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AMA launches Careers Advisory Service

The AMA recently launched a new AMA Careers Advisory Service to assist doctors as they set off on their medical careers and to advise when they are contemplating changing their career direction or the location where they practise.

Stage 1 of the Service, will be of particular benefit to medical students who are about to graduate, doctors in training, and international medical graduates working or hoping to work in Australia.

The Service provides practical assistance in producing a professional resumé, completing job applications, and preparing for job interviews.

Stage 2 of the Service, to be developed over the next six months, will concentrate on helping experienced medical practitioners take on new career challenges or move to new locations.

As well as the one-to-one advice, there is also a dedicated AMA Careers Advisory Website, which will be constantly modified and updated to meet the needs of doctors as they progress in their medical careers.

The AMA Careers Advisory Service provides information on:

- Medical institutions including medical schools, medical societies, and vocational colleges;
- Domestic and international medical graduate information on registration, employment, and immigration requirements;
- Resumés, job applications and cover letters, and interview skills assistance;
- Education and training information with links to medical colleges and State/ Territory training institutes
- Doctors' health support services; and
- Career change opportunities.

The Service is available nationally, with priority given to AMA members – who are also able to access some "members only" support and information.

The service will operate from the AMA (ACT) in Canberra. Further information is available from **Kathryn Morgan, Careers Consultant, 02 6270 5410 or 1300 884 196 or careers@ama.com.au**

The AMA Careers Advisory Service website is at **http://careers.ama.com.au**

TERRITORY TOPICALS – from President, Dr Andrew Miller

Dr Andrew Miller

Quite understandably many of us would be wondering what comes next. After losing so many of our number in such a short time; Damian McMahon, Marjan Kljakovic and Toni Peadon are all sorely missed. Our condolences also go to Jim Purchas following the passing of his wife Jan. We are too small and close knit a community for such losses to pass unremarked.

This last month has been very busy in less distressing departments; with the government's announcement of the needle exchange programme at the AMC and the signing of the heads of agreement for the third hospital signalling the opening of the constituent hunting season.

Support for harm reduction measures such as needle exchange programmes in our prisons has long been AMA policy; the AMA released its position paper on health and the criminal justice system (http://ama.com.au/position-statement/health-and-criminal-justice-system-2012) at the same Public Health Association conference. The government's policy presents a needle exchange programme as part of a suite of measures to reduce transmission risk for blood borne viruses including counselling, detoxification services, methadone programmes, access to condoms and dental dams, and access to individualised razors and toothbrushes. As a community we need to recognise that we have moved beyond the transportation for life model of criminal justice; and that courts alone have the task of prescribing sentences. The system cannot be excused when neglect allows lifetime sentences with viral illness as collateral damage.

The process is now to be passed into the hands of an implementation group. It is no foregone conclusion that the policy will move forward.

The establishment of a third, sub-acute, public hospital for the ACT is common policy for both major parties. The signing of the heads of agreement contract between the Health Directorate and the University of Canberra neatly snookers the opposition; but at the same time ties Canberra to a system made more logistically and administratively complicated. We have expressed concerns in the past about the capacity of the system to recruit enough staff to adequately and safely manage another hospital. It is not sufficient to rely on student labour to keep the system afloat and solvent.

Whilst the new hospital will increase access to beds in the ACT hospital system, these will be limited to a select patient group and it seems too naïve to rely on the trickle-down effect freeing patient beds throughout the system without making significant changes to the bed management systems of the other hospitals.

I note that the issue of Accident and Emergency performance is once again capturing public attention. The continued increase in attendances, together with the rising admission rate through ED remains a major planning issue for health service providers. The increase in ED bed numbers and ED staffing will certainly go some of the way towards improving measured performance; but the recent patient surge has emphasised that a whole of hospital planning approach is needed to keep the system moving.

The new general medical unit will help by absorbing some "undifferentiated" medical admissions; allowing them to be moved from ED and for work-up to continue on the wards and sub-specialty units to act as consulting attendants. In the past these patients were the classic buff and turf candidates, with ED staff struggling with their pitch to get the patients accepted for admission by specialists.

Other downstream delays in managing non-elective surgical admissions have also been pointed out to me. In particular a lack of emergency theatre access appears to have become a rate limiting step; resulting in patients' admission being prolonged while they wait for theatre time. It would seem that the answer lies in sensible and measured increases in health budgets all around.

It is clear that the increased demand for acute non-elective hospital beds is an ongoing phenomenon. What is not immediately clear is why this is occurring. Some of this reflects a change in practice standards. We older types may often hark back to the good old days; but expectations of service and standards have moved on. I suspect that many of the patients now admitted to hospital would previously have been dealt with in ED and discharged to the community for follow-up. I can recall the practice of a quick Beir's block and good hard pull followed by some plaster. Standards have certainly changed for the better, but perhaps bed and ongoing care management models have been slow to catch up; contributing to these downstream delays.

It also seems that as many elective procedures have become simpler and less traumatically invasive, bed numbers were allowed to contract and occupancy rates rise. These "efficiencies" have now caught us by the tail because the other cases requiring extended or higher level care are by definition more complex and challenging, more demanding of resources; and these appear to have become a greater proportion of our inpatient population.

The need for out of the square planning is also critical to the ongoing training of our junior doctors.

The great wave is an appropriate analogy I believe. It is of great concern to the AMA that training opportunities, and quality of training and supervision, are not sacrificed as "band-aid" solutions are sought to the problem of accommodating the increasing numbers of medical graduates. An integrated whole of system approach needs to be found so that such vital human capital isn't wasted. The classification system for junior doctors' appointments is currently under review; and the AMA is trying to engage as vigorously as possible, however the process has had a rocky start and we trust that all parties to the discussion will work with good will towards a worthwhile outcome.

Perhaps it is fortuitous timing then that the AMA Careers Advisory Service has now "gone live". It can be accessed on-line at http://careers.ama.com.au. This enterprise represents a significant benefit to members, and will help our junior doctors navigate the troubled waters of early career planning. It has taken a great deal of work on the part of our secretariat to get the scheme to this point and all are to be congratulated.

