Canberra DOCTOR
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Celebrating our 25th Birthday in 2013
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"Art In, Butt Out" 2013 winner announced

The winner of the 2013 "Art in, butt out" competition is Sally Witchalls, a year 8 student from Canberra High School. Sally's winning design was a standout and the judges were unanimous in their decision. They considered that Sally's design was simple, imaginative and creative and very much in keeping with the theme of the competition and has earned its place alongside previous winning entries.

Sally's message clearly states that not smoking, or giving up the habit, provides for a brighter future as depicted in yellow, sunshine and flowers when compared with the darker vision of the smoker. More oxygen and fresh air for all.

Sally's prize winning entry was announced by Chief Minister and Minister for Health, Katy Gallagher, in a ceremony at the ACT Legislative Assembly.

Sally's winning entry will be very visible as it will be distributed on Canberra's some 60000+ Canberra Milk cartons through the month of September.

The "Art in, butt out" campaign is an initiative of the AMA ACT and its Tobacco Task Force. The Task Force members include the AMA ACT, Cancer Council ACT, Diabetes Australia ACT, Heart Foundation ACT, Canberra ASH and Winnunga Nimmityjah Aboriginal Health Service.

Its terms of reference include recommending strategies to reduce the uptake of smoking by young people particularly, and to increase the awareness in the community of the health benefits of "quitting" the smoking habit.

The Task Force has a history of engaging with young people to develop peer-to-peer anti-smoking messages. "Art in, butt out" is a competition for young designers in year 8 secondary school (public, private and home schooled) to design an anti-smoking advertisement for "Canberra Milk" cartons to be distributed across the Territory.

There is a cash prize for the winner of the design competition. The public exposure of the artist and the artwork provides an added incentive to enter the competition.

Katy Gallagher with Sally Witchalls and family.

"Art in, butt out" provides opportunities for media students to exercise their design and art skills in a real-life situation by devising and developing marketing strategies to positively influence their peers and translate these strategies into very visible advertisements. Importantly, the competition encourages young people to think about their health and well-being in a positive way and specifically brings into focus the harmfulness of smoking and tobacco products.

"Art in, butt out" is supported by the ACT Education directorate and was launched by the then ACT Education Minister, Andrew Barr at Lyneham High School six years ago. ACT Health Minister, Katy Gallagher has provided public and private support to the initiative.

TERRITORY TOPICALS – from President, Dr Andrew Miller

Dr Andrew Miller

Before I deal with the elephant that is just about everywhere, I must pass on a warning about a possible scam highlighted by our colleagues in AMA WA. People claiming to be doctors ringing from overseas are trying to obtain contact details for key staff members in medical practices in WA. The stories offered are compelling and the callers most insistent. It would be advisable to warn your front desk staff in case the problem raises itself here. I must also report about our successes in the VMO contract negotiations, but will keep you on tenterhooks for now.

Well it's finally on!! The election campaign has hardly begun and it has degenerated into name calling. What an impression our democracy must give to an outsider, with a brutal auction of demonisation of asylum seekers alternating with arguments about tax cuts. I am not sure if so much of this reflects the role of electronic media; but I remain always concerned about the vitality of democracy when I see the debate being limited to slogans and smears. It is not altogether dysthymia that reminds me that some of the worst monsters of the 20th century were elected by democracies with a disillusioned and disconnected populace.

What is clear so far is that both the major parties are keen to keep health off the agenda in the election campaign. I can understand why. On a community basis we have out of pocket expenses higher now than they have ever been. This is due in part to the entrenched policy of discounting indexation of the MBS and the overly weighty administrative burden of programmes such as PIP payments limiting their value to practices. The PBS, despite headline grabbing inclusions of some hugely expensive drugs, is poorly administered and leaves patients with excessive personal costs and burdens the nation with gilt-plated generic costs. Elective surgery waiting times are not improving meaningfully; raw hospital bed numbers remain below the OECD average and bed occupancy rates exceed the ideal resulting in all to frequent "bed block" contributing to delays in emergency departments.

We also face a huge demographic change in the medical workforce, with a huge increase in medical graduates but as yet there is no evidence of a long term plan to ensure that quality of training will be maintained. The projected demand for vocational training places greatly exceeds the planned supply.

It is up to us as a profession to ensure that these issues become points of debate and that we can draw the major parties out on their policies, so voters' decisions may be properly informed.

The AMA has been able, by drawing a coalition of industry, education and professional groups, to obtain a deferral of the $2000 self-education expenses cap. I see this as a face saving way for the government to quietly sweep an embarrassing and poorly conceived policy under the carpet. It still seems extraordinary to me that the policy was dreamt up in the first place, but also that it took so long for people to see past the class war rhetoric that came from Wayne Swan's office aimed directly at silver tail doctors and understand that it was really dumb, and would have a dumbing effect on our entire economy and workforce. It is a great credit to the AMA that such a diverse coalition could be brought together, and continue to sing from the same song-sheet.

Whilst delivering ourselves plaudits I must also report that the arbitration process for the VMO contracts is drawing to a close. So far we have had some mixed results, with a disappointing indexation outcome, but nevertheless more than the 2% the government had on offer. Many of the less headline grabbing operational clauses of the contract have been tidied at our suggestion and to our satisfaction. We have also, as a national precedent, succeeded in obtaining recognition that GPs employed as VMOs by ACT Health are specialists in their own right and so will be paid at the same specialist hourly rate as all other specialists, save a few special case exceptions. We have also succeeded in overturning the historic differentiation between surgical and medical specialists so that all will be paid at the same rate.

On a different note I read in the 6 Minutes News that aggression in the medical workplace is again making headlines. I find the advice that general practices should employ security guards and CCTV extraordinary. I can understand the advice that doctors should sit next to the door; I can still recall my disquiet when working in A&E at St Vincents in Sydney as an intern, in a small room with the patient between me and the door and no defence other than a Bic, my stethoscope and a prescription pad; when the patient informed me that it would not be his fault if he hurt me. I did not feel entirely reassured when he elucidated that the bomb in his brain hurt. This is of course no laughing matter, and we need to make sure that legislators understand that aggression towards health care workers is completely unacceptable. And sit closer to the door.

I have read that there is one influence that our profession may, albeit indirectly, bring to bear on this election. It appears that, at least in Adelaide, doctors' wives represent a seriously confounding group in poll analyses and so in electorates with a large resident medical population, polling may become unreliable (ABC Local Radio 891 Adelaide). Apparently "they are natural 'Tories' who nevertheless have enough time on their hands to worry about liberal causes" (Michael Wilmore, The Conversation, 6 August 2013). It is a sad commentary that suggests the political debate is so debased that one needs extra time on our hands to worry about causes, liberal or otherwise.

I tested myself on the same ABC Electoral compass (ABC.net.au/votecompass). I won't tell you the outcome; but I can't help a certain wistful nostalgia for Peter Walsh's fairies at the bottom of the garden.

I think our focus on politics is neatly encapsulated in James Carville's 3 slogan summary for President Clinton's campaign in 1992; "the economy, stupid"; "change vs. more of the same" and "don't forget health care". I am not sure that change for the sake of it is a noble ambition, however it is the economy, stupid. And we must never forget the social context of the economy; especially not health care.

Industry opposition strengthens new alliance's resolve to reduce alcohol harms in the ACT

Last week the NSW ACT Alcohol Policy Alliance (NAAPA), a new coalition of health, community and frontline organisations working to prevent and reduce alcohol-related harms, was launched in Canberra.

With the ACT Government shortly embarking on a review of the *Liquor Act 2010*, NAAPA's 'arrival' was applauded by Attorney General, Simon Corbell, MLA, and the ACT's new Chief of Police, Rudi Lammers, with both men acknowledging that more needs to be done to reduce alcohol harms in the territory.

Commending the twelve ACT-based members of NAAPA for their engagement in the alliance, Mr Corbell remarked on the role played by the alcohol industry in shaping the 2010 Liquor Act review, and strongly encouraged NAAPA to be similarly engaged and active in the current review process.

