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It's all over, and only time will tell if they listened ...

After a particularly lack lustre political campaign, the result is as predicted and the new Liberal Government under Tony Abbott will determine the health agenda for the next three years. Whilst it is anticipated that Peter Dutton will be the new Health Minister this is yet to be confirmed.

Big gaps in health policies from major parties

On September 4, just ahead of the election, AMA President, Dr Steve Hambleton urged the major parties to plug the gaps in their election health platforms.

Dr Hambleton said that there are lots of votes in positive, forward-looking health policies and there is still time for Mr Rudd and Mr Abbott to pitch more comprehensive health policies to the electorate.

"I set a health policy challenge at the National Press Club in July," Dr Hambleton said.

"We currently have a new set of problems and challenges in meeting the health needs of the Australian community, and they require a new set of solutions – and that is the great task for the major parties.

"Any change must be tested against the reasons we need proper health reform – mainly our increasing burden of chronic disease and our ageing population.

"Proposals should be moving us toward a joined-up, strengthened primary health care system built on team-based solutions.

"The Labor emphasis to date in this campaign has been on hospital infrastructure, while the Coalition is concentrating on primary care, especially general practice.

"The Greens have focused on access to healthcare, public health and environmental health. They have a policy that supports the AMA proposal for an independent panel to assess the health of asylum seekers.

"No party has yet produced a comprehensive Indigenous health policy that would provide significant new funding and direction to build on the modest but welcome successes to date of the Closing the Gap strategy.

"The ideal health policy for this election would combine elements of each of the policies on offer from Labor, the Coalition and The Greens – topped with a 'big bang' Indigenous health policy and a well-articulated approach to dealing with the growing impact of chronic disease.

"We encourage the major parties to commit to practical and affordable policies that would improve public health, help the most vulnerable and disadvantaged in the community, and ensure a strong, highly skilled medical workforce to meet the future health needs of the community.

"The AMA released a Key Health Issues plan in July, which set out achievable policies that would deliver health service improvements at the front line, directly to patients.

"Some elements have been addressed, but many haven't.

"We remind our political leaders of what they can do to bolster their health credentials in the final days of the campaign."

Indigenous Health

No significant new funding or direction to build on the modest but welcome successes to date of the Closing the Gap strategy.

Scrap the Cap

The Government deferred its ill-considered cap on the tax deductibility of self-education expenses, but no party has yet been prepared to dump this policy, which is bad for education, productivity, and the economy, as well as the safety and quality of our health services.

Medical Training

The AMA remains committed to working with the next Government to come up with a long-term policy that supports medical education and training.

Despite the major parties announcing additional intern places in the private sector, which were welcomed, no party has tackled the need to better coordinate the medical training pipeline or address the looming shortage of prevocational and specialist training positions as predicted by Health Workforce Australia.

There needs to be a concerted effort through COAG processes to commit to additional prevocational and specialist training places, including in general practice, with funding to match, in order to ensure that Australia can properly address future community health needs

Chronic Disease

The major parties need to do more to tackle the impact of chronic disease so that we can keep people well and out of hospital. Current Medicare arrangements impose too much paperwork on GPs and limit access to services for patients with higher health care needs.

The major parties need to do more to support GPs in caring for these patients by streamlining current Medicare arrangements and by looking to adopt innovative approaches such as the Department of Veterans' Affairs Coordinated Veterans Care program more broadly.

Rural Health

Rural health has still missed out on the big funding boost it needs to address rural medical workforce shortages.

The AMA/RDAA Rural Rescue Package outlines the funding required to get more doctors into rural and remote Australia, with the right mix of skills to deliver services to these communities

Healthier Australian Families

There has been no specific policy announcement from Labor or the Coalition on significant public health concerns around Better Environmental Health (effects of climate change, better standards for

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TERRITORY TOPICALS – from President, Dr Andrew Miller

Dr Andrew Miller

This is a year of notable anniversaries. It is with great pleasure that I report that our CEO Christine Brill has just celebrated her 30th anniversary with the AMA. Christine has been a stalwart of our organisation, providing energy and wisdom to our enterprises such as Canberra Doctor. She has also brought together a skilled team of dedicated staff to our secretariat that enables us to punch well above our weight. Congratulations Christine and thanks.

The ACT government is undertaking a review of motor vehicle third party insurance arrangements. This has in part been inspired by the impending NIIS which will provide a care structure for the catastrophically injured. In a recent meeting I was reminded that the government has already introduced a measure to accelerate treatment, with a rehabilitation focus, to people injured in motor vehicle accidents in the territory. This provides them with early access to care up to $5000 without the need to access any common law "remedy". Receipts or invoices should be presented to the third party insurer, together with the accident notification and police report no later than 30 days after the accident. This scheme has not been widely taken up and as practitioners we should be aware of its availability to our patients.

So the election is over and Australia is again open for business. It remains a concern that both major parties struggled so hard to keep health off the election agenda. Politicians use the word mandate a great deal to argue for, and against, the activities of government. I suspect that we will hear a great deal about mandates over the next few months. We would have to search high and low to find anything "mandatable " however in the health debate leading up to the election. I can well understand that some readers may now be searching for a napkin to mop up their spilled coffee as they wonder where they were when the debate happened.