AHPRA has announced the detail of its Health Profession Agreement with the Medical Board of Australia. Much has been made of the efficiencies being made within the system, and the importance of maintaining transparency in accounting. There were, I will admit, some amongst us who were concerned that as the system bedded in and figures for costs of services were calculated; it would be revealed that medical practitioners may need to pay increased fees. There were many who felt that the fees were excessive and that once the "others" were accounted for, our fees should reduce. Well, in fact, we are it seems paying our way and no more. I can't however help thinking that as efficiencies are identified, we should benefit from cost savings. Perhaps one way would be to offer discounted fees for on-line renewals? I know that it took me considerably longer dealing with a cranky and slow server to renew my registration on-line than a quick dash of a pen over a few dead trees would have done.

For those of you concerned about the wombat I have to report that the unfortunate creature died; not from firm application of a presidential posterior, but from complications of chronic pyoderma from sarcoptic mange. Which it gave to our dogs. The joys of rural life continue.

Health groups celebrate decision to trial a needle and syringe exchange program at Alexander Maconachie Centre

It was opportune for AMA Vice President and Chair of the AMAs Public Health Committee, Professor Geoffrey Dobb, to launch the AMAs position statement "Health and the Criminal Justice System 2012" at the recent Justice Health Symposium, hosted by the Public Health Association.

ACT Chief Minister and Minister for Health, Ms Katy Gallagher, announced the release of the government's strategic framework for blood-borne virus management at the AMC. Part of that strategic framework includes the commitment for detainees to have access to injecting equipment.

The Public Health Association of Australia, Alcohol and other Drugs Council of Australia and Hepatitis declared this was a "triumph for common sense and evidence based approaches to addressing the spread of blood-borne viruses in the community." The AMA ACT has lent its support to the introduction of a NSP as a vehicle to reduce blood-borne virus spread at the AMC and in the wider community.

The Chief Minister said, "This will, when it's delivered, operate alongside counselling, and current treatment options, including education.

"The strategy proposes a trial of a one-for-one medical model exchange. A medical officer will issue a clean needle only in exchange for a used one. This addresses the correctional officers' concerns that there would be an influx of needles into the gaol.

'Under this model and based on the advice I've had from the clinical staff at the Hume Medical Centre, a doctor would make a decision about whether it was part of that detainee's best treatment program to have access to sterile injecting equipment and it could only be provided if used injecting equipment was returned. I think that addresses the concern that has been raised.

"Importantly, this model also offers the opportunity for medical staff to counsel the recipient about drug use, harm minimisation, and other available treatment options to end their dependency, with the aim of having as many prisoners as possible emerge from gaol drug-free.

"The model encourages access to treatment by medical professionals. In many ways I've come to the decision that access to sterile injecting equipment should not be a decision taken by a politician. It should be a decision taken by a health professional, in this case, between the relationship, and the close and confidential relationship between a doctor and their patient".

The Chief Minister stated that the needle exchange trial was just one element of the blood-borne virus strategy and that other elements included providing access to vaccinations against blood-borne viruses, as well as post-exposure prophylaxis and comprehensive education and training for all AMC staff in relation to blood borne virus transmission.

With nine documented cases of in-custody transmission of Hepatitis C at the Alexander Maconachie Centre, it is important that ACT government take the initiative to tackle what is a difficult issue. Prisoners leave gaol and return to the community and without a NSP and other strategies, the prisoner's families and social contacts will be at higher risk of contracting a blood borne disease – with significant public health implications for the wider community.

Public Health Association CEO and ACT former Health Minister, Michael Moore, recommended three proposed models of NSP in his report to Government; "Balancing Access and safety – Meeting the challenge of blood borne viruses in prison".

The AMA ACT believes that prisoners and detainees have the same right to access, equity and quality of health care as the general population.

The health of prisoners is also important for the occupational health and safety of the staff of correctional facilities. Governments and prison authorities have a duty of care to all prisoners under their control and to ensuring that prisoners and detainees are not subject to further punishment (in addition to deprivation of liberty) only because of the conditions of detention. The ACT Corrections Management Act provides for this and further that prisoners receive a standard of health care equivalent to that available to other people in the ACT and that as far as practicable, detainees are not exposed to risks of infection".

This initiative is a positive step towards achieving this objective.

The AMA position statement is available at www.ama.com.au

The blood-borne virus strategy is available at www.health.act.gov.au

ACT Government and UC reach agreement on new hospital

It has long been mooted that the new hospital would be built on the UC campus and had been identified in January as the preferred site.

The Chief Minister and University of Canberra Vice-Chancellor Professor Stephen Parker signed a Heads of Agreement confirming the 'University of Canberra Public Hospital' will be built on the northwest of the University's Bruce campus, a location identified in January this year as the preferred site.

"This secures a new hospital for our city and signals the start of an exciting partnership that integrates the University of Canberra with the provision of healthcare," the Chief Minister said.

"The hospital will be a 'sub-acute' facility offering a range of rehabilitation services, such as neurological rehabilitation and older persons' rehabilitation, as well as mental health services and day hospital services, such as hydrotherapy. It will be closely linked with the University, with spaces allocated for teaching and research within the hospital itself," the Chief Minister said.

An initial sum of $4 million has been allocated towards the planning and design of the hospital, which is scheduled for completion by 2017.

Once built, this new hospital will significantly increase bed capacity, as Government continues to increase beds across the health system.

Professor Parker said the new hospital would build on the University's success in integrating teaching, research and treatment in health.

"The University of Canberra already trains a significant proportion of the region's health workforce, our researchers are finding new ways to tackle the health problems our community faces and our staff and students are delivering health services to the community – locating a hospital on our campus builds our capacity to serve the community in all these areas," Professor Parker said.

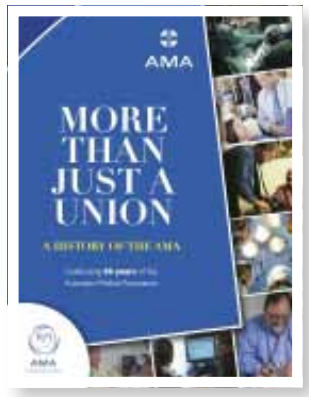
"An on campus hospital provides more high quality clinical placements to students, academic and research opportunities for clinical staff and additional benefits to patients in rehabilitation and sub-acute care.

"The University has experience delivering health services through its Faculty of Health Clinics and has developed innovative student-led models of care that provide students with hands-on experience and patients with an affordable service.

"Together with a new GP super clinic and our Faculty of Health, the hospital will be part of an emerging health hub at the University of Canberra," Professor Parker concluded.

See President, Dr Andrew Miller's comments on page 2 of this edition.