His support for NAAPA is encouraging. Alcohol use and misuse presents the greatest public health challenge faced by any government in Australia today. ACT data released last week highlighted that no jurisdiction in the country escapes unscathed.

Just under half (44.5%) of all ACT residents aged over 14 consume alcohol at levels that place them at risk of an alcohol-related injury from a single occasion of drinking, while one in five (19.5 per cent) consume at levels that place them at risk of lifetime harm.

Alcohol-related hospital admissions in the Territory have risen 53 per cent for men and 35 per cent for women between 2000-01 and 2009-10 and treatment episodes where alcohol was the principal drug of concern were also up 43.5 per cent between 2001-02 and 2010-11.

Michael Moore, Public Health Association of Australia, Michael Thorne, Foundation for Alcohol Research and Education, Ronan O'Connor, Ted Noffs Foundation, Chris Bourke, Labor MLA, Mary Porter, Labor MLA, Carrie Fowlie, Alcohol Tobacco and Other Drug Association ACT, Camilla Rowland, Karralika Programs Inc, Rudi Lammers, ACT Chief of Police.

To address those harms, NAAPA is advocating a number of policy measures. We know that lower prices, higher availability and reckless promotions contribute to alcohol-related harms. We have called on the government to improve the collection of data on alcohol-related consumption and harms, toughen the regulation of harmful discounting and promotions of alcohol and wind back trading hours to 3am for those venues currently trading beyond that time.

The evidence shows that the introduction of a modest reduction in trading hours will lead to a very significant reduction in alcohol-related harms. When trading hours were wound back to 3.30am in Newcastle there was a 37 per cent reduction in alcohol-related assaults in 12 months.

It is reassuring that on Thursday we witnessed strong assurances from both the Attorney General and the Chief of Police that they believe the job of tackling alcohol harms is not complete.

While noting that the levels of alcohol-related violence in the ACT community have decreased in recent years, both men agreed that more needs to be done.

Chief of Police Lammers indicated his support for measures to address low prices, high availability and reckless promotions that contribute to alcohol-related harms, noting that the ACT police deal with the aftermath of alcohol-related violence every day of the week.

The ACT Government deserves praise for its past alcohol policy successes. The Government's support of NAAPA gives me great confidence that the Liquor Act Review process will provide a valuable opportunity to further strengthen the legislation and reduce alcohol harms in the ACT.

Michael Thorn
Chief Executive
Foundation for Alcohol Research and Education

The NSW and ACT Alcohol Policy Coalition (NAAPA) is an alliance of health and community organisations active across NSW and the ACT that has been formed with the objective of promoting action to reduce alcohol-related harms. The Coalition of NSW and ACT organisations has been formed to lobby and campaign for alcohol policy reform to reduce alcohol-related harms across the two jurisdictions. www.naapa.org.au

Twelve of NAAPA's 40 organisations are based or work in the ACT and surrounding area and include:

- Australian Medical Association (ACT)
- Karralika Programs Inc
- Alcohol Tobacco and Other Drugs Association ACT (ATODA)
- Ted Noffs Foundation (ACT)
- Canberra Recovery Service, Salvation Army
- Public Health Association of Australia (PHAA), ACT Branch
- Cancer Council ACT
- Foundation for Alcohol Research and Education
- The Royal Australasian College of Surgeons
- Australian Drug Foundation
- The Royal Australasian College of Physicians
- Hello Sunday Morning (HSM)

NAAPA NSW/ACT Alcohol Policy Alliance

Australia's General Practitioners Rate Highly

The CEO of Eastern Melbourne Medicare Local, Kristin Michaels said national research carried out in June confirms that Australia's GPs are highly regarded.

"A staggering 87 per cent of Australians say they are satisfied with their GP, or GP practice. 45 per cent say they are 'very satisfied'," Ms Michaels said.

"The level of satisfaction rises to 94 per cent for people who have been to their GP in the last month," she said.

"The research shows that Australians obtain information from a number of sources but have the most trust in their GP (94 per cent) as a source of information, with pharmacists coming a close second at 89 per cent."

"When asked about behaviours of GPs that would support patient rights outlined in the Australian Charter of Healthcare Rights, Australians continued to give positive rankings."

"86 per cent of Australians said they had a good relationship with their GP, or GP practice, and 45 per cent rated the relationship as 'very good'."

Other key results are:

- 85 per cent agree 'My doctor explains treatment options with me'.
- 84 per cent agree 'My doctor is very easy to relate to'.
- 81 per cent agree 'My doctor always makes adequate time for me during appointments'.
- 77 per cent agree 'My doctor encourages participation in decision making'.
- 70 per cent agree 'My doctor gives me choices when making referrals'.

"The research shows that only 58 per cent of Australians are generally satisfied that the health system is actually delivering the rights set out for them in the Australian Charter of Healthcare Rights."

"However, when thinking about GPs, there is a high level of acknowledgement of behaviours and actions that are essential for protecting patient rights."

Ms Michaels said the Crosby/Textor research confirmed not only that GPs remain the cornerstone of primary health care, but also the cornerstone of protecting health care rights.

The full research results are available online: http://www.emml.com.au/images/uploads/EMML_National_Health_Survey_Jun_2013.pdf

Hydroxyethyl starch (voluven and volulyte) and increased risk of mortality

The Therapeutic Goods Administration (TGA) has advised health professionals not to use hydroxyethyl starch in patients with sepsis, renal failure including those requiring dialysis, severe liver failure, fluid overload, sever hyperchloraemia or hypernatraemia, patients with incracranial bleeding, and in patients with a known hypersensitivity to hydroxyethyl starch.

Recent publications have indicated the use of hydroxyethyl starch is associated with an increased risk of mortality as well as an increased risk of requiring dialysis when used in certain patient populations, in particular, inpatients with sepsis.

Health professionals are asked to report any serious adverse events including cases of renal impairment or bleeding disorders associated with the use of hydroxyethyl starch to the TGA. Further information is on the TGA website: http://www.tga.gov.au/safety/ews-medicine-hydroxyethyl-starch-130709.htm

Australian Government
Department of Health and Ageing
Therapeutic Goods Administration

Australian Healthcare and Hospitals Association supports earlier indexation of rebates

"Australians have had access to universal health care for nearly 30 years, but our system is not immune to the pressures of increasing demand, ageing populations and escalating costs", Alison Verhoeven, Chief Executive of the AHHA said recently.

"Reforms to Medicare are needed to ensure that patients continue to receive high-quality and timely access to care. These reforms need to build on the strengths of the existing system and preserve the principles that Medicare was founded on: equity, efficiency, simplicity and universality."

"The Labor governments' freeze on indexation is a temporary measure only – not a longer term solution. The indexation freeze only defers cost increases for the government. It does not affect the actual costs of providing services and so it is likely to affect bulk-billing rates and increase out-of-pocket expenses for the public as the increased costs are passed on to patients."

"Rather than temporary measures, more focused on achieving the Government's promised budget surplus, governments should consider developing health care financing and payment methods that are more cost-effective and better able to ensure patients receive seamless care in and out of hospital."

Safe Medicines

The medicines watchdog has admitted that pharmaceuticals and medical devices proven to be unsafe may still be sold on the market.

Unveiling a new early warning system to alert doctors and patients to potential safety concerns regarding some treatments, the Therapeutic Goods Administration said that withdrawing regulatory approval was only one of the options for dealing with unsafe drugs and devices.

"The TGA has to consider the balance between the benefits offered by a therapeutic product and the potential risks associated with its use for the population as a whole (or individual patient groups where the risks may be higher) before it makes a decision on an appropriate response," the watchdog said.

While the regulator said it may withdraw or suspend approval for products deemed to be dangerous, other options included warnings to doctors and consumers, changes to product information, tightening conditions for use, demanding an investigation by the manufacturer or recalling the product.

"In some cases, no action may be recommended, and the TGA will continue to monitor the safety concern," it said.

The watchdog made the revelation as it announced the introduction of an early warning system to alert doctors and consumers to potential safety concerns about pharmaceuticals and medical devices.

Under the two-stage system of alerts, health workers and patients will be notified as soon as concerns are raised about the safety of a treatment, with follow-up warnings where evidence shows it could cause harm.