In The Conversation (10 September 2013) Stephen Duckett has provided an interesting insight into the reasons why Labor may have been reticent in producing real policies for the election. The "small target" tactics played by the Coalition enabled them to duck effectively the epithets and accusations launched in their direction. So what did the coalition promise, and how may this reflect on health care in the ACT?

One of the first that comes to mind is the promise to work with gambling venues to reduce the social and family costs caused by problem gambling. This process will start with the scrapping of the mandatory pre-commitment trial being conducted in the ACT (although admittedly the trial was faltering). Instead we will have an industry council established to develop "a detailed plan for the roll-out of appropriately targeted counselling and support services for problem gamblers at gaming venues".

The commitment to halt the super clinic programme must be welcomed. Actual outcomes of the scheme have been few, and the accusation has been made repeatedly that the decision making processes behind the scheme had favoured marginal Labor electorates. The AMA has long opposed this scheme in favour of better targeted and more cost effective general practice infrastructure grants. The Coalition has promised to expand this scheme but will be requiring the practices to have a financial stake of their own in the infrastructure project.

The Coalition has also promised to increase payments to general practices for teaching medical students. The ANU has an extensive programme of general practice placements for its students and we must all applaud this move. There is also an allocation for expansion of intern places by 100 per year including funding for non-traditional placements. Here I think we need to be watchful. Paul Smith in Australian Doctor (9 September) has discussed the diversion of PGPPP positions to provide extended intern positions for international graduates from Australian medical schools. Of course the PGPPP was developed to encourage young doctors to consider a career in general practice as a first choice of professional direction. I leave it to readers to decide how supporting our medical schools' commercial product by securing intern places for international students may serve this ambition.

The effect that private health insurance policy has on public hospital case-load, and on private health insurance uptake has long been a subject of debate. The Coalition has promised to restore the private health insurance rebate when fiscally practicable. The available data suggests that the introduction of means testing for rebate eligibility has not resulted in an exodus from private health insurance. There has nevertheless been a steady increase in the number of privately insured individuals electing for admission as public patients. This almost certainly reflects concerns about the increasing out of pocket expenses that Australians face; and general uncertainty about the economy and personal financial security. I direct readers to articles by Anthony Harris and Terrence Cheng in The Conversation (1 July 2013) for a provocative discussion of these issues.

It remains beyond debate that the public hospitals sector is underfunded and lacks capacity. The best way of funding the system is a matter of agreement between both parties, with activity based funding being the consensus approach. Territorians must nevertheless be feeling a frissance of concern regarding federal funding commitments for our local public hospital system (alas, Steve Bracks).

I am glad to see that the Coalition has promised a review of the PCEHR. The cost to date has been huge, an estimated $1 billion, with the target of 500,000 individual records by 30 June being missed by a 20% shortfall; and less than 5000 practitioners signing up to access the portal. It is a little disingenuous I suppose to overlook the fact that development costs will undoubtedly precede any output volume. The fact is that nothing I hear about the record in its more recent iterations reassures me that it will be at all useful in patient care without posing a huge distraction and offering little time benefit over the traditional ways of acquiring patient information (it's called a phone). When doctors are asked what they need the aspirations are simple; allergies, medications, diagnoses and investigation results. I see little progress so far in meeting these in any utilisable format. I note with concern the mass resignation of medical advisors from NEHTA.

The last word on mandates must come from the new Prime Minister; "(Brendan) Nelson is right to resist the intellectual bullying inherent in talk of "mandates". What exactly is Rudd's mandate anyway: to be an economic conservative or an old-fashioned Christian socialist? The elected Opposition is no less entitled than the elected Government to exercise judgement and to try to keep its election commitments"(*Sydney Morning Herald*, 5 December 2007).

It's all over ... continued

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clean air, greater health monitoring of non-conventional gas mining projects), Preventing Harms of Alcohol (curbs on alcohol marketing to young people, minimum pricing for alcohol products), or Asylum Seeker Health (independent panel).

Dementia, Aged Care and Palliative Care

We acknowledge and welcome recent policy announcements around palliative care and dementia, but they do not go to the key issue of access to medical care.

The major parties need to ensure that people with dementia, those who require palliative care, and older Australians with complex and multiple conditions can receive appropriate medical care. The major parties need to do more to ensure the Medicare arrangements are geared to deal with the increasing numbers of these patients and the need to better manage these patients in the community.

Better recognition of and support for the time that doctors spend assessing patients, organising services and providing support to the patient's family and carers would ensure that quality dementia, palliative and medical care for the elderly is provided inappropriate settings. This would relieve the counterproductive use of acute services.

Affordable Medical Services

Immediately restore indexation of MBS patient rebates. Reverse the decision to raise the Extended Medicare Safety Net threshold from 2015. Restore tax deductibility of out-of-pocket medical and health care gaps.

Authority Prescriptions

While the major parties mention tackling red tape, no party has committed to reducing the time wasted by doctors having to telephone the Department of Human Services (DHS) to obtain an authority to write prescriptions for certain PBS medicines. Based on DHS information, up to 25,000 patient consultations are lost while doctors wait for their calls to DHS to be answered.

In the weeks ahead of the election and having considered all the "promises", President, Dr Steve Hambleton stated on 22 August that the Coalition has delivered on a strong package of practical, affordable health policies that would strengthen general practice, the cornerstone of quality primary health care in Australia.