Your Chance to Rewrite History



More than Just a Union: a History of the AMA. Bondi: Faircount Media, 2012.

In early times there was no national organisation for doctors, because there was no need for one; the six colonies went their own way with little regard for what the others were doing. Organisations of doctors, however, were needed locally. Often shortlived, they formed in each colony. Sometimes there was more than one organisation in a colony, and insults were traded in the way of those times. But eventually stable branches of the BMA came into being in each colony.

Then there was federation, and it was not long before the Federal Government, as it was then known, was considering a national health system. A national response was needed. By 1911, the SA Branch of the BMA was seeking to form a national body. The Commonwealth had, for example, powers relating to quarantine, a subject on which the need for national uniformity had been evident for some time. (But it did not, as implied on page 40, then have powers in relation to medical and dental services; these were available only after a referendum in 1946.)

A Committee was formed, but war intervened, and it was not until 1923 that the BMA formally approved a Federal Council. In the meantime the various state branches of the BMA carried on separately, and when a national health insurance scheme was proposed in the 1930s, there was no agreed policy on this crucially important subject! In the event, the government fell before anything happened, and another war intervened.

After World War II the Chifley government introduced pharmaceutical benefits, but lost office before it could legislate for its hospital scheme, bitterly opposed by the profession as civil conscription. Good relations established with the successive Menzies governments became strained under his Coalition successors, but that strain was nothing compared to what followed.

In the meantime the AMA had been formed in 1962 as an association independent of the BMA. The events of the last 50 years are within living memory of our older members, and there is not space here for a participant in some of them to offer analyses. Suffice it to say that it is very readable, illuminates the political processes of the time, and shows how important it is for the profession to be represented by leaders with whom governments can deal.

The series of one-page reflections by former Presidents, interspersed through the text, reveals much about how each personality contributed. Bryce Phillips insists he made an offering, but his thoughts remain unpublished: I wonder why.

If you have not already received your own copy, you can download it http://ama.com.au/a-history-of-the-ama. If you do not like what is said, you can even lodge your own comments!

John Donovan is a former AMA ACT President and member of the Canberra Doctor editorial committee

Level or stepped?

Choosing the right premium on your insurance

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GENERAL INSURANCE SERVICES

When applying for personal insurance - whether life insurance, income protection, total and permanent disability (TPD) or trauma - you usually need to choose between stepped or level premiums.

How do you know which is best for you?

Stepped premiums tend to be more common. This is where the premium increases with the age of the person insured because as people get older, they become a higher risk to the insurance company.

Level premiums, on the other hand, are fixed at a flat amount to age 65[1]. Premiums are not increased until after this age, which is when they revert to a stepped premium.

The key advantage of a level premium is that you know what the premiums will be in advance without the risk of discovering later that you can't afford the cover when you need it most. In the early years of a policy, level premiums tend to be more expensive than stepped premiums, but if the cover is held over the medium to long term, the savings can be significant. The earlier you commence cover on a level premium, the cheaper the total cost of premiums will be in the long term.

This example shows how a 29-year-old male medical professional, a non-smoker, can significantly benefit by paying a level premium to age 70 for both life insurance (including trauma and TPD) and income protection.1

Some points to consider when choosing between stepped and level premiums include:

1. How long will you hold your policy?

You may need to hold an income protection policy for at least seven years before becoming better off with level premiums. Level premiums can offer considerable savings if your policy is held for longer periods.

2. What pattern of cash flows suits you best?

If you are presently comfortable with your cash flow, you may prefer to pay a higher level premium now so that future payments are not a burden. Level premiums can help keep the cost of insurance affordable and allow the cover to be maintained until at least age 65.

3. Will you need the same level of cover in the future?

While your current level of cover might suit your present situation, you need to consider whether you may require more or less cover in the future.

Don Thompson is a risk specialist with Experien Insurance Services working across NSW & ACT. He has substantial specialist knowledge in the medical industry and a comprehensive understanding of the insurance needs within this professional sector.

Please contact Don Thompson on 02 9293 2064 or 0404 011 708 for further information.

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1. Level premium does not mean your premiums are guaranteed or do not change. Level premium rates may increase over time due to rate increases, CPI increases and policy fee increases. However, unlike stepped premiums, a level premium (excluding CPI and the policy fee) doesn't go up by age-related increases. All insurance premiums quoted are from leading Australian Life Insurers. Premiums are subject to change and are for illustration purposes only. Insurance premiums quoted do not include policy fees or stamp duty; they assume a monthly payment frequency, and all stipulated insurance cover has been medically underwritten and accepted by the Insurer at Standard Rates. Actual rates may vary depending upon a person's individual circumstances (ie. health, occupation, hobbies, etc) and are not guaranteed until underwritten by the insurer. TPD insurance premiums quoted are based on the any occupation definition.

Type of cover	Benefit	Cumulative premiums to age 70: Stepped	Cumulative premiums to age 70: Level	Saving
Life linked with Trauma and TPD	$1,000,000 lump sum	$1,460,960	$190,395	$1,270,565
Income Protection	$15,000 per month	$529,273	$143,930	$385,343

Source: Iress Risk Researcher

Board and AHPRA publish Health Profession Agreement

The Medical Board of Australia and AHPRA recently increased public access to financial information about the National Registration and Accreditation Scheme.

In the interests of transparency and accountability, the Board and AHPRA have for the first time published the Health Profession Agreement that outlines the services that AHPRA will provide to the Board in 2012/13.

Under the National Law, the Board and AHPRA work in partnership to implement the National Scheme, each with specific roles, powers and responsibilities set down in the National Law.

The guiding principles of the National Law require the National Scheme to operate in a 'transparent, accountable, efficient, effective and fair way'; and for registration fees to be reasonable 'having regard to the efficient and effective operation of the scheme'.

Medical Board of Australia Chair, Dr Joanna Flynn AM, said the Board was accountable to the profession and the community.

'We are responsible for using practitioners' registration fees wisely in regulating the profession in the public interest,' Dr Flynn said.

'The Board is pleased to provide more detailed information about how registration fees are allocated to regulate the profession in Australia,' she said.

AHPRA CEO, Martin Fletcher, emphasised that the Board and AHPRA were committed to increasing transparency and accountability in financial reporting.

'As AHPRA's reporting capability strengthens, we are able to publish more detailed information about each National Board's financial operations and AHPRA's performance. This complements the audited data and performance reporting included in each year's annual report,' Mr Fletcher said.