In an advance on previous arrangements, the Trans-Tasman Early Warning System, jointly developed by medicines safety regulators in Australia and New Zealand, intends to alert both doctors and consumers when there may be a problem with a medicine or device.

In the first stage, the TGA will issue what it calls "monitoring communications", drawing attention to potential safety concerns that are yet to be investigated or substantiated.

This is followed up with an alert if a demonstrable link between the treatment and safety concerns is established.

In its advice to health professionals, the TGA was at pains to point out that announcements issued through the early warning system were to keep doctors and patients informed, and did not necessarily imply that a particular treatment was unsafe.

"Monitoring communications highlight potential safety concerns identified, but not yet fully investigated by the TGA, and are intended to encourage further reporting and research," the watchdog said. "Patients should not have their treatment changed because of a monitoring communication."

Similarly, even when investigations justify safety concerns about a medicine or device, this did not necessarily mean that its use should immediately cease.

"Even though an alert has been issued, it does not necessarily mean that a medicine or medical device is considered to be unsafe," the TGA said. "Health professionals should use clinical judgement in applying this information to individual patients.

"As always, the balance of benefits and risks of a medicine or medical device should be discussed with the patient before starting or continuing treatment."

The system has been under development for the past two years, and began operating early this month.

Celebrating the success of Winnunga Nimmityjah AHS

Winnunga celebrated its 25th anniversary in May 2013, and continues to go from strength to strength - providing responsive, appropriate services, tailored to the needs of the local Aboriginal and Torres Strait Islander community.

The Ngunnawal people are the Traditional Owners of the lands the ACT is located on. However, there are many Aboriginal people from other parts of the country living in and visiting Canberra. This is mainly due to the mobility of Aboriginal people generally, connecting with family, the histories of displacement, and employment opportunities particularly in the ACT and Commonwealth public service.

Winnunga was established in 1988 by local Aboriginal people inspired by the national mobilisation of people around the opening of the new Parliament House in May and the visit by the Queen. The late Olive Brown, a particularly inspirational figure who worked tirelessly for the health of Aboriginal people, saw the need to set up a temporary medical service at the Tent Embassy site in Canberra and this proved to be the beginning of Winnunga.

Mrs Brown enlisted the support of Dr Sally Creasey, Carolyn Patterson (registered nurse/midwife), Margaret McCleod and others to assist. Soon after ACT Health offered Mrs Brown a room in the office behind the Griffin Centre to run a clinic twice a week (Tuesday and Thursday mornings) and on Saturday mornings. Winnunga operated out of this office from 1988 to 1990. The then Winnunga Medical Director, Dr Peter Sharp, began work at Winnunga in 1989. Other staff worked as volunteers. In January 1990 the ACT Minister for Health at the time, Wayne Berry, provided a small amount of funding. By 1991 the clinic was operating out of the Griffin Centre as a full time medical practice. In that same year the ACT attained self-government.

Olive Brown passed away in 1993 and this was felt as a great loss to Winnunga and the community. On the passing of Mrs Brown a Health Board was formed that comprised Judy Harris, Bonnie Brown, Lorna McNiven, Julie Tongs, Chris Jard and Glenda Humes.

In 1993 ACT Health provided a part-time worker to assist in the organisation of the clinical service. The following year they provided space in their offices at Moore St for the administration of Winnunga. The clinical service continued to operate from the Griffin Centre.

The National Centre for Epidemiology and Population Health (NCEPH) undertook an analysis of the needs of Canberra/Queanbeyan Aboriginal people, especially with regard to alcohol and other drug problems and HIV/AIDS risk in 1993. Survey data indicated that Aboriginal people were more likely to access services provided by either Aboriginal specific agencies or by agencies employing Aboriginal workers. Only those services with Aboriginal workers reported a high proportion of Aboriginal clients.

In 1996 the Framework Agreement on Aboriginal and Torres Strait Islander Health was signed by the ACT Minister for Health and Community Care, the Commonwealth Minister for Health and Family Services, and the Chairperson of ATSIC.

In October 1997 Julie Tongs resigned from the Board and took six months leave without pay to work at Winnunga as an administrator. At that time the organisation employed 5 staff members. Ms Tongs' first task was to secure the full amount of funding for Winnunga that was coming as a specific purpose grant from the Commonwealth through the ACT Department of Health who deducted the salary of the Aboriginal Liaison Officer (ALO) at The Canberra Hospital from this budget. She was also given the task of getting the service relocated as the Griffin centre was inadequate in terms of space and general conditions with a physical separation of the clinical and administrative work (Moore St).

The clinic entrance was at the back of the building - from a small concrete veranda about a metre wide with a mesh and barbed wire fence around it that fenced off the Total Care car park. It was not uncommon to find used syringes lying on the veranda or stuck in the fence. The fenced off car park was also used as a dumping ground for used syringes. Many times staff and clients were confronted by someone ready to self-inject within a metre of the clinic entrance. The clinic comprised four rooms - a reception area, a waiting room, a tiny office off the waiting room (for counselling and administration) and a doctor's room. The toilets and shower were down a dark stairway. The service had two telephone lines and a one-page photocopier. There were three vehicles including a small bus for pick-ups.

The administrator borrowed a lap top computer from ATSIC, bought a fax machine and worked as a health worker by day and an administrator by night to progress the service. The Chairperson at that time was Judy Harris and she and Julie worked through many nights to ensure that the service was given the priority it deserved and the health needs of Aboriginal peoples in the ACT and region were being addressed. In March 1998, following negotiations with ACT Health both the clinical services and the administrative staff relocated to Wakefield Gardens, Ainslie. In July 1999 Winnunga received funding directly from the Commonwealth government.

The years 1999-2000 was a tumultuous time for Winnunga as there was a very public takeover bid for the service. A small group set up a ghost Board that resulted in Letters of Offer not being able to be signed off and an action in the Supreme Court. The judge dissolved both Boards leaving the CEO and appointing an accountant. The CEO and the accountant were finally able to sign off on the Letters of Offer. The membership was opened up and a special AGM was held to elect a new Board. 101 Aboriginal people turned up to vote at the special AGM and 80 voted for the members of the initial Winnunga Board.

In 1999, Winnunga developed its first Strategic Plan. An infrastructure review of Aboriginal community controlled health services (ACCHSs) was conducted by Ove Arup for OATSIH at around the same time. This review concluded that Winnunga had significant infrastructure needs even though at the time there were only 7 staff members.

In March 2000 Winnunga and ACT Corrections developed a Memorandum of Understanding (MOU) and medical visits to Belconnen Remand Centre commenced. In July 2000 clinics at Goulburn Jail commenced. In this same year a number of other programs commenced.

A Health Promotion Officer position was established; a psychiatrist was employed and a consortium comprising Winnunga, Katungal Aboriginal Corporation (Narooma) and Riverina Medical and Dental Aboriginal Cooperative (Wagga Wagga) was established as the Regional Centre on Social and Emotional Health.

In January 2001 Winnunga employed a fulltime finance officer and the Midwifery Program commenced. In May 2002 an Opiate Program in partnership with the ACT Division of General Practice (ACTDGP) and funded by ACT Health commenced.

In 2004 Winnunga moved to its current premises at Boolimba Cres in Narrabundah, and employs over 60 staff. Winnunga has grown into a major health service resource for the Aboriginal and Torres Strait Islander communities of the ACT and surrounding region, and delivers a wide range of holistic health care services.

Winnunga today is a multi accredited service, with AGPAL Quality in Practice Accreditation under RACGP standards and QIC. Winnunga's doctors are also accredited to provide supervision to our many GP registrars and medical students. Additionally Winnunga received a 'low risk' rating in May 2013 from the Quality Compliance Section, OATSIH on site risk assessment run by DoHA.

Winnunga provides approximately 40,000 episodes of care per annum. Services have expanded to include a dental clinic, GP and nursing services, midwifery clinic, immunisations, health checks, men's health, women's health, child health, hearing health, physiotherapy, dietician (nutrition), psychiatrists/psychologist, counselling, diabetes clinic, drug and alcohol services, quit smoking support services and a needle and syringe program.