Dr Hambleton said the Coalition has listened to the medical profession and responded with targeted funding that will build on successful existing general practices in local communities and help ensure a steady flow of medical graduates into general practice into the future.

"The Coalition has wisely chosen to invest in local GPs, the health professionals that most Australians choose to see first for quality health care and advice," Dr Hambleton said.

"General practice delivers the greatest return for every health dollar invested. Properly resourced and supported general practice keeps people well and out of hospital.

"The AMA called for more GP infrastructure grants for general practice and the Coalition has promised 175 grants at a total cost of $52.5 million. The Australian National Audit Office has endorsed GP infrastructure grants as a far better investment than money going to failed and discredited GP Super Clinics.

"The AMA called for a doubling of the Practice Incentive Payment (PIP) from $100 to $200 to help local GPs teach medical students and encourage them to pursue a career in general practice, and the Coalition has delivered.

"The AMA has been lobbying long and hard for more intern places to meet growing demand from the increasing numbers of medical graduates, and the Coalition has promised 100 new intern places a year, which is a better package than the 60 places promised by Labor.

"We also support the review of Medicare Locals to ensure funding gets to frontline care.

"These promised measures will be warmly welcomed by Australia's hardworking GPs who have been calling for greater support to help them meet increasing demand from an ageing population and more patients with chronic and complex conditions.

"Under these measures, patients can be confident of better access to quality primary health care from their local family doctor."

Dr Hambleton said the AMA also welcomes Coalition commitments on bowel cancer screening and diabetes research, but urges the Coalition to at least match Labor's funding promises for public hospitals.

So exactly what has been promised:

Peter Dutton, in his debate with former Health Minister, Tanya Plibersek said:

"The Coalition's health policies are policies for the future.

"The Coalition's *Policy to Support Australia's Health System* will tackle chronic diseases, provide faster access to newly approved medicines, invest in Australia's medical workforce and help prepare the health system for the demographic changes ahead.

"I understand, and Tony Abbott understands, that a healthier Australia means a stronger and more productive Australia.

The last Coalition government invested significantly in our health system underpinned by a growing, strong economy.

"The Coalition has the experience and plan to deliver a sustainable and strong health system into the long term.

The Coalition's *Policy to Support Australia's Health System* will:

- Strengthen primary care by providing $52.5 million to expand existing general practices for teaching and supervision;
- Invest $119 million to double the practice incentive payment for teaching in general practice;
- Secure greater certainty for our future health workforce by providing $40 million for 400 medical internships;
- Provide 500 additional nursing and allied health scholarships for students and health professionals in areas of need;
- Restore the independence of the Pharmaceutical Benefits Advisory Committee (PBAC) and restore integrity to the Pharmaceutical Benefits Scheme listing process so that medicines can get to patients faster;
- Provide the Health Minister with authority to list medicines recommended by the PBAC that do not cost more than $20 million in any of the first four years of its listing;
- Develop a new National Diabetes Strategy as well as provide $35 million to find a cure for Type One Diabetes;
- Provide biennial bowel cancer screening for all Australians between 50 and 74 by 2020 through the National Bowel Cancer Screening Program;
- Restore the Private Health Insurance Rebate as soon as we responsibly can;
- Deliver a more efficient funding model for hospitals through activity-based funding; and
- Support greater community involvement in the management and responsibility of local hospitals.

"My approach to health, if the Coalition is elected, will be careful, collegial and consultative.

"We will work with the States and Territories in delivering a world-class health system.

"This will be a stark contrast to Labor's chaotic approach to health.

"With demand for health services expected to grow, we want to direct more resources to the frontline and remove unnecessary bureaucracy.

"By cutting waste, streamlining bureaucracy and providing strong and competent leadership, we can provide much-needed resources to support frontline services and build our health and medical workforce.

"The Coalition has a proud record of strong and capable leadership in health.

"It is my firm belief that the Coalition's reforms can deliver Australians the high quality health system they deserve into the future.

"By shifting the focus to patient outcomes from bureaucracy, we can deliver for all Australians.

The Government will not control the Senate in the short term, so the Greens' and Labor party health policies may also influence the Government's health legislation and legislative timetable.

The AMA lobbied hard on the issues it considered important to the profession and to patients and the AMA will continue to argue for implementation of its agenda over the next three years and beyond. The profession will need to be vigilant and continue to argue for the reforms it sees as important.

Mental and substance use disorders cause rise in global disease burden

Mental and substance use disorders were the leading cause of non-fatal illness worldwide in 2010, according to a new analysis from the Global Burden of Disease Study, published in The Lancet recently

A team of researchers from Australia and the US, led by Professor Harvey Whiteford from The University of Queensland's School of Population Health, reported that the leading contributors were depressive disorders (accounting for 40.5% of mental and substance use disorder burden) followed by anxiety disorders (14.6%), illicit drug use disorders (10.9%) and alcohol use disorders (9.6%).

Professor Whiteford said the burden from mental and substance use disorders is rising, especially in developing countries.

"If the impact of mental and substance use disorders is to be reduced, a global effort is required to implement cost-effective prevention and intervention strategies and to develop innovative ways to deliver these to communities," Professor Whiteford said.

"Treatment rates for people with mental and substance use disorders are low, and even in developed countries, treatment is typically provided many years after the disorder begins.