The Medical Board of Australia Health Profession Agreement is available for review on the Medical Board of Australia website.

ACCC conditionally authorises collective bargaining for small private hospitals

The Australian Competition and Consumer Commission has granted conditional authorisation to allow prospective members of the Private Hospital Collective Bargaining Group to bargain collectively with suppliers and health funds.

The condition limits the size of the bargaining group nationally and also its concentration in each state. It would also allow the hospitals to share certain information for benchmarking purposes.

The ACCC considers that the condition addresses potential concerns about the size that the group may reach, while allowing it sufficient scope to obtain economies of scale.

"The ACCC considers that the collective bargaining is likely to result in cost savings and provide small private hospitals greater input into their contracts," ACCC chairman Rod Sims said.

"Group members will also share information about processes and procedures relating to their operations and patient care. Performance benchmarking has the potential to improve the management or efficiency of participating private hospitals."

The PHCBG is newly formed and does not yet have any members, but several hospitals have expressed an interest in joining the PHCBG and the ACCC considers that the benefits are likely to occur once the PHCBG is established.

The proposed five year authorisation would provide prospective members of the PHCBG, private hospitals and groups of private hospitals with up to 200 beds, statutory protection to negotiate as a collective with health funds and medical and nonmedical suppliers. The authorisation would also protect the PHCBG for sharing information about processes and procedures for the purpose of benchmarking.

Authorisation does not represent ACCC endorsement of a group or scheme. Rather, it provides statutory protection from court action for conduct that might otherwise raise concerns under the competition provisions of the Competition and Consumer Act 2010. Broadly, the ACCC may grant an authorisation when it is satisfied that the public benefit from the conduct outweighs any public detriment.

More information about the application for authorisation, including a copy of the ACCC's final determination, will be available on the ACCC website atwww.accc.gov.au/AuthorisationsRegister.

AMSA outraged by Coalition suggestion of increased student fees

The Australian Medical Students' Association (AMSA) is deeply concerned by indications of Coalition support for university fee deregulation and Christopher Pyne's public statements affirming the Coalition's commitment to reintroduce Domestic Undergraduate Full Fee places if elected.

President of the Australian Medical Students' Association, Mr James Churchill, said that student fee increases including the reintroduction of Domestic Undergraduate Full Fee tertiary places would be unacceptable.

"The recent Higher Education Base Funding Review indicates that many courses, including medicine, are chronically and severely underfunded," Mr Churchill said.

"Universities clearly need more funding, but Australia's students simply cannot afford to foot the bill.

"Domestic Undergraduate Full Fee tertiary places were abolished for good reason and the Coalition's proposal to reintroduce them represents a huge step backwards for Australia's university students.

"Increased student fees may deter students from disadvantaged backgrounds and undo the good work Government and universities are doing to improve equity of access.

"In addition, medical graduates with excessive debt upon graduation are more likely to enter high paying specialties and less likely to pursue careers in primary care as necessary to cater for Australia's population health needs," he said.

AMSA has called for domestic full fee places to be banned and for increased university funding from Government without increases in student fees.

Book Review:
Medical and Party Politics – Dr Peter D Hughes

ISBN-13:9781470133702

This is a remarkable book by Peter Hughes who has been at the forefront of affairs, both political and medical, since he arrived in Canberra to practise as a Urologist in 1962. His approach reminds me of the advice of Saint Mary MacKillop to her nuns: "Never see a need without doing something about it." There is something in this book for every doctor, those who have lived and worked through these fifty years and those who can draw on the past to help manage the future.

In most groups the doves outnumber the hawks and we owe a lot to those who are prepared to sacrifice their comfort and time to protect our independence. Battling for what one believes can cause resentment even among those who will eventually benefit. In Peter's case, the fight was for principles and never became personal.

The book covers the history of Health Insurance and ALP policies in regard to it, politics in the Federal and Local Assembly spheres, disputes with governments, both federal and local, in 1984-85, 1987 and 1994-95, the ACT Medical Association from 1958 to 1998, the planning, construction, operation and eventual lease of the John James Memorial Hospital, the history of the ACT Visiting Medical Officers Association and of the Provincial Surgeons Association. There is also a summary of the history of VMO contracts in the ACT. It concludes with a list of Peter's 33 medical publications and presentations.

Throughout the book, Peter has relied upon quotations from the Canberra Times, other publications, transcripts from radio and television interviews and letters and circulars which he had distributed, so there is a genuine immediacy.In reading the political chapters it is hard to believe that he had time for any clinical work but he was well known for the time and care which he gave to his patients.

In the Canberra Times newspaper of 5 January, 1977, Jack Waterford, a prominent local journalist, had some very complementary things to say of him.

The various disputes between governments and doctors are described from the trenches.

In 1965, long before most of us were concerned, he encouraged his colleagues to begin planning for the construction of a private hospital to be known as the John James Memorial Hospital to provide some protection from the government hospital monopoly. It was opened in March, 1970. Its history is covered in Chapters 9 and 10. He was Chairman from 1966 to 1972 and resigned as a Director in November, 2001.

On 2 December, 1972, the Whitlam Labor government was elected and in 1973 there was a government decision to change the working arrangements of the specialists in the hospitals, which took a lot of time and effort to defeat.In 1993 there was a dispute about VMO contracts which was eventually resolved.

Chapter 6 deals with the Medical Advisory Committee of the Canberra Hospital and the gradual development and expansion of the services available in our hospitals. In 1968, before the coercion of the Whitlam era, Dr Hughes raised the question of altering the Ordinance to allow Salaried Medical Officers to attend VMO meetings.

There are some flashes of humour in the book, for example, in an interview on the ABC with Julie Derritt on 19 January, 1994, Peter said: "A totally unbiased arbitrator is a rare bird".

Chapters 11, 12 and 13 cover his involvement with the Private Hospitals Organisation in Australia, the ACT VMOS Association Inc. and the Provincial Surgeons Association. These are all examples of what I mentioned earlier: he saw needs and did something about them.

It is very unlikely that a book on this scale and of such historical interest to nearly every section of the ACT Medical Community will ever be attempted again and I strongly recommend it.

Frank Long, Retired Physician

The book is available for $29 from Dymocks in the Canberra Centre and from Dr. Hughes, 5 Ryan Street, Curtin, phone 6161 3137, email: hughespande@grapevine.com.au.