***"Canberra Doctor"* congratulates Winnunga on its first 25 years of service to the community.**

Doctors kept hanging on the telephone

Doctors are being forced to waste hours every week that could be spent with patients, waiting for government bureaucrats to answer phone calls under the Federal Government's cumbersome prescription authorisation rules.

An AMA survey has found that around 17 per cent of family doctors seeking permission to prescribe certain medicines have to wait 10 or more minutes a day to get through to a Department of Human Services clerk, while 3 per cent reported having to wait half an hour or more every day.

Overall, it is estimated that the time spent by doctors on the phone waiting for authority prescription approval is equivalent to more than 25,000 consultations a month.

The system was set up to control the use of certain types of dangerous or addictive medications but, following evidence that it was overly burdensome and prescriptive, the list was trimmed from 450 to 200 items in 2007.

But the AMA said that even in its more streamlined form, the PBS Authority system created significant extra work for doctors with no demonstrable benefit to patients, and should be scrapped.

Drugs for cancer treatment, palliative care and pain management are among more than 100 medicines on the Pharmaceutical Benefits Scheme (PBS) that require medical practitioners to obtain authority from the Department of Human Services to prescribe them.

Under the system, doctors phone the Authority Freecall service, where an administrative officer decides if they can have the necessary authority.

But the evidence shows that it has little affect on prescribing behaviour.

In 2008-09, 6.4 million calls were made to the Authority Freecall Service, of which only 2.8 per cent did not result in an authority being provided.

A Department of Health and Ageing review in 2009 showed that "'there were no substantial changes relative to historical growth trends observed in either total script volume or total PBS outlays" from moving PBS authority medicines to streamlined arrangements.

In its 2009 review of the regulatory burden on business, the Productivity Commission recommended that the system be axed, and AMA President Dr Steve Hambleton said it was time for Government to act on this advice.

"There is no justification, on clinical or economic grounds, for this red tape," Dr Hambleton said. "Time spent by family doctors waiting on a phone line is time stolen from patient care."

He said Government could easily make a significant improvement in the productivity and efficiency of the medical workforce by axing the system.

Can I prescribe ...?

Most doctors know what the rules are for prescribing medicines in Australia. Or do they?

AMA members frequently ask whether they are able to prescribe in certain circumstances. The most common questions are:

- Can I prescribe for myself?
- Can I prescribe for my family?
- Can I prescribe for someone who isn't directly my patient (a third party)?
- Can I backdate prescriptions?

It is understandable that doctors are uncertain, because there is no simple answer.

Prescribing in Australia is regulated by a range of laws.

For a medicine to be prescribed in Australia, the Therapeutic Goods Administration (TGA) must approve it for sale.

However, each State and Territory has its own laws regulating the prescription of medicines. These laws determine who can prescribe, which medicines, in what circumstances, in what manner, for what purpose and additional conditions that must be met to prescribe certain classes of medicines such as certain S4 medicines or S8 medicines.

These laws vary in each jurisdiction, so doctors must be careful they understand and comply with the laws in force where they practice.

Another layer of compliance is added for patients to receive a government subsidy under the Pharmaceutical Benefits Scheme (PBS) when they purchase prescribed medicines. Doctors must comply with requirements and restrictions under Commonwealth laws in order to prescribe under the PBS.

Finally, all doctors are bound by the Medical Board of Australia's code of practice – *Good Medical Practice* – as a condition of their registration to practice in Australia.

So can doctors self-prescribe, prescribe for family or for a third party? Here's what the different laws say.

- Commonwealth, NSW, Queensland, Tasmanian and South Australian laws do not appear to prohibit self-prescribing, prescribing for family or for a third party.
- However, doctors practicing in Victoria cannot prescribe any S4 or S8 medicines for themselves or for a third party.
- In the Northern Territory, it is slightly more complicated as doctors cannot self-prescribe S8 medicines or certain restricted S4 medicines, and cannot prescribe for a third party unless the third party is the partner of a patient being treated for Chlamydia who is also likely to have Chlamydia.
- In the ACT, doctors are only prohibited from prescribing for themselves if they are still an intern or the medicine is a restricted medicine.
- WA law simply prohibits prescribing for the purpose of self-administration.

Good Medical Practice cautions against prescribing for self, family, friends or 'those you work with'. It recommends 'seeking independent, objective advice when you need medical care, and being aware of the risks of self-diagnosis and self-treatment'. It also advises to 'avoid providing medical care to anyone with whom you have a close personal relationship … because of the lack of objectivity, possible discontinuity of care, and risks to the doctor and patient'.

No State or Territory law appears to specifically prohibit backdating of prescriptions. Interestingly, neither does Commonwealth law. While the PBS website states that prescriptions must be not backdated, in fact neither the *National Health Act* or the *National Health (Pharmaceutical Benefits)* Regulations provide any power to enforce this.

However, all prescribing related laws require that the prescriber signs and dates prescriptions. It is likely that the intention, while not enforceable, is that the date is contemporary with the signature.

In summary, it is important that you understand the laws in force in the State or Territory in which you practice. Don't rely on hearsay (or this article) because laws change or can be misinterpreted without legal expertise.

If in doubt, check with the drugs and poisons unit in your State/Territory. The TGA maintains up-to-date contact details on its website at: www.tga.gov.au/industry/scheduling-st-contacts.htm.

Information about PBS prescribing rules is available at www.pbs.gov.au.

The Good Medical Practice is available at: www.medicalboard.gov.au/Codes-Guidelines-Policies.aspx.

(copy supplied by Australian Medical Association)

Key Health Issues for the 2013 Federal Election

At the nationally televised address to the National Press Club to celebrate Family Doctor Week, Dr Steve Hambleton, President of the AMA, outlined the AMAs recommendations to key health issues. They are common sense, practical, and affordable, he said.

Healthier Australian families

The wellness of Australian families is fundamental and must be a priority for the Australian Government. The wellness of families will be enhanced through measures including:

- curbs on alcohol marketing to young people, and appropriate minimum pricing for alcohol products;
- measures to improve environmental health, including better standards for clean air, and greater preparedness for the effects of climate change;
- measures to ensure that all existing coal seam gas extraction projects are regularly monitored for any adverse health effects and for the presence of air and ground water pollutants in their local environment;
- support for the 5-star food labelling system that has been agreed upon by Australian and New Zealand food ministers that will give consumers simple at-a-glance information about the healthiness of packaged food; and
- taking steps to control the exposure of children and adolescents to energy drinks that contain caffeine and other stimulants, and drinks with high levels of sugar.

These simple measures would strongly contribute to healthier Australian families.

Affordable medical services

We must also ensure that health care remains affordable, Dr Hambleton said.

There were five measures in this year's Federal Budget that together will wreak havoc on the affordability of medical services for Australian families.

These changes shift the cost of medical services onto the chronically ill, the elderly, young families, accident and trauma victims – patients who need medical care.

To restore affordability, the next Government must reverse the Budget changes by:

- immediately restoring indexation of MBS patient rebates;
- lifting future indexation of patient rebates to levels that are higher, and are set more realistically, to achieve a slowdown in patient out-of-pocket medical expenses;
- reversing the decision to raise the Extended Medicare Safety Net threshold from 2015;
- restoring tax deductibility of out-of-pocket medical and health care gaps; and

Public hospitals

One of the pillars of our health system is our public teaching hospitals.

We have not included Public Hospitals in our election document, but I cannot leave them out of this speech today, Dr Hambleton said.

They are currently covered by the National Healthcare Agreement between the Commonwealth and the States. Given recent events, Agreement is probably not the right word.

The blame game continues and it must end.

Our public hospitals must be strongly supported with funding and resources. We still need to build capacity in our public hospitals.

Funding must be better targeted, patient-focused, and clinician-led.

This will require unprecedented cooperation between the Federal and State Governments – something we are not seeing at the moment.

