development (OECD) – found that ageing populations and increasing rates of non-communicable diseases would generate demand for 40 million new health workers by 2030, a doubling of the current global health workforce.

"But most of these jobs will be created in the wealthiest countries," the report said.

"Without action, there will be a shortfall, primarily in low- and lower-middle-income countries, of 18 million health workers needed to achieve and sustain universal health coverage.

However, investments in the health sector are shown to pay handsome dividends, with a return of 9 to 1, and the aggregate size of the global health sector is more than US$5.8 trillion each year.

Across the OECD countries, employment in health and social work grew by 48 per cent between 2000 and 2014, while jobs in agriculture and industry declined.

"For too long, countries have seen health workers as just another cost to be managed, instead of an investment with a triple return for health, economic growth, and global health security," WHO Director-General, Dr Margaret Chan, said.

The Commission made 10 recommendations, ranging from stimulating investments in creating decent health sector jobs to advancing international recognition of qualifications to optimise skills use and reduce the negative effects of health worker migration.

"These recommendations will chart the course to achieve greater and more effective investment in the health workforce," OECD Secretary-General Angel Gurria said.

"This will be a critical element to promote better lives and help our economies flourish and achieve their full potential."

The OECD, ILO, and WHO will convene all relevant stakeholders by the end of 2016 to develop a five-year implementation plan for the recommendations.

The Commission was established by United Nations Secretary-General Ban Ki-moon in March 2016. It delivered its final report in September.

The full report can be accessed at http://www.who.int/hrh/com-heeg/en/.

MARIA HAWTHORNE

Unique Zika threat a 'silent epidemic': CDC

Zika has been declared a "silent epidemic" by the US Centers for Disease Control and Prevention expert amid reports it has spread to more than 60 countries and caused birth defects affecting thousands of babies.

Dr Thomas Frieden, Director of the CDC, said that the threat posed by the Zika virus was unique and there was "no time to waste" in efforts to develop a vaccine and control its spread.

"Never before, to our knowledge, has a mosquito-borne virus been associated with human birth defects or been capable of sexual transmission," he said in a column in the *Journal of the American Medical Association.*

But, while the effects of disease could be lifelong and devastating, including brain damage caused by microcephaly and cases of Guillain-Barre syndrome, Dr Frieden lamented that because most of those infected had no symptoms, the level of public alarm was muted.

Other vector-borne pathogens like dengue and chikungunya drew attention because of their painful symptoms.

But because Zika did not cause symptoms and its effects took months to become apparent, it did not attract the same level of attention.

"Zika is a silent epidemic," Dr Frieden said. "The consequences of widespread Zika transmission only become apparent many months after infection."

He said more than 1700 cases of microcephaly had been recorded in north-east Brazil, and warned that toll was likely to rapidly mount as women in other Latin American countries began to deliver babies with evidence of Zika-related complications.

Earlier this year the World Health Organisation declared the Zika virus epidemic a public health emergency of international concern, and widespread transmission has been reported in 38 countries, most of them in Central and South America.

So far, the only cases in Australia have involved people coming from Zika infected areas, and the Health Department has said there is no evidence it has been locally transmitted, largely because the mosquito identified as the carrier is only present in some parts of central and northern Queensland.

But the infection has gained a foothold in the United States.

By August, the country had recorded 1700 cases of travel-associated Zika infection, including in 479 pregnant women, and 13 cases of locally-acquired infection have been identified in a neighbourhood close to the centre of Miami.

The American territory of Puerto Rico, meanwhile, is in the midst of a large epidemic that is estimated to have infected a quarter of the population, including between 6000 and 11,000 expectant mothers.

Dr Frieden reiterated advice from Australian health authorities that pregnant women should avoid travel to areas of Zika transmission and, because the virus can live in semen for months, men who have been in affected areas should use a condom every time they have sex with a woman who is, or may be, pregnant.

So far the best way to detect whether Zika is present is to test people for infection, and tests have been developed to diagnose recent and current infection, and nucleic acid detection methods have been developed to screen the blood supply.

In Florida, eradication teams have been going house-to-house to detect and eliminate Aedes aegypti mosquitos, and an aerial spraying program has been initiated.

Dr Frieden urged the development of new insect repellents, and said the development of safe and effective vaccines was vital.

"Experience with the recurrence of other flavivirus epidemics [such as dengue and yellow fever] suggests that large populations will be susceptible to Zika for years to come," he said. "Implementing comprehensive research efforts today can yield substantial returns."

ADRIAN ROLLINS

The medical profession is under attack: WMA

The physical safety and professional autonomy of doctors around the world is under attack from governments, armed groups and individuals, hampering their work and putting the health of patients at serious risk, according to incoming World Medical Association President Dr Ketan Desai.

Speaking following a spate of deadly attacks on hospitals and medical centres in war-torn Syria, Yemen and Afghanistan, Dr Desai told the WMA annual assembly in Taiwan that increasingly the Geneva Convention was being "practised more in breach than observance, invariably ending up in flagrant violation of human rights".

UN Secretary-General Ban Ki-moon has condemned the sustained bombing of medical facilities in the besieged Syrian city of Aleppo as war crimes, amid claims that 95 per cent of pre-war medical personnel in the city have fled since the conflict began.

In Yemen, Saudi-led forces have been accused of targeting several health facilities, including a strike on a Medicins Sans Frontieres hospital in which 11 died and 19 were injured.

Dr Desai praised the dedication of doctors and health professionals working in these countries, and said they deserved protection: "To a physician, a patient is neither a friend nor an enemy. They legitimately need protection from violence while at work, whether in war or civil conflict situations".

Doctors also risked physical attack outside war zones.

The WMA President, who was elected to the post after serving as President of the Medical Council of India, said medical practitioners working in many parts of the world, particularly in Asia, were being assaulted, and hospitals and clinics ransacked and damaged, by angry patients and their families.

In addition to these physical threats, Dr Desai said that in countries as diverse as Turkey, India and the United Kingdom, governments were attempting to encroach on the independence and autonomy of the medical professional, to the detriment of patients.

"Regulation of clinical practice, framing evidence-based standard treatment guidelines, defining and checking professional malpractice and medical education all need vital professional independence and a democratic system based on meaningful participative decision-making," he said. "In many countries there are continued political attempts to undo or marginalise autonomy and self-governance of the medical profession, including mauling and trampling on the trinity of professional autonomy, clinical independence and self-governance."

WMA - Tairwan - Canadian Brisih and NZ med assoc plus outgoing WMA President Sir Michael Marmot

Dr Desai said the WMA was alert to these threats and would continue to fight government efforts to make the medical profession subservient.

But he said part of this involved ensuring the medical profession acted with honesty and integrity, something that was at risk in many countries because physicians were prescribing and referring patients based on pecuniary self-interest or kickbacks.

In other developments, the WMA General Assembly:

- approved ethical guidelines on the collection and use of identifiable health data (the Declaration of Taipei);
- demanded an immediate and impartial inquiry into the bombing of hospitals in Aleppo;
- urged national medical associations and other health groups to divest fossil fuel stocks;
- called for greater focus on care of the elderly; and
- said doctors must be prepared to intervene to protect girls from undergoing female genital mutilation.

ADRIAN ROLLINS

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