Aged care medical workforce is ageing – AMA survey

An AMA survey of medical professionals working in the aged care sector has found that the aged care medical workforce is ageing and that more than 15 per cent are intending to reduce their aged care visits over the next two years.

The survey of general practitioners, consultant physicians, geriatricians, emergency physicians, psychiatrists, and palliative medicine specialists was conducted in July 2012 and received 845 responses.

AMA President, Dr Steve Hambleton, said that the survey shows clearly the older medical workforce is providing the majority of medical services to older Australians in residential aged care.

"Our survey shows that the medical workforce in aged care is ageing and individuals are starting to cut back their visits, and that younger health professionals are not moving in to fill the gap," Dr Hambleton said.

"Current aged care policies ignore medical workforce issues and medical workforce planning.

"This survey shows that governments and aged care advocates must urgently embrace policies to build and support medical care in aged care. If not, older Australians who lack mobility and cannot travel to the surgery are going to have less and less access to quality medical care in coming years," Dr Hambleton said.

Key findings of the 2012 AMA aged care survey include:

- of the medical practitioners providing medical care to older Australians in residential aged care facilities, just 8 per cent are under 40 years of age;
- the average number of visits by medical practitioners per month to residential aged care facilities is 6.14 – down from 8.36 visits per month in 2008;
- the average number of patients seen by medical practitioners per visit to residential aged care facilities is 5.36 – up from 4.77 patients in 2008;
- the average time spent with each patient is 15.71 minutes– up from 13.12 minutes in 2008;
- the average time spent for each patient managing the care of the patient with the facility and/or family is 13.67 minutes – up from 13.20 minutes in 2008;
- 31.39 per cent of survey respondents have decreased their visits to residential aged care facilities over the last five years – up from 21.64 per cent in 2008;
- 16.03 per cent of survey respondents will increase their visits to residential aged care facilities over the next two years – up from 15.95 per cent in 2008; and
- 95.27 per cent of survey respondents identified the need to improve the availability of suitably trained and experienced nurses and other health professionals in residential aged care to support the medical workforce.

AMA Guide to using the PCEHR

The AMA has prepared a guide for doctors on how to use the personally controlled electronic health record (PCEHR) system.

The AMA Guide to Using the PCEHR, which has been developed in close consultation with practitioners, is available on the AMA website at http://ama.com.au/pcehr.

It provides information and guidance to help medical practitioners decide whether or not to participate in the PCEHR system, and explains how they might use the PCEHR in their day-to-day practice.

AMA President Dr Steve Hambleton said the AMA supports patients taking responsibility for their own health, and giving them control of their health information could help encourage them to do so.

But Dr Hambleton warned that, by putting patients in the driver's seat in terms of managing their health information, the PCEHR also limited its own clinical usefulness for medical practitioners, because of concerns about the content, accuracy, and accessibility of information in the system.

He added that medical practices would also have to make significant investments of time and money to meet all of the PCEHR's legal obligations. This would include changes to clinical and administrative workflows, and practices would have to draw up new operational policies and protocols to comply with the PCEHR legislation.

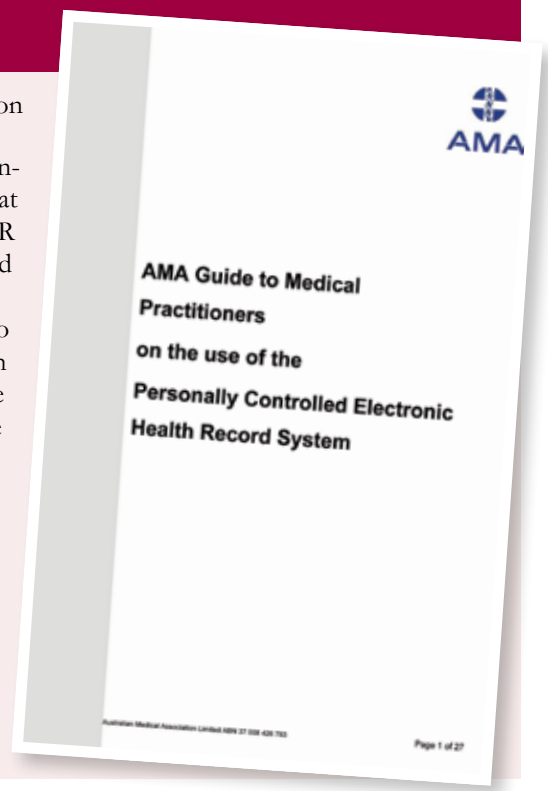
While these limitations and start-up costs are real, the PCEHR holds the promise of reducing adverse events and duplication of treatments. With the right system and the right support, the PCEHR can help doctors to improve the patient health care experience.

Some elements of the PCEHR system have yet to be put in place for doctors and practices, but key concerns are being addressed (see Doctors win recognition for PCEHR work, p5).

As important aspects of the PCEHR are finalised, including the ability to integrate with practice software, the PCEHR should become a valuable addition to quality health care.

The AMA will continue to work to ensure that the best possible PCEHR is available for patients and health professionals.

The AMA Guide to Using the PCEHR, which has been prepared with the cooperation of the National Electronic Health Transition Authority, will help doctors get a better understanding of what is involved when they are considering using the PCEHR system, and assist them in making a more informed decision about participating.



Government provides greater incentives for doctors to engage with the PCEHR

Health Minister Tanya Plibersek recently provided important policy clarity and greater incentives for GPs to become fully engaged more quickly with the Personally Controlled Electronic Health Record (PCEHR).

The AMA is a strong supporter of a quality workable shared health summary and has been in discussions with the Minister and the Department of Health and Ageing for some time seeking further clarification on how GPs could confidently provide PCEHR services for patients under existing Medicare Benefits Scheme (MBS) arrangements.

AMA President, Dr Steve Hambleton, said that the Government has listened to the AMA's concerns and delivered an outcome that will encourage doctors to become actively involved in the implementation of the PCEHR.

"The Government has clarified that additional time spent by a GP on a shared health summary or an event summary during a consultation will count towards the total consultation time, and that the relevant time-based GP item can be billed accordingly," Dr Hambleton said.

"The Minister has fully explained how doctors can now safely and confidently provide new PCEHR clinical services such as a shared health summary under current MBS items.

"The Minister has also delayed the PCEHR e-health practice incentive payment (PIP) capability requirements until May 2013.

"The AMA strongly welcomes both announcements.