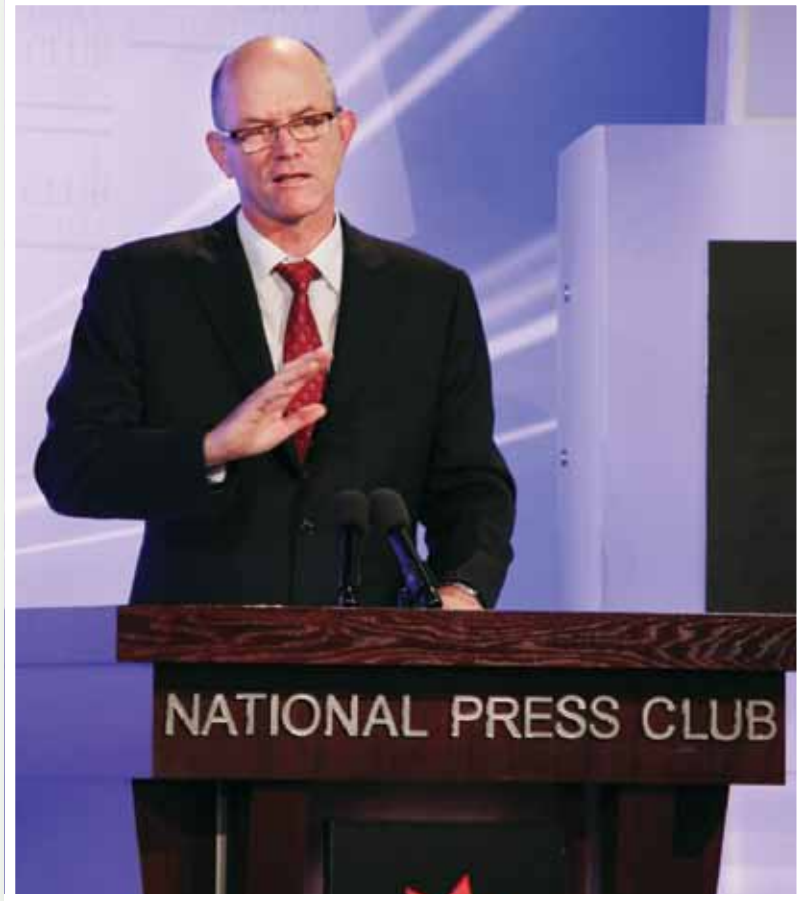
Medical workforce and training

We also need all governments to work together on medical training.

Last year, we saw the blame game play out over intern places - with a last minute deal struck between the Commonwealth and some States and Territories. Crisis management is not a good approach to long-term health workforce planning.

The AMA calls on the next Government, through Health Workforce Australia, to urgently finalise a five-year medical workforce training plan and for the Council of Australian Governments to:

- reach agreement on the number of quality intern, prevocational and specialist medical training places needed, based on the analysis provided by HWA;
- reach agreement on the respective financial contribution of each government; and
- agree on robust performance benchmarks to measure achievement against Health Workforce 2025 targets and COAG commitments, with regular reporting by HWA on progress against these targets.



DrSteve Hambleton

Indigenous health

Some of our governments also need to renew their commitment to improving Indigenous health.

Closing the gap and achieving health equality between Aboriginal people and Torres Strait Islanders and other Australians is a national priority that requires long-term funding and political commitment.

The next Federal Government must continue to show leadership so that all governments sign up to a new COAG National Partnership Agreement on Closing the Gap.

The Partnership Agreement is for another five years starting this year, and there must be at least the same level of funding as allocated in 2008.

Some States are slow in signing up. They must do it now. That would be genuine health reform in action.

Providing medical care for dementia, palliative and aged care patients

As stated earlier, we must also be looking to our ageing population and their special health needs.

Medical care for dementia, palliative and aged care patients requires the regular attention of doctors.

And it requires ongoing doctor management of the patient with the patient's family and carers, mostly outside the doctor's surgery.

Australia's system for funding medical care for these patients is

inadequate. It does not appropriately recognise the time that doctors spend assessing patients, organising services, and providing support and working with the patient's family and carers.

Medicare rebates for services provided by doctors and practice nurses must reflect the time and complexity of providing ongoing dementia, palliative and medical care in the community.

How much more cost effective would that be, compared to spending day after day in an acute hospital bed?

Tackling chronic disease

Likewise, we need specific solutions for the dramatic increase in chronic care needs across all age groups. GPs are already increasingly treating older patients with more complex needs.

The management of chronic and complex disease is a key part of general practice, comprising more than a third of all problems managed.

The chronic problems most often managed by GPs are hypertension, depression and anxiety, diabetes, cholesterol-related disorders (brain and heart attacks), chronic arthritis, oesophageal disease, and asthma.

Many older patients suffer from two or more such chronic illnesses simultaneously, and this significantly complicates diagnosis and management. This is also true for Aboriginal people and Torres Strait Islanders.

Australia has moved to implement more structured arrangements through Medicare to tackle chronic and complex disease, but more needs to be done.

The Department of Veterans Affairs (DVA) has initiated the Coordinated Veterans Care (CVC) program. It provides additional funding support to GPs to provide comprehensive planned and coordinated care to eligible veterans with the support of a practice nurse or community nurse.

This program is designed to reduce avoidable hospital admissions and deliver overall savings to the health system. The DVA CVC program was developed with strong clinical input and has broad stakeholder support.

We need a broad coordinated care program to tackle chronic and complex disease based on this model.

General practice infrastructure

We also need a coordinated plan for general practice.

For starters, the AMA wants to see the end of the GP Super Clinics program. It has been an expensive failure.

In contrast, the smaller and more modestly funded Primary Care Infrastructure Grants Program has been evaluated by the Australian National Audit Office and shown to be excellent value for money.

For an investment of just $117 million over four years, the Commonwealth has been able to support around 450 practices.

These practices have been able to expand services for patients and become more involved in teaching and training the next generation of GPs.

The next Government must increase GP infrastructure grants funding by an additional 600 grants at the level of the existing grants. This would enable a third round of GP infrastructure grants to support quality primary care through general practice.

Medicare Locals

In regard to broader primary care reform, the AMA has, at times, been critical of the role of Medicare Locals.

The AMA generally supports the Medicare Locals concept to improve the interface between hospitals and primary care and to help GPs to give their patients better access to services.

The problem, to date, with many Medicare Locals has been inefficient implementation, which has been characterised by poor engagement with GPs and the loss of GP involvement in decision-making structures.

This must be addressed if the AMA is to become more supportive of Medicare Locals.

The Personally Controlled Electronic Health Record (PCEHR)

The same can be said about the approach to electronic health.

The AMA has been a strong supporter of the concept of a shared electronic health record.

An e-health system that connects patient information across health care settings, and which can be accessed and contributed to by treating medical practitioners and other health practitioners, will improve the safety and quality of medical care in Australia and underpin the reform that Australia needs.

The benefits of e-health in making the best use of existing health care services and avoiding errors, duplication and waste are well known.

To treating doctors, e-health means being able to access all of the clinically relevant medical information about a patient at the time of diagnosis or treatment.

We note that the roll-out of the Personally Controlled Electronic Health Record (PCEHR) has been slow and patchy across the country. The AMA is not surprised.

The design of the PCEHR means that its use is limited for doctors in terms of accessibility, content, accuracy, and the comprehensiveness of information.

Health care of the patient is best served when the doctor has access to the most basic information that is critical to patient care.

This includes pathology and diagnostic imaging results, hospital discharge summaries, information on prescribed medications, and GP health summaries.

Doctors want to use the PCEHR to enhance clinical care.

If the Government wants to see increasing use of the PCEHR, it should be a reliable source of the information that makes a difference to clinical care.

We urge the next Government to consult more closely with the profession to overcome these hurdles.

The AMA wants to see the benefits of e-health flow on to efficient and effective patient care.

Appropriate health care for asylum seekers

Another issue of great concern to the AMA is the health of asylum seekers. We have raised our concerns regularly in political forums.

The arrival of asylum seekers to this country has been politicised to the extent that it has become an ugly, bitter and divisive matter in the community.

I will not go into the politics of it, but I will go into the health and social justice elements of it.