"In all countries, stigma about mental and substance use disorders constrain the use of available resources, as do inefficiencies in the distribution of funding and interventions.

"We need commitment from policy-makers, governments and other stakeholders to prioritise mental and substance use disorders."

The Study's key findings include:

- Mental and substance use disorders were responsible for more of the global burden than conditions such as diabetes or stroke or infectious diseases such as HIV/ AIDS and tuberculosis combined.
- The burden of mental and substance use disorders varied by age and sex, with the largest proportion occurring in those aged between 10 and 29 years.
- The burden of mental and substance use disorders increased by 37.6% between 1990 and 2010. For the majority of mental disorders, this was due to an increase in population growth and aging; for the substance use disorders it was also due to an increase in prevalence.
- In Australia, the burden of mental and substance use disorders increased between 1990 and 2010 but this was mainly due to increases in population growth and ageing (although opioid use increased significantly in Australia).
- In Australia, mental and substance use disorders, as a group, were the 4th leading cause of total burden and the 2nd leading cause of disability, after musculoskeletal disorders.
- Individual mental and substance use disorders were ranked similarly in Australia to other comparable nations such as the UK, USA and New Zealand (e.g. depression was the 2nd leading individual cause of disability in all these countries, including Australia).
- From the 10 – 14 year age group onwards, girls and women had a greater burden of death and disease from mental disorders than did boys and men, whereas men had a greater burden from drug and alcohol dependence in all age groups.
- The overall findings mask striking differences between world regions for some of the disorders analysed, with eating disorders showing the greatest overall variation; the proportion of total burden attributed to eating disorders was nearly 40 times higher in Australasia, where it was highest, than in western sub-Saharan Africa, where it was lowest.
- The burden of mental and substance use disorders was lower in China, North Korea, Japan and Nigeria when compared to the global average.

Other Australian authors involved with the Study were Dr Rosana Norman, Amanda Baxter, Alize Ferrari, Fiona Charlson and Holly Erskine from the UQ School of Population Health and Professor Louisa Degenhardt from the University of New South Wales.

To read the full article go to: http://press.thelancet.com/GBDsubstancementaldisorders.pdf

Pertussis (whooping cough) immunization in late pregnancy is safe

– writes A/Prof Steve Robson
Vice-President, RANZCOG

Whooping cough is a highly-contagious disease that is well-known around Canberra. Caused by infection with the bacterium Bordetella pertussis, whooping cough commonly begins with runny nose, fatigue, and a low-grade fever, often indistinguishable from a cold. Over a few days, a cough develops that comes in paroxysms that can be followed by a deep gasping breath, or 'whoop.' This is particularly seen in unvaccinated children, and some coughing bouts end in vomiting. While adults and older children may have a less serious clinical course, the coughing component can be very persistent and last for a month or more, irrespective of any treatment. Pertussis has been called the 'hundred day cough' for this reason.

The group at particular risk are young children, especially those under six months of age. Pertussis can lead to pneumonia, and indeed hypoxic brain damage during coughing paroxysms, and death can occur. Almost all deaths from pertussis in Australia occur in infants, usually in children under six months who have not had the first dose of the vaccine. Fortunately, the take-up rate of immunisation for the pertussis vaccination is high, with about 95% of Australian children receiving the full three-dose course (given to healthy children at two, four, and six months). Despite this, the incidence of pertussis cases is actually increasing, and records show that there were nearly 40000 proven cases reported in Australia in 2011, the highest number since national record-keeping began. Some studies have reported that almost one third of all subacute chronic coughing illnesses in adults are due to pertussis.

The most disastrous time of life to contract pertussis is as a newborn, and most pregnant couples now seem to be aware of making sure that the new baby's father, and grandparents and other significant carers, should be immunised against pertussis with Boostrix. However, there is a widespread community perception, shared by a number of primary care doctors, that pertussis immunisation is in some way harmful in pregnancy. This is not the case, and the Royal Australian and New Zealand College of Obstetricians and Gynaecologists (RANZCOG) recently presented a submission to the *Australian Immunization Handbook* supporting universal pertussis immunisation in the third trimester. Unfortunately, our recommen-

dation did not appear in the final version of the handbook.

The current pertussis vaccine is an acellular vaccine, consisting of the key antigenic proteins, and as such does not contain whole virus. The older attenuated virus vaccine was actually withdrawn in the late 1990s, and the new acellular vaccine is not quite as effective. It is designed to reduce the chance of infection, but also to reduce the severity and duration of symptoms if infection occurs, and most importantly, reduces the risk of infecting others. While the older vaccine seemed to be more effective, side effects were frequent, with fever, crying, and irritability in children. These are much less common with the newer acellular vaccine.

These days, grandparents are very commonly involved in the care of young children, and it is a pity that funding for vaccination of grandparents has been withdrawn.

The Royal College of Obstetricians and Gynaecologists (RCOG) of the UK successfully lobbied the British Government to fund a program of universal vaccination of pregnant women in the third trimester. There is absolutely no evidence to suggest that pertussis immunisation of otherwise normal healthy pregnant women is in any way unsafe. All of the individual components of the combined vaccine have been used in pregnant women around the world with an excellent safety record for both fetus and mother. There is good evidence that immunisation while pregnant provides protection to newborns in the first weeks of life, before the childhood vaccination course begins at two months.