"They will allow doctors more time to make the transition to the new e-health environment in their practices, and are a positive outcome from the ongoing discussions the AMA has had with the Minister's office and the Department."

Dr Hambleton said the shared health summary is a key feature of the PCEHR.

"The activity that is required to create and maintain a shared health summary is a new clinical service for doctors that will need to be factored into current clinical practice. The work involved in creating an event summary will also have to be factored into clinical practice.

"These activities are clinically relevant services that will require extra work for the doctors who choose to provide them.

"The announcements are significant incentives for doctors to take part. The Government has delivered a catalyst to accelerate the implementation of the PCEHR."

VALE!

The President, Dr Andrew Miller, Board, Members and Staff of the AMA ACT extend their sincere condolences to the family, friends and colleagues of their late esteemed Colleague, Dr Marjan Kljakovic

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The costs of the criminalisation of drugs

Arbitrary decisions taken decades ago have established for the world, a program of prohibition of an arbitrary group of pharmaceutical agents that have psychoactive properties. The effort to eradicate use of these psychoactive substances through international treaties and criminalisation of their possession and use has failed comprehensively. The criminalisation process has resulted in profound social and health harm and has done little to curb the widespread availability and use of these substances, writes Bob Douglas.

By declaring drug use a criminal act, governments abrogate responsibility for production, regulation and distribution of these widely used substances and hand it over to criminal gangs. This denies the possibility of basic quality control, reasonable market regulation and taxation.

In 2011, a Global Commission on Drug Policy that included former Secretary-General of the UN, Kofi Annan and a number of former national Presidents and leaders from around the world declared that "The War on Drugs" declared in 1971 by Richard Nixon to help him win re-election, had failed disastrously and that countries everywhere should reconsider their national policies on illicit drugs.

Australia 21, a non-profit company which specialises in bringing networks of thinkers, researchers and stakeholders together to discuss issues of national importance has held 2 roundtables of eminent Australians and experts in drug policy during 2012. Our first report in April 2012 was entitled "Prohibition of Illicit Drugs Is Killing and Criminalising Our Children and We Are All Letting it Happen." The report described a roundtable that included 2 former State Premiers, two former Federal Health Ministers and a former ACT Chief Minister and Health Minister from both sides of politics, which argued the case for reopening the national debate on illicit drug policy and for considering the growing international evidence about alternative approaches.

The second report, launched recently in Adelaide by the Editor of the Lancet, Dr. Richard Horton, describes a roundtable held in Melbourne in July to consider evidence from different approaches to the illicit drug problem that have been in place for a number of years in four countries in Europe and have been evaluated.

The new report is entitled "Alternatives to Prohibition. Illicit Drugs: How We Can Stop Killing and Criminalizing Young Australians." It calls for a national summit on the topic and referral of this issue to the Australian Productivity Commission. A number of specific options for change were discussed which we think should be considered broadly by the Australian community. The report recognizes that progress in this difficult area will only come slowly through incremental steps and careful evaluation of the experience gained along the way. It argues however that it is time for Australia, with its very high rates of drug use and 400 heroin deaths a year, to consider some of the alternative approaches that have effectively reduced death rates without seriously increasing drug use in Portugal and the Netherlands.

The report, contains a proposal by former Melbourne University Vice Chancellor David Pennington whereby Australia could embark on decriminalization for possession and use of cannabis and ecstasy for people aged 16 and over, who are willing to be recorded on a national confidential users register and who will then have access and permission to purchase them from an approved government supply in regulated quantities with careful record keeping.

The AMA was represented in the 2nd meeting by Victorian president Dr. Stephen Parnis who is quoted in the report as follows. "Criminalisation can act against achieving the right policy goals. Criminalisation of drug use and trafficking is often defended as a powerful deterrent to initiation or continued use. For some, it probably is. But for some others, the deterrent effect will be weak and ineffective. And for those people who do initiate or continue their drug use, criminalisation will also add significantly to the potential health and other risks that drug users are exposed to. For example, exposure to drugs of variable dose and quality; barriers to accessing health supports, equipments and facilities that can minimise the risks of drug use, exposure to criminal underworld and those who market the drugs… Whether Australia decriminalises or not, there is a continuing need for more effective and well resourced health and education responses to potentially harmful drug use."

Vivienne Mpxham-Hall, a University of Sydney student says in the report "I am sure Australia can do better. The debate that has commenced in recent months around alternative positions to prohibition needs to be led by those who are most affected. We must take in to consideration a range of alternative approaches to drug laws and make life safer for young people. I encourage all young people and advocates for youth to take the problem seriously and focus on considering alternative solutions proposed in this report.

The full text of the 52 page Australia 21 report can be downloaded from the Australia 21 website: www.australia21.org.au

Em Prof Bob Douglas AO is former Director of the National Centre for Epidemiology and Population Health at the ANU and was a co-author of both of the two Australia21 reports.

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Is cash still king?

For a few heady months at the beginning of 2010, as Europe seemed to teeter on the edge of full-blown economic crisis, cash was king to Australian banks. Even though that uncertainty remains, the demand for cash seems to have slowed down, with Canstar noting the margin between the official Reserve Bank of Australia (RBA) cash rate and a one-year term deposit shrinking to one percent (from a 2.35 percent difference two years ago). Does this mean cash has lost its shine? Not necessarily, says Investec's Cindy Arthur.

"We know the markets are still volatile and there's still a lot of uncertainty out there," she says. "Cash remains a critical component of most portfolios, and until the situation in Europe settles, cash is still a safe haven. Cash can offer a respite from the roller-coaster ride of other investments like equities".

Things have changed since the savings boom of 2010, and the main reason, Arthur says, is the end of that cycle where banks were chasing cashed-up customers. "When the Global Financial Crisis started, banks were under serious pressure to build liquidity and as a result interest rates for savings were very competitive," she says "but that has slowed down now. The rates are still competitive, but they're certainly not as aggressive as they were. Over the last year and since the RBA started decreasing interest rates the banks have slowly cut interest rates on deposits."

"This is not to say banks have lost interest in cash—with a considerable amount of their funding coming from the wholesale market", says Arthur, "there will always be competitive offers out there. However, as interest rates on savings accounts change regularly, it is important for people to ensure that they are receiving a fair and competitive rate".

According to financial products ratings agency Canstar, Investec already has one of the most attractive term deposits in the marketplace, but Arthur says opportunities exist to give clients more flexibility when it comes to cash, which is why Investec developed the 32 Day Notice Account.