The AMA believes that once we take responsibility for people seeking asylum in Australia, they should have access to an appropriate level of health care, whatever the detention arrangements or location in which they are placed.

Those held offshore inherently have poorer access to specialist health and medical care than those held onshore.

Asylum seekers typically have multiple health conditions that require complex treatments, and health emergencies need to be treated quickly – but being offshore makes it harder.

The prospect of indefinite detention poses a great risk to the mental health of detainees, often resulting in self-harm and attempted suicide.

The stress and trauma of indefinite detention has life-long health effects on children. Community detention is much less likely to cause harm.

We need independent and systematic monitoring of the health of asylum seekers. There are currently no Commonwealth agencies that are free to report on this.

The Commonwealth Ombudsman and the Australian Human Rights Commission periodically undertake inspections of immigration detention facilities, but their expertise does not extend to assessing the health of asylum seekers.

The hamstrung Detention Health Advisory Group – DeHAG – has become the Immigration Health Advisory Group – IHAG. Unfortunately, IHAG – despite its best intentions - is also severely constrained in its ability to monitor or speak out about these issues.

The next Government must establish a truly independent medical panel to oversee, and report regularly on, the health services that are available to asylum seekers in immigration detention facilities, both onshore and offshore.

This would be a true sign of a compassionate country.

Greens' asylum seeker health panel policy must be supported by major parties

AMA President, Dr Steve Hambleton, today called on the major parties to support the Australian Greens' policy to establish an independent health panel to monitor the health of asylum seekers in detention.

The AMA has been calling for such an independent Expert Health Care Panel for two years.

The Greens today released a policy to address the health needs of asylum seekers sent to detention in Nauru and PNG.

Dr Hambleton said that the Greens' policy is very welcome and goes a long way towards addressing AMA concerns about the health of asylum seekers detained offshore.

"Asylum seekers usually have multiple health conditions that require complex treatments," Dr Hambleton said.

"People held offshore inherently have poorer access to specialist health and medical care than those held onshore.

"But all asylum seekers in detention are vulnerable to serious and chronic conditions that require constant medical care and supervision.

"There are still thousands of people in onshore immigration detention with serious health and mental health issues.

"The prospect of long-term detention – both onshore and offshore – poses a great risk to the mental health of detainees, often resulting in self-harm or attempted suicide.

"The stress and trauma of indefinite detention has life-long effects on children.

"We would like to see the Greens extend their policy to include the monitoring of the health care of asylum seekers in onshore detention facilities

"And we urge the major parties to support this initiative. It is the right thing to do."

Extension to ePIP Secure Messaging Product commissioning deadline

General practices that have booked, arranged or registered by Thursday, 1 August 2013 for their compliant secure messaging delivery (SMD) product to be commissioned will now have up until 31 October 2013 for the commissioning to take place.

This extension for the Secure Messaging requirement under the Practice Incentives Program (PIP) eHealth incentive was announced last Friday evening.

Practices that have taken steps by Thursday 1 August 2013 to arrange for the SMD product to be commissioned will need to retain evidence to demonstrate eligibility for the extension.

You can arrange commissioning through your SMD product supplier, secure messaging service provider, Endpoint Location Service operator or systems integrator. More information about the SMD requirement can be found at www.ama.com.au

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Joining Fee: $230 (save $140)
1 Year Membership: $372 (save $113)
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To renew your Qantas Club Corporate Membership contact the secretariat to obtain the AMA corporate scheme number.

For new memberships download the application from the Members' Only section of the AMA ACT website: **www.ama-act.com.au**

For further information or an application form please contact the ACT AMA secretariat on **6270 5410** or download the application from the Members' Only section of the AMA ACT website: **www.ama-act.com.au**

Urological Society welcomes prostate cancer testing consensus

Most of the conclusions reached on prostate cancer testing by an international panel of urologists, and announced in Melbourne recently, are consistent with the position of the Urological Society of Australia and New Zealand, which launched its own official recommendations on PSA testing in 2009.

The statement supported a Baseline Prostate-Specific Antigen (PSA) test for men in their 40s as a useful tool in predicting the future risk of prostate cancer, coupled with the use of active surveillance to reduce overtreatment of lower risk disease.

"We acknowledge and appreciate the contribution of these international experts to the latest statement," says Vice-President of the Urological Society, Professor Mark Frydenberg.

However, there are still unanswered questions regarding frequency of PSA testing in men of all ages and these questions, among others, are currently under review by both the NH&MRC and PCFA/Cancer Australia, and the Urological Society is pleased to be invited to contribute to both panels.

"This means consensus can be built, not only among urologists, but also the non-urological community, so GPs and patients have clear and concise guidelines, and can be reassured they are getting multi-disciplinary agreement about early detection strategies for prostate cancer," says Professor Frydenberg.

Men's Health

An obese grandfather could heighten the risk of unhealthy weight gain in both his children and grandchildren in a disturbing insight into the long-lasting affects of poor nutrition and lifestyle.

Researchers from the University of Adelaide's Robinson Institute have found that molecular signals in sperm of obese fathers can lead to obesity and diabetes-like symptoms in two generations of offspring, even if the offspring eat a healthy diet.

The researchers examined two groups of mice, one fed a high fat diet for ten weeks and the other kept on a control diet. Both groups were mated with mice on a control diet.

Researchers found the offspring of the mice whose fathers were on the high fat diet were 21 per cent more likely to become obese.

Lead researcher Dr Tod Fullston said the father's diet changed the molecular makeup of their sperm, which in turn may have programmed the embryo for obesity or metabolic disease later in life.

"For female offspring, there is [also] an increased risk of becoming overweight or obese. What we've also found is that there is an increased chance of both male and female offspring [of an obese father] developing metabolic diseases similar to type 2 diabetes.

"This is the first report of both male and female offspring inheriting a metabolic disease due to their father's obesity.

"It's been known for some time that the health of a mother before, during and after pregnancy can impact on her child's health, but the father's health during this period is often overlooked.

"If our laboratory studies are translatable to humans, this could be a new and as yet unexplored intervention window into the epidemic of childhood obesity."

The research was published in the *FASEB* journal.

University of Adelaide researchers have also found that men who get up more than once a night to pee could be suffering from a range of health conditions.

Professor Gary Wittert, Director of the Freemasons Foundation for Men's Health, said the need to urinate at night is a problem with urine storage, and this disrupts sleep. He said it is an indication of, and can also exacerbate, other health conditions.

"Nocturia, combined with the sensation of not being able to hold on (urgency), or frequent urination, suggest the presence of overactive bladder syndrome," Professor Wittert said. "We are now beginning to understand the broader relevance of this in relation to other health problems."

One on five Australian men aged 40 years or older, and a third of men aged 70 years and older, have overactive bladder syndrome.

Researchers examined lifestyle, metabolic and physical factors associated with the progression or improvement of lower urinary tract symptoms.

Researchers found that men with a higher level of physical activity were found to reduce or eradicate lower urinary tract symptoms more quickly than men who were less active.

Men who were widowed, had higher plasma estradiol and had depression were more likely to suffer an increase in the severity of their condition, but the symptoms reduced dramatically when these issues were addressed.

Lead researcher Dr Sean Marin said the presence of lower urinary tract symptoms, although commonly thought to relate to the prostate, may have more to do with factors outside the bladder and prostate.

"These urinary problems are associated with other conditions, such as sleep apnoea, depression or anxiety and obesity, and many of these problems are treatable or modifiable," Dr Martin said.

"As we've seen in our study, men can overcome their urinary problems if the underlying issues are correctly managed."

Professor Wittert said nocturia and overactive bladder syndrome are also risk factors for type 2 diabetes and cardiovascular disease.

"Often when a man presents to his GP about urinary problems, the first assumption is that it's all because of the prostate. However, our message is: men who are suffering from any of these waterworks problems are also likely to be suffering from a range of other health problems that should be looked for and managed.

"In this way, men have a greater chance of reversing their bladder problems and potentially preventing more serious disease."

The research was published in The Journal of Urology.

‘Cap’ deferral will allow proper consultation on education expenses

AMA President, Dr Steve Hambleton, said the wise decision by the Government to defer the introduction of the proposed $2000 cap on work-related self-education expenses until July 2015 would allow proper informed discussion that should lead to the scrapping of the cap by the next Government.