Prescribing information with the immunisation points out that safety in pregnant women has not been established, but this is because pregnant women are routinely excluded from clinical trials, not from any concern about safety in pregnancy. No international body has ever found evidence of harm in pregnancy where the woman is otherwise healthy and eligible for immunisation.

When healthy pregnant women approach family doctors and medical practitioners to request pertussis immunization, this can be provided with safety and confidence in the third trimester (the earlier the better, after about 28 weeks). Practitioners who have any questions at all should feel free to contact either RANZCOG, or their local obstetrician

Cautionary tale of science commercialisation

The inventor of one of the most widely used health screening tests for newborn babies would have found today's attitudes to the commercialisation of science "distasteful", according to international research involving the University of Adelaide.

In a paper published recently in the *New England Journal of Medicine*, Dr Diane Paul (Harvard University and University of Massachusetts Boston) and Associate Professor Rachel Ankeny (University of Adelaide) detail the commercialisation-gone-wrong story of the Guthrie test, also known as the newborn heel prick test.

Invented in 1960 by microbiologist Dr Robert Guthrie, the heel prick test takes blood from newborn infants to screen for the genetic condition phenylketonuria (PKU) which, if left untreated, can lead to mental retardation, seizures, and other health problems in children.

"Efforts to patent and license the Guthrie test generated controversy at the time but it is not as well known today as it should be. This episode in history can be seen as a cautionary tale for the current debates about commercialisation of research, such as the gene patenting debate," says Associate Professor Ankeny, from the

University of Adelaide's School of History and Politics.

Guthrie believed that commercial production of testing kits would be the most efficient way to rapidly screen more than 400,000 babies across the United States. He filed a patent application and signed an exclusive licensing agreement with a commercial laboratory, handing over his percentage of the profits to groups dedicated to helping children.

When the company couldn't produce enough test kits, Guthrie started making them himself at home, for a cost of $6 a kit. He later discovered that the company planned to charge $262 for their kits.

"Guthrie was appalled by this, and when the company ignored his appeal to drop the price, he alerted public health authorities who had funded most of the research," Associate Professor Ankeny says.

The surgeon general of the Public Health Service later repealed the licensing agreement.

"This whole episode was painful for Guthrie, who realised he'd made a serious mistake in signing the licensing agreement," Associate Professor Ankeny says. "He had a commitment to universal screening and to public health.

"Although attitudes towards commercialisation, and laws, have swung in the opposite direction since the Guthrie case, this story from our recent history still has great relevance.

"The key principles debated in the Guthrie case underlie the conflicts that remain today: between political and economic imperatives to commercialise research, and the social and moral imperatives to promote public health"

The full paper can be found at the New England Journal of Medicine's website

Continued dispensing – coming to a territory near you?

The AMA remains firmly opposed to pharmacists dispensing prescription medication without a valid prescription and without reference to the patient's treating doctor.

Commonwealth legislation for the Pharmaceutical Benefits Scheme was amended last year to allow this - despite the AMA Federal President writing to all parliamentarians asking them to oppose it.

Changes are also required to state and territory legislation to give it effect.

In recent advice from the Department of Health and Ageing, it would appear that the South Australian, Victorian, Tasmanian and Northern Territory governments were expected to amend legislation by 1 September this year, with ACT, NSW and Queensland governments following later.

Western Australia has already amended its legislation to allow continued dispensing to proceed.

The AMAs concerns with the proposal were at the time this was mooted, and still are:

- The initiative represents a significant change in the role of the pharmacist and dispensing medication without a valid prescription is, it can be argued, prescribing, regardless of any protocols on the circumstances when this might occur;
- There was no consultation with the medical profession or other health care providers about how this new role for pharmacists changes the management of patients before it was enshrined in the Fifth Pharmacy Agreement
- There is no collaboration between the pharmacist and the patient's usual general practitioner in managing the patient's medication;
- There is no clarity about what "problem" continuing dispensing is seeking to address; there is no explanation why existing emergency supply provisions are insufficient to deal with truly urgent cases;
- There is no evidence to demonstrate improved patient outcomes, and cost effectiveness; and
- There is no evidence to justify lipid modifying agents as requiring urgent supply.

Medical practitioners place a high value on the professional role of pharmacists and work with them to improve the medication management of patients and their clinical outcomes. Continuing dispensing will allow pharmacists to operate autonomously without acknowledging and examining the effect it will have on fragmentation of care, patient outcomes and quality of prescribing.

A survey of AMA members conducted in 2009 showed that:

Three out of four GP practices have arrangements in place to provide owing scripts to pharmacists within legislative timeframes; and

Nine out of ten GP practices have arrangements in place to see patients who urgently need a prescription and could also provide a prescription to a patient without a consultation if clinically appropriate.

The AMA is of the view that it would be safer for patients and more effective if there were instead consultation with the medical profession that aimed to identify solutions to specifically address the problems the initiative seeks to resolve and has proposed a number of alternative approaches.

In short, the AMA does not consider that dispensing prescription medicines without a valid prescription is not in the interests of better medical management and would be pleased to engage with governments (State or Territory) before they legislate to provide for continuing dispensing.

Continued dispensing – facts for AMA members

'Continued dispensing' is a joint Commonwealth Government and Pharmacy Guild of Australia initiative that allows pharmacists to supply a standard pack of an eligible PBS medicine to patients who request it without a prescription from a medical practitioner.