"A lot of people like the flexibility of a call account because it gives them instant access to their money but call accounts generally pay a very low rate of interest and some pay no interest at all," she explains. "The contrast to a call account is a fixed term deposit where you're locked in for a specified period but you earn a competitive interest rate. We have an innovative new product called the 32 Day Notice Account, which is a hybrid of the two. With the 32 Day Notice Account, you still get a competitive monthly interest rate, which is currently 5.15 percent (variable) - with new medical and dental clients to Investec earning an extra one percent on top of that for the first 90 days. However, the difference between the 32 Day Notice Account and a term deposit is that with the 32 Day Notice Account you can give 32 days' notice at any time before withdrawing funds. With a term deposit, if you select a fixed term, say for example 90 days, your money is not available to you again until the end of the period, although some banks will allow you to break the term with a penalty fee. We believe the 32 Day Notice Account gives the client more options combining the appeal of a higher interest rate than is generally offered for call accounts with increased flexibility around accessing the funds," she says. "Giving people more options makes saving appealing."

The 32 Day Notice Account is just one of a suite of deposit products available to Investec's Medical and Dental clients. We also offer call accounts and term deposits. "We offer a full range of options". Arthur explains, "We believe that our clients care more about their patients than their own finances. They don't have time to shop around for financial solutions and we offer a comprehensive suite of products so they don't have to."

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TechWatch

Invitation to participate in a research study

TechWatch – tracking computer problems that affect the safety of Australian general practice

We invite you to participate in a study about computer problems in general practice.

Purpose

Information technology has many benefits for clinical medicine. But problems with computer use can introduce new errors that affect the safety and quality of clinical care and may put patients at risk of adverse events. General practitioners from across Australia have been invited to join the TechWatch Study and help identify and track safety and quality issues arising from the use of computers in general practice.

Requirements

We are inviting you to report *critical incidents* involving computer use in your practice, i.e. risks of patient harm identified due to a computer problem or difficulty in using the computer. One example of a *critical incident* is when an incorrect dosage of a medication is selected from a computer drop down list while a prescription is being created.

An incident can be reported online or by telephone in just a few minutes. The study will run for 12 months and participants will be offered an honorarium of $200 on completion of the study.

Benefits

Information collected though the TechWatch Study will be used by researchers to gain a better understanding of how to improve the safety of using computers in routine clinical practice. Our findings will guide the future safe design and use of information technology in general practice.

Confidentiality

The TechWatch Study has been declared as a quality assurance activity under the *Commonwealth Qualified Privilege Scheme*. This means that the identity of the general practitioner and the information they provide to the study database is protected and cannot be subpoenaed in legal action.

TechWatch is being led by Farah Magrabi, Michael Kidd, Teng Liaw and Enrico Coiera from the University of New South Wales and Flinders University and is funded by the National Health and Medical Research Council (NHMRC).

To join the TechWatch Study, please:

- **Register on our website, www.techwatch.unsw.edu.au**

or

- **Register by calling the following free number 1800 892 824 (1800 TWATCH)**

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Flu losing its grip as season turns

The influenza scourge that has gripped much of the country this winter appears to be on the wane.

Official figures show the number of new influenza infections reported by health authorities has declined since peaking in mid-July, with less than 6100 laboratory-confirmed cases between 21 July and 3 August, down from almost 6500 identified in the preceding fortnight.

"Although some jurisdictions have continued to report widespread activity above baseline levels, influenza activity decreased across most of Australia," the Department of Health and Ageing's latest *Australian Influenza Surveillance Report* said. "Influenza-like illness activity has continued to decrease, with current activity levels similar to the peak levels experienced during the 2010 and 2011 seasons."

The exception was Queensland, where the number of cases has continued to increase. In the two weeks to 3 August, the northern state accounted for almost 45 per cent of new cases, with 2664 people confirmed with the infection, compared with 903 in Western Australia, 779 in South Australia, 727 in Victoria, 548 in New South Wales and 347 in Tasmania.

The figures show Queensland has been hardest-hit by the virus, accounting for 31 per cent of all cases nationwide, compared with 21 per cent for NSW, 16 per cent for SA, 13 per cent for WA, 12.2 per cent for Victoria and 3.4 per cent for Tasmania. The territories combined had 3 per cent of cases.

The report said the predominant flu virus this year has been influenza A (H3N2), with "very few" notifications of the pandemic H1N1 2009 virus, which the Department speculated might be due to changes in immunity among the population.

"In recent years the proportion of influenza A viruses circulating in the community has been low," the report said. "This may have led to some reductions in immunity across the population, and thus might be a contributing factor to both the predominance of this virus among the population, and the apparent intensity of the season."

While health experts have raised the alarm about what appears to have been an unusually severe and pervasive flu season, this perception may have been driven more by a rapid spike in infections rather than the total number of cases.

According to the Department, the influenza season began earlier in 2012 than it has in recent years, and the number of cases accelerated much more sharply.

"The intensity of the rise in cases for 2012 has also meant a higher peak in notifications," the Surveillance Report said. "However, the total number of notifications for the entire season (up to 23,553 as at 3 August) may not result in a substantial variance compared to [sic] previous seasons."

The report said that the predominance of the influenza A virus compared with the H1N1 virus has meant that the age profile of those infected has returned to the more familiar patterns of years preceding the 2009 pandemic, with the number of cases peaking among children less than four years of age and among adults older than 70 years.

So far 23 deaths have been officially attributed to influenza, with the median age 74 years.

According to the FluTracking online data collection system, those vaccinated against the flu were marginally less likely to suffer fevers and coughs or lose time from work because of illness than those not immunised.

Copy supplied by Australian Medicine.

AMA welcomes Greens' bill to establish expert health care panel for refugees

AMA President, Dr Steve Hambleton, said the AMA welcomes the Australian Greens' Bill to establish an independent Expert Health Care Panel to oversee the health of asylum seekers and refugees in immigration detention.

The AMA President called for an Expert Panel at the AMA Parliamentary Dinner in Canberra last month, saying the Panel would *"add some humanity to an otherwise inhumane policy"*.

Dr Hambleton urges all Parliamentarians to support the Greens' Bill.

"Indefinite detention has a serious mental health impact on detainees," Dr Hambleton said.

"The remoteness of Nauru and Manus Island for offshore processing will make effective health care delivery more difficult.