Treasurer Chris Bowen announced the cap deferral as part of the Government’s Economic Statement.

Dr Hambleton said the AMA and the Scrap the Cap Alliance have been lobbying against the proposed cap since former Treasurer, Wayne Swan, released the ill-informed policy back in April.

“This decision is a big win for common sense ahead of the election,” Dr Hambleton said.

“The education expenses cap was a bad policy in April this year and it will still be a bad policy in July 2015 – but we now have more time to convince the next Government to scrap the cap.

“The cap would provide a significant disincentive to doctors to continue their training and education throughout their careers, with their patients and communities the ultimate losers.

“Quality medical education is expensive and the $2000 cap defied the reality faced by doctors wanting to improve and broaden their skills.

“Rural doctors and doctors in training would be the worst affected.

“Opposition to the cap is significant and growing, with many of Australia’s peak professional organisations joining the Alliance to fight the imposition of this new tax on learning.

“The Alliance met in Canberra recently and sent a strong message to the Treasurer’s advisers who attended the meeting.

“The AMA is pleased that the cap has been deferred, but we vow to continue our campaign to have this dumb policy scrapped altogether,” Dr Hambleton said.

GP shortages a thing of the past ...

The recently released the ACT General Practitioner (GP) Workforce Scoping Study Report for 2013 shows that the GP shortage has eased.

The GP Workforce Working Group (GPWWG), as part of reviewing its role, the effectiveness of its activities and to plan strategies for the future, decided to seek a new survey of GP workforce along with projections. The survey team, Rural Health Workforce Australia, acknowledged the GPWWG’s leadership in commissioning the study and acknowledged the Chief Ministers’ commitment to the process and the ACTML for funding the survey. Dr Ian Pryor, former AMA ACT President, chairs the GPWWG.

This survey also compares the data obtained from the Government’s GP Taskforce workforce study completed in 2009.

The survey’s intention was to provide up to date information on the local GP Workforce following the implementation of a number of specific initiatives to assist the work of GPs and encourage more doctors to consider life as a GP.

“With 400 GPs in the ACT, we are now on par with the last recorded (2010-11) national average of 1 GP for every 893 people, demonstrating an easing of workforce pressures, which is good news for the Canberra community,” the Chief Minister said.

“It is particularly pleasing to note that 88% of practices report they are taking on new patients and GP numbers have increased overall in the Territory.

“The ACT GP Workforce Scoping Study report is another example of collaboration between ACT Health and the ACT Medicare Local to conduct research to better understand the general practitioner workforce in the ACT. It will help with workforce forecasting and forward planning to meet the healthcare needs of the city and the region.

“It shows that our investments in programs such as the Education Infrastructure Support Grants Payment, the GP Scholarships Program, the GP Development Fund, the GP Aged Day Service and the Prevocational GP Placement Program have been making a difference,” the Chief Minister said.

ACT Medicare Local (ACTML) Chair, Dr Rashmi Sharma said to address GP workforce shortages, ACTML and the ACT Government jointly employ a Marketing and Support Advisor to motivate and inspire potential GPs to see Canberra as a viable employment option.

“Since 2008, the program has attracted 51 GPs to take up a position in Canberra through a recruitment marketing campaign. ACTML also formed a partnership with ACT Government’s *‘Canberra your future’* team who promoted GP vacancies at international and national employment expos,” said Dr Sharma.

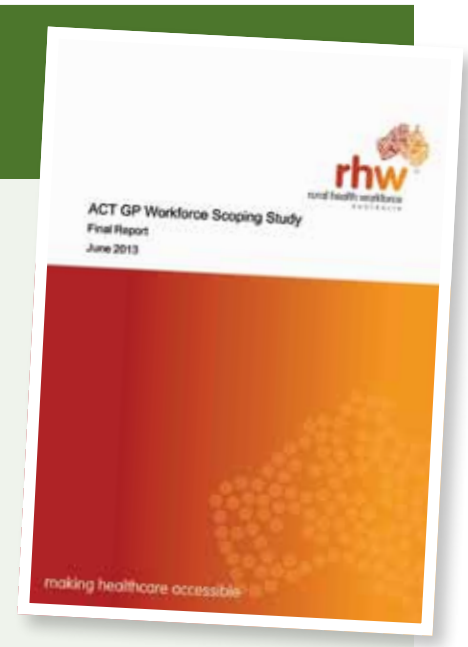
Dr Sharma said ‘growing our own’ GPs is key to increasing and strengthening our general practice workforce, a view supported by the AMA ACT. Local general practices are supporting undergraduate ANU Medical School students and graduates by offering experience in general practice.

“It’s become increasingly apparent that if we are able to train more GPs in Canberra, they are more likely to stay here. This encourages junior doctors to take up general practice as a career and remain working in the town in which they were trained,” said Dr Sharma.

“The report highlights how important it is to continue initiatives that promote general practice as a professionally rewarding and stimulating setting in which to work to retain these GPs in Canberra. Modern general practice is no longer a solo GP but a team with expanded roles so we need to focus on infrastructure investment so they can train new GPs, work in multidisciplinary teams and continue to offer comprehensive primary care services to the community,” said Dr Sharma.

“The study also reports that 26% of ACT GP’s indicate they may retire or move in the next five years. While the true number of GP’s who choose to retire or move on may not in reality be this high, it is something that we will continue to monitor in coming years,” the Chief Minister said.

“We will continue to work with the General Practitioner Workforce Working Group and ACT Medicare Local to continue to achieve improved levels of GP numbers in the ACT,” the Chief Minister concluded.



The ACT General Practice profile:

- Headcount of 400 GPs (including 31 registrars), equivalent to 283 FTE
- On average GPs worked 27 clinical hours per week
- 41% of ACG GPs work part time
- 50% male/female split
- 41% of GPs intend to reduce their hours within the next 5 years
- 26% of GPs plan to retire or leave the ACT within the next 5 years
- 17% of GPs are above the average retirement age of 59
- 34% of GPs will be above the average retirement age in 10 years or less

Key findings:

- ACT has 77 practices that responded to the Practice Manager snapshot
- 24% of GPs work across multiple practices
- 88% of practices report taking new patients
- Medical practices aver 4.7 GPs
- Medical practices are attempting to recruit 1.2 GP FTE on average
- The average recruitment time for 1FTE GP is 68 weeks

Service provision:

- 81% of the practices offer some after-hours service
- 57% indicated an interest in providing training for medical students and registrars
- The majority of practices that were not interested in providing training (69%) cited a lack of time as the major reasons
- 67% of the practices surveyed involved at least one GP visiting aged care facilities
- 30% of GPs in practices reported they spent 60-100% of their time managing chronic conditions.

LETTER TO THE EDITOR

Sir,

Re: "Vitamin D test and deficiency: New patient results for GPs."

Vitamin D is an interesting hormone – made in one organ, that is the skin and active elsewhere in the body such as brain, nerves, bone, muscle, ligament, cartilage, discs etc. The issue of "when it is deficient" continues to raise interesting points of discussion.

I respect the latest NPS MedicineWise Educational Programme on preventive activities, in particular with vitamin D and in particular with regard to public health issues, as published in the June 2013 Canberra Doctor..

However the question of adequate replacement of vitamin D is complex. I would take issue with their recommendation that routine assessment of Vitamin D not be undertaken. Vitamin D is associated with the regulation of around 3000 of our 25000 genes. From my reading vitamin D receptors crop up in probably all areas of the body, but we have been conditioned by our teachings that its main purpose is related to calcium homeostasis and thus bone health.

The current recommendations for vitamin D levels are based on community sampling during our recent population lifestyle habits whereby we are far less sun exposed than ever before in our evolution. It could be reasonable to suppose that homo sapiens have developed with optimal levels of vitamin D at the high end, and quite possibly beyond, the current recommended "normal range" (50 to 150 nmol/L).