The Federal AMA lobbied hard to oppose legislation to allow 'continued dispensing' within the Pharmaceutical Benefits Scheme, including writing to all Federal parliamentarians to explain the risks to patients, however the legislation was passed last year.

Legislation in Western Australia, Victoria, Tasmania and South Australia has now also been amended to specifically provide for 'continued dispensing' and may be passed in other jurisdictions over the next few months.

The eligible medicines under 'continued dispensing' are:

- oral hormonal contraceptives for systemic use.
- lipid modifying agents, specifically the HMG CoA reductase inhibitors ('statins') as listed in the Schedule of Pharmaceutical Benefits.

(Refer list below.)

The practice guidelines issued by the Pharmaceutical Society for Australia states pharmacists can supply these medicines by continued dispensing if they consider:

- there is an immediate need for supply of the medicine to facilitate continuity of therapy, and it is not practicable for the patient to obtain a prescription for the medicine from an authorised prescriber;
- the medicine has been previously prescribed for the patient, their therapy is stable, and there has been prior clinical review by the prescriber that supports continuation of the medicine;
- there is an ongoing need for supply and the medicine is safe and appropriate for that patient.

The pharmacist must also be able to identify the most recent prescriber of the requested medicine and their practice address.

The practice guidelines also state that pharmacists will need to balance the risk to patients of delaying review by their medical practitioner with the benefit of continuity of therapy.

Pharmacists must advise the patient's medical practitioner within 24 hours that the medicine has been supplied without a prescription. Information must include

- patient details
- date medicine supplied
- medicine details
- reason for supply by continued dispensing
- declaration co-signed by the patient indicating their understanding and consent to the supply.

Pharmacists must not supply these medicines to a patient if the medicine has already been supplied by any pharmacy by continued dispensing in the previous 12 months.

Continued dispensing is supplementary to existing urgent or emergency supply provisions existing in each State and Territory.

Continued dispensing - eligible PBS medicines

Oral hormonal contraceptives

- Levonorgestrel
- Levonorgestrel with Ethinyloestradiol
- Norethisterone
- Norethisterone with Ethinyloestradiol
- Noresthisterone with Mestranol
- Lipid modifying agents
- Atorvastatin
- Fluvastatin
- Pravastatin
- Rosuvastatin
- Simvastatin

Feedback

The AMA wants to hear about your experiences with continued dispensing.

In particular:

- Have you been contacted by pharmacists to establish that you have recently reviewed the patient for that medication?
- Is the information provided to you by pharmacists after continued dispensing has occurred useful?
- Has there been an impact on the management of your patient?

Please forward any comments to: ama@ama.com.au

Update on "optional protocol to the convention against torture (OPCAT)

In the May 2013 edition of "Canberra Doctor" we reported that the AMA was seeking the support from State and Territory AMAs to advocate for legislation in each State and Territory to allow visits from the UN sub committee on the Prevention of Torture prior to ratification of the Protocol.

The AMA ACT wrote to ACT Attorney General, Mr Simon Corbell seeking his support to legislate to support international monitoring.

Mr Corbell in a letter to President, Dr Andrew Miller, dated 23 May stated:

"The ACT Government is proud of its commitment to human rights, including its upport for ratification of the OPCAT. Like you, we recognise that it is an important opportunity to support monitoring and accountability mechanisms to safeguard the health of detainees.

"On 21 March 2013, I introduced the Monitoring of Places of Detention (Optional Protocol to the Convention Against Torture) Bill 2013 into the ACT Legislative Assembly. I look forward to the full passage of the legislation, and to other Australian States and Territories passing the necessary legislation to ratify the OPCAT.

"Thank you for your letter supporting ratification of this important treaty.

This Bill is still before the Assembly.

AMA congratulates coalition on election win

AMA President, Dr Steve Hambleton, congratulated the Coalition on its election win and said that the AMA looks forward to working with the new Government to provide better health services for all Australians.

Dr Hambleton said that the AMA had a positive and rewarding working relationship with new Prime Minister, Tony Abbott, when he was the Health Minister in the Howard Government, and in recent times the AMA has consulted closely with Shadow Minister for Health and Ageing, Peter Dutton.

"We have a strong foundation with the new Coalition Government, and we would welcome Peter Dutton as Health Minister should he stay in the portfolio," Dr Hambleton said.

"The health policies that the Coalition took to the election responded in part to concerns raised by the AMA, especially in providing greater support for general practice.

"We will be seeking an active role in the review of Medicare Locals and we will be urging the new Government to immediately scrap the cap on claims for work-related self-education expenses.

"In campaigning for this election, Tony Abbott said that he would "under-promise and over-deliver". The AMA is confident that this slogan will apply to health funding and services."