"Asylum seekers and refugees are at particular risk from a range of health conditions including psychological disorders such as post-traumatic stress disorder, anxiety depression, and the physical effects of persecution and torture.

"They also suffer poor dental hygiene, poor nutrition and diet, infectious diseases, and health problems associated with the general living conditions in detention facilities.

"Children especially are more vulnerable. Detention can cause serious harm to a child's development, particularly when there is ongoing exposure to traumatised adults.

"It is important that independent medical experts be allowed to inspect the health services and conditions in detention facilities and report back to the Parliament.

"The Bill being introduced by the Australian Greens must be supported by the Parliament to show the world that we are a compassionate society.

"The AMA would like to see the Expert Panel's responsibilities extend to inspecting and reporting on health services and conditions in onshore facilities as well," Dr Hambleton said.

The AMA believes that people who are seeking, or who have been granted, asylum within Australia have the right to receive appropriate medical care without discrimination, regardless of citizenship, visa status, or ability to pay. Like all seeking health care, asylum seekers and refuges in Australia should be treated with compassion, respect, and dignity.

The AMA Position Statement on the Health Care of Asylum Seekers and Refugees is at http://ama.com.au/asylum-seekers

Asylum seekers must be treated humanely says Red Cross

While arrangements for processing asylum seekers who arrive in Australia are ultimately decisions of government, Red Cross is concerned to ensure any proposals for change take full account of the humanitarian needs of these vulnerable people.

These needs include appropriate care for their health and wellbeing, the timely resolution of a person's refugee application, the availability of durable solutions for people in need of protection, and ensuring people are able to restore family links both while awaiting an outcome of their refugee application and beyond.

Asylum seekers are some of the most vulnerable people in Australia, and Red Cross' priority is to ensure that, regardless of how they arrive, they are treated humanely, with dignity and respect.

Red Cross has been supporting asylum seekers in Australia for over 20 years and approaches these issues from a humanitarian perspective, consistent with our Fundamental Principles. How people are treated during the process of refugee determination is our key area of focus.

Red Cross has advocated that community care is a better and more humane arrangement than immigration detention and would expect that any future arrangements ensure that the standard of care offered to asylum seekers in Australia is upheld as a minimum.

Red Cross will closely monitor the situation as it unfolds and continue to engage directly with government around issues of humanitarian concern. There is still much more we need to understand about the recommendations and how government may decide to implement them, but any proposals for change must be humane, durable and sustainable.

Mobility scooters not restricted to the elderly: NRMA & ACCC release report

The Australian Competition and Consumer Commission and NRMA Motoring & Services are highlighting the need for more education on integrating mobility scooters into local communities after survey results show scooter use is widespread across all age groups and people are using scooters to fill a variety of needs.

The research survey conducted by the Australian Competition and Consumer Commission (ACCC), CHOICE, EnableNSW, Flinders University, the NRMA and other mobility experts found that around 230,000 Australians use scooters, with more than half under the age of 60.

NRMA President Wendy Machin said the survey was a first of its kind in Australia and was funded by the NRMA to find out more about how mobility scooters were being used in local communities.

"Some people might think mobility scooters are mainly used as a replacement for cars when older people retire their licences, but our research shows that loss of a licence is a relatively low trigger for buying one," Ms Machin said.

"Reduced walking and physical mobility is the main reason why nine in ten users buy a mobility scooter, with the scooter seen as a replacement for legs rather than a car.

"Scooters are also being used in conjunction with other forms of transport depending on individual needs; some people use their scooter as the main form of transport outside their home while others transport their scooter to another location like a shopping centre and use it there.

"Our research revealed just how treasured mobility scooters are as lifelines to providing independence and to maintaining social connections.

"We also found that mobility scooter use is higher in regional areas and this has ramifications on where users can go to access expert advice, training and other services."

ACCC Commissioner Sarah Court said that the results also provided an insight into the type of safety incidents associated with mobility scooters.

"About five per cent of respondents to the extended version of the survey reported experiencing an incident. This included their scooter toppling over, colliding with an object, or tripping or falling from their scooter," Ms Court said.

"Scooter users also identified a range of factors they felt contributed to these incidents, including not being noticed on roads or in parking lots.

"Although this research was focused on providing a better understanding of the demographics of mobility scooter users and patterns of use, the ACCC has also been working with a range of other stakeholders towards improving the safe use of mobility scooters themselves. This work is ongoing."

Ms Machin said the NRMA looked forward to working with the ACCC and other stakeholders to raise the awareness of all road users (motorists, pedestrians, cyclists and scooter users) regarding the changing nature of mobility in Australia and how to safely integrate scooters into this new transport mix.

A summary report on the findings of this research can be found atwww.productsafety.gov.au/mobilityscooters or mynrma.com.au/scooters

Cancer Council seeks participants in world-first study on spiritual wellbeing

On the eve of Daffodil Day, Cancer Council Australia launched a world-first study to further understanding of how spiritual wellbeing affects the quality of life for those affected by cancer.

The study will seek to measure the importance of feelings such as hope, love, peace and forgiveness and their impact on patients' emotional and physical wellbeing - such as energy levels and pain - at different stages of the cancer journey.

Cancer patients, survivors, friends, family members, professional and informal carers and even people who have never been affected by cancer are being sought to take part in an online questionnaire.

Cancer Council Australia researcher Dr Hayley Whitford, based at The University of Adelaide, and Cancer Council Australia CEO, Professor Ian Olver, will analyse the information provided to determine which aspects of spiritual wellbeing, including the less acknowledged aspects such as appreciation and connectedness, are the most important in improving cancer patients' resilience and quality of life.

Professor Olver said it was an important area of research for anyone coping with, or treating, cancer. "This study builds on a decade of research on hope and spiritual wellbeing and is the first of its kind to attempt to psychometrically assess the underlying aspects of spiritual wellbeing such as love, peace, meaning and faith, and how they each affect people's resilience against depression, anxiety and stress," he said.

"It's also unique because it aims to compare the experiences of people at different stages of the cancer journey and which aspects of wellbeing are the most important at which stage. This will help us better support the emotional needs of cancer patients and their families in the areas they need it most, when they need it most."

Participants over 18 years of age, who have had a diagnosis of cancer; a cancer survivor; a past or present carer of someone with cancer. are invited to take part in the research by simply completing an online questionnaire now and again in six months. It should take 20 to 30 minutes.

Find out more and complete the questionnaire at www.cancer.org.au/2020vision

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