So conversely there may in fact be a "Public Health" logic in routinely screening for vitamin D so that there can be subsequent supplementation if necessary to obviate any related disease process for that individual. I myself have preferred to know recently that my levels are low (35 nmol/L) at my age, such that over a period of restitution I may hopefully obviate any long term adverse effects, subtle as perhaps they may well be across all organ systems.

Thus one could modify the recommendations to suggest that for the person in front of you, it may be in their interest to determine their current vitamin D level. There are numerous emerging papers confirming the widespread prevalence of low vitamin D levels in the community, including several studies in the ACT. With medical student Julian Wicks I recently completed an audit at Calvary John James Hospital Rehabilitation Ward whereby 32% of our average normal community-dwelling patients who are undertaking rehabilitation following largely elective orthopaedic procedures (mainly arthroplasties) had levels below 50 nmol/L. These low levels occurred from the age of 35 onwards, despite purported good sun exposures.

Of course, I would be happy to be informed otherwise of the importance of vitamin D deficiency by those more learned in the field. In the meantime I will prefer to continue to optimise my, and my patients', vitamin D levels over the longer term, starting at a younger rather than older age.

Kind regards,
Dr Geoffrey Speldewinde

A lovely new kite, but we need to make it fly

Opponents of smoking have had a rather good year.

After legislation was passed earlier in 2012, from October last year we saw repulsive packaging replacing the glamorous packs of old.

But what did the change in packaging actually achieve? There is evidence that it reduced enjoyment of smoking, but was there any acceleration in quitting in an already declining market? That will be hard to demonstrate.

We can take heart, however, from the recent announcement by the UK government that it was 'deferring' promised legislation until evidence of effectiveness came from Australia. Would Big Tobacco have continued its lobbying in the UK if it did not still fear that conversion of packaging would reduce consumption even further?

Big money

Recently the (present) government announced 12.5% increases in excise over the next four years, starting from 1 December 2013. We should expect whoever wins the election to keep this promise, if only because they will need the revenue.

One thing that all concerned, even the manufacturers, agree on is that increases in price reduce demand for tobacco products. Cancer Council Australia CEO, Professor Ian Olver, estimates the excise increases would prompt around 210,000 Australian smokers to quit.

Quitting reduces harm. "More than half of all long-term smokers will die prematurely of a smoking-caused disease," Professor Olver said. "So if people who are prompted to quit by the measure would otherwise have smoked long-term, we can estimate that up to 100,000 Australians can avoid a premature death.

"Add to this a projection that at least 40,000 fewer kids aged 12 to 17 would be deterred from smoking, and the estimate of 100,000 deaths avoided is conservative."

Professor Olver said increasing the cost of tobacco products was particularly effective for people on lower incomes, who bear the brunt of tobacco disease burden in Australia, and young people.

Licence to kill?

But we mustn't stop there. New approaches are needed to keep pressure on parliamentarians and the tobacco industry. Last year Prof Simon Chapman of the University of Sydney, who has done more than most over a long time to reduce smoking in Australia, proposed a licensing system for adult smokers using identity-verifying smart-card technology. Cards would be issued to adults who

wished to buy tobacco products, and swiped at each sale.

Could this work? The technology is there, according to Magnusson and Currow in the MJA of 5 August. A licensing scheme would give us lots more information on smoking habits, and in turn this would give us better directed anti-smoking programs. In addition it will inhibit sales to minors, which even recalcitrant politicians have difficulty arguing against.

Is it politically feasible? I think not yet, as politicians can move only a certain distance ahead of public opinion. That means we need to talk about the idea, because the more we do that, the more we increase its acceptance.

In the meantime we need more information about smokers' purchasing habits. The loyalty schemes of supermarket chains could tell us a lot. It is time for health and consumer interests to ask questions of Woolworths and Wesfarmers.

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ACCC warns small business as 'Yellow Pages' directory scam strikes again

The Australian Competition and Consumer Commission is warning small business operators to watch out for a business directory scam.

There has been a surge in reports from small businesses who have received a fax claiming to be from 'Yellow Page Australia' and 'Open Business Directory Ltd'. On first glance, the fax appears to be seeking confirmation of the contact details for their business. However on closer inspection, the fax is in fact an agreement to sign up to an online business directory service charged at $99 per month for a minimum two-year period.

Businesses are tricked into thinking the fax is affiliated with Sensis' Yellow Pages® directory by using this well-known Australian company's name and 'Walking Fingers' logo. However, Sensis warns that 'Yellow Page Australia', 'Online Business Directory' and the website 'www.yellow-page-australia.com' are in no way connected with Sensis or Telstra.

A 'Yellow Pages' scam has previously targeted Australian businesses. In April 2011, the ACCC successfully prosecuted two overseas companies for sending thousands of these types of faxes to local businesses. The Federal Court imposed penalties totalling $2.7 million against the perpetrators. Authorities in the United States and Canada also successfully prosecuted other scammers behind this global scheme. Whilst the perpetrators from this round of faxes appear to be different, the conduct is nearly identical.

"Scammers are very sophisticated and target small businesses at busy times when they're more vulnerable to fall victim. The perpetrators behind this 'Yellow Pages' scam would likely be trying to take advantage of the new financial year period to trick busy businesses into signing up to an unwanted service," ACCC Deputy Chair Dr Michael Schaper warned.

"While reports suggest that Australian businesses are alert to the scam and haven't been duped, this batch of faxes indicates an invoice due date right in the middle of tax time. As in the past, these scammers may soon start hassling businesses for payments, including threatening them with late payment fees. If you refuse to pay, the scammers might try to intimidate you by threatening legal action or debt collection."

SCAMwatch urges small business operators to be alert and follow these three key rules:

- If you receive a 'Yellow Pages' fax or email, bin it. Sensis will never approach you this way.
- If you get a threatening phone call, email or fax demanding payment - ignore it and report it.
- Spread the word. Ensure employees are aware of this scam and know how to protect your business.

"Don't let scammers slip under your radar during tax time. Stop and think twice before you respond to any unexpected offers, tax invoices or demands for payment," Dr Schaper said.

If you think you have come across a scammer, you can report it to the ACCC via SCAMwatchhttps://www.scamwatch.gov.au/content/index.phtml/tag/reportascam/ or by calling 1300 795 995.

The SCAMwatch radar is available at http://www.scamwatch.gov.au/content/index.phtml/itemId/1069844

For more information on the ACCC's successful 2011 court action against this type of scam, seehttp://www.accc.gov.au/media-release/27-million-penalty-for-fake-yellow-pages-directory-scam

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GP after hours support increased by ACT Medicare Local

In the July edition of "Canberra Doctor", the AMA advised GPs regarding contracts with Medicare Locals for provision of after-hours services.

Leanne Wells, CEO of the ACT Medicare Local (ACTML) has advised that the ACTML continues to assist and advocate for general practices in the ACT to provide after hours care.

ACTML is pleased that 100% of eligible practices submitted an Expression of Interest for participation in the ACTML After Hours Incentive Payment Scheme. To date, 63 out of 65 revised contracts have been executed.

To achieve this success, ACTML swiftly acted on GP concerns about particular aspects of the initial service agreements. ACTML quickly raised GP member issues with the Department of Health and Ageing (DoHA) around the initial agreement. Within 24 hours of DoHA informing ACTML of revised contracts guidelines, ACTML received legal advice and issued a letter of variation highlighting altered and deleted clauses to all 65 practices (despite 25% of initial service agreements already being signed).

To ensure general practices already providing after hours services maintained financial assistance, earlier this year ACTML proposed to DoHA a model to replace the Medicare Australia's After Hours PIP Program. ACTML advocacy was successful and all funding that was previously directed to general practice through the After Hours PIP (which ceased 1 July 2013) and General Practice After Hours Grants Scheme, has been redirected by the ACTML Scheme. General practices have continued to be supported financially.

In addition, 18 months prior to the PIP ceasing, ACTML has funded general practice an additional $250,000 to support improvement in capacity and provision of after hour services through two grant funding rounds. In 2013/14 ACTML made a further $100,000 available through an additional grants round. The assessment process is currently underway.

For further assistance, please contact Hailey Shaw, ACTML After Hours Program Manager on 6287 8099.