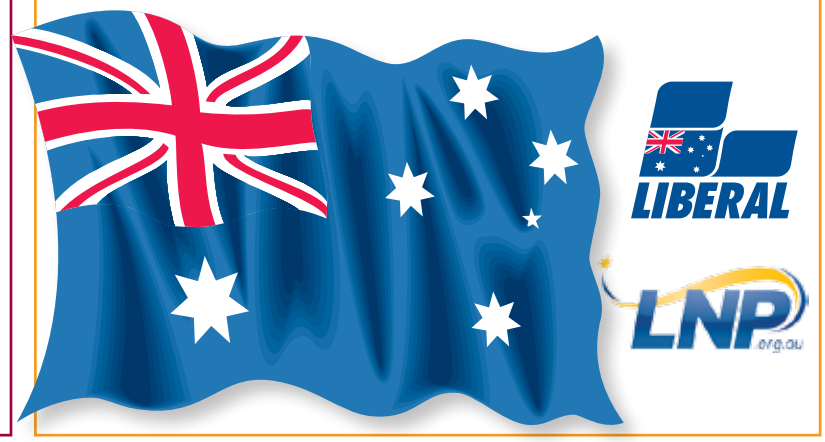
Dr Hambleton also paid tribute to the outgoing administration.

"The AMA at all times had access to Prime Ministers Kevin Rudd and Julia Gillard, both of whom took the advice and views of the AMA seriously," Dr Hambleton said.

"Tanya Plibersek and Nicola Roxon were both quality Health Ministers who will leave a strong legacy in the health sector, especially in public health.

"The tobacco plain packaging legislation is a landmark achievement by Labor in Government.

"We wish Julia Gillard and Nicola Roxon every success in their post-politics careers and look forward to working with Tanya Plibersek and Kevin Rudd in their new roles in Opposition."



Book review

Drive (2006), Driven (2012), and Death will have your eyes (1997): Novels by James Sallis

No Exit Press, Harpenden, Herts, UK (GBP 9.99 each)

James Sallis's neo-noir novels comprise episodes in the life of the enigmatic "Driver". Driver begins as a movie stunt-car driver who becomes a getaway specialist. Drive (2006) centres upon a robbery gone wrong, tracking back and forth between the set-up of the robbery and the relentless arc of Driver's revenge upon those who derailed the robbery and killed his friend.

The narrative careens inevitably forward, crashing through brutal revenge against mob bosses and his existential wanderlust. Set in Los Angeles, a city with arteries of asphalt and concrete, the background is peopled with the shadows and ghosts of Driver's past.

"Driven" (2012) picks up six or seven years later when Driver has morphed into a businessman engaged to be married. However, his fiancé is shot by his former mob enemies and he begins to run again, turning back to chase his pursuers. He recruits new allies and a love of sorts, meticulously exacting relentless revenge, as his wanderlust wakens anew.

In these novels, Sallis's precise, taut prose seems to draw upon his poetic skills, perfectly sketching the parameters of the stories without being terse. The sense of motion: emotional, physical and existential is visceral. Each character and scene is neatly shaded in with just enough detail to appreciate and allowing the reader to fill in and imagine the rest.

"Death will have your eyes" (1997) could be regarded as part of this triptych of road novels, prefiguring the Driver. Ostensibly an espionage novel centring on the first-person narrative of David, a retired elite Cold War spy, the narrative is also threaded through with roads literal, metaphorical and existential. David has been re-activated to pursue a rogue agent and runs a ragged nightmarish route to track his target. As it transpires, the byzantine intrigues that underpin the events gradually loom from the fog of misinformation provided as guidance from his former employers, and David appears to be pursuing perhaps versions of his self, symbolically and maybe literally.

In a sense, in all three novels the endings are prefigured as in the ancient Greek tragedies, such as Sophocles's Theban Plays (see translation by David R. Slavitt, Yale University Press, 2007) or the Norse sagas where the skein of each person's life is woven by the Norns (see Penguin Book of the Norse Myths by Kevin Crossley-Holland, 1980); yet this only sharpens the poignancy of the paths foreshadowed, taken and forsaken, as ever with the tales of our lives.

Reviewed by Associate Professor Jeffrey Looi, ANU Medical School

Consumers, health system and health literacy

AMA recently responded to Australian Commission on Safety and Quality in Health Care consultation paper on Consumers, the health system and health literacy: Taking action to improve safety and quality

The AMA acknowledges that improved patient understanding of their health, health treatments and the health system is advantageous for individual patients and the health care system more broadly.

At a broad level, the AMA supports the concepts and discussion set out in the Commission's consultation paper. There are three areas that require consideration:

- Analysis of existing health literacy activities;
- A balanced expectation of patient participation; and
- The need for health systems literacy initiatives.

Existing activities

The AMA is disappointed that the discussion in the consultation paper implies that very little has been done in Australia to improve health literacy. This is not the case.

In *Health Literacy Stocktake: Consultation report*, the Commission acknowledges that most initiatives are occurring at the health service level. Despite this, the proposals in the consultation paper for addressing health literacy lean heavily on organisations that deliver healthcare services and individual healthcare practitioners.

The Commission must acknowledge the activities that the health sector has already adopted to advance health literacy along the lines the Commission has proposed. This would ensure that any initiatives that eventuate from the Commission's work are targeted and do not duplicate or interfere with existing activities, or impose extra and/or unnecessary expense on the health care sector.

The AMA wishes to highlight to two areas to illustrate this point:

Medical practitioner training

The Australian Medical Council (AMC) *Accreditation Standards for Primary Medical Education Providers and their Program of Study and Graduate Outcome Statements* sets out training and education requirements for communicating and presenting information to patients.

Similarly, the AMC *Global outcomes statement for intern training* builds on the health literacy training in primary medical education.

The Commission proposes that "more intensive training about communication and consultation styles might be appropriate for doctors". The Commission should be very clear about where it considers the existing training for medical practitioners is falling short in order to better focus this proposal. As it stands the consultation paper implies that current training is very limited when that is not the case.

Accreditation

The very first standard of the Australian Council on Healthcare Standards EquIP5 effectively embedded health literacy into healthcare organisations' systems. Criterion 1.1.2 requires for care to be "planned and delivered in collaboration with the consumer/patient and when relevant, the carer, to achieve the best possible outcomes". Within the standard there is reference to: education strategies; the provision of services and support; that explanations should be delivered in a manner suitable to patients, etc.

Similarly, The Royal Australian College of General Practitioners *Standards for general practices* sets out indicators for informed patient decisions, such as providing information to patients and using leaflets, brochures and other written material to support explanations – refer to Standard 1.2 Criterion 1.2.2.

The Commission may want to discuss how current accreditation arrangements are working already to advance health literacy in healthcare organisations and very clearly identify the apparent gaps that have been prompted the Commission's proposal.

Patient participation

The first target of any health literacy initiatives must be to ensure that individuals are able to be healthy and to stay healthy.

An obvious vehicle for this type of learning is through the primary and secondary education systems, ideally embedded in the national curriculum. Investment to improve health literacy in children and adolescents could result in reduced health care costs and improved patient outcomes for future generations.

The second target is health literacy at the time healthcare services are required. At this level the discussion paper is silent on two fronts:

- Patients' needs and preferences; and
- Cost effectiveness of health literacy initiatives.

Patient preferences

Every day treating medical practitioners are faced with a spectrum of patients with varying needs and desires to participate in their health care decisions. This does not necessarily reflect an absence or low level of health literacy on the part of the patient, but rather a preference to utilise professional expertise in order to make health related decisions.

Some patients have no desire to acquire a high level of health literacy or even have input into the decision making process: these patients have sought the expert advice and guidance of their trusted medical practitioner.

Some patients are absolutely prepared and expect to have a strong involvement in the decision making process.

Most patients fall somewhere in between, and even then, depending on their health issue at the time, will have different needs and desires for information about and participation in their health care decisions.

Every day medical practitioners seek to accommodate their individual patients, within the constraints of the health care system and the available time for each patient.

It appears from the discussion that the Commission assumes that all patients want to have a high level of health literacy all of the time. Further, the degree to which health literacy initiatives will enable patients to 'share' health care decision making is contestable. Patient preferences needs further consideration in the discussion paper.

It would not be appropriate to impose requirements on health care organisations or health care providers that would have the effect of forcing health literacy on all patients all of the time. This would be an expensive undertaking for the health care sector, and given that resources are finite, would come at the expense of the delivery of health care services.

Costs

The discussion paper is silent on the issue of the cost of health literacy initiatives.

The statistics on overweight and obesity in Australians recently published by the Australian Bureau of Statistics highlight the challenges of targeting effective health literacy initiatives.

There must be a balanced approach that does not aim too high, but identifies where reasonable steps can have the greatest effect. Given the wide range of health literacy initiatives that already exist, we may almost be there already.

Any new and additional health literacy initiatives proposed by the Commission must be demonstrated to be effective and cost effective.

Health systems literacy

Finally, the AMA notes that the focus of the consultation paper is on health literacy in order to "make effective decisions about health and health care and take appropriate action" as per the terms described.

There is a clear need for improving health systems' literacy so that patients have a better understanding of how the Australian health system works, its structure, how it is funded and what its limits are. This aspect of health care decision making can often be the most challenging and yet unclear aspect for patients. It is an area that medical practitioners, their practice staff (and even the AMA offices) explain to patients on a daily basis, with little support from information published by governments and (non-service provider) health organisations.

Over the coming years, more limits will be placed on the health system as a way of managing the costs of health care to governments, health insurers and patients. It is therefore timely and appropriate for the Commission to encompass health systems literacy in its work.

The responsibility for health literacy must be shared equally between the individual, their community, the education system, media, governments, health insurers and health care providers.

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First-rate defence personnel getting second-rate health service coordination

AMA President, Dr Steve Hambleton, has called on the next Government to commission an urgent audit into the coordination of the delivery of health services to Australian Defence Force personnel by Medibank Health Solutions (MHS).

The call comes amid reports that doctors are experiencing long delays in receiving payment for providing quality off-base care to defence personnel.

The Government announced in February this year that all Defence Health services had been transferred to MHS, with the transition process having been underway since October 2012

Dr Hambleton said that a major AMA survey last year showed that many specialists across the country had refused to sign up to the arrangements being put in place by MHS for the provision of off-base medical services.

"We are concerned that first-rate defence personnel are being provided with second-rate coordination of their health services," Dr Hambleton said.

"It is our understanding that MHS still faces problems in arranging access to off-base specialist services, particularly in areas where major defence facilities are located such as Canberra, Darwin, Townsville and the South Coast of New South Wales.

"We are told that MHS has been forced to use non-contracted specialists as a result.

"It has now emerged that many doctors are not being paid for the provision of services to ADF personnel in a timely fashion.

"The best way to sort out this mess – and deliver to our defence personnel the health services they deserve – is for the new Government to next week call an audit into the MHS operations," Dr Hambleton said.

Despite MHS coordinating appointments for ADF personnel with medical specialists, MHS is insisting on further evidence to be included on invoices and, since August 1, it has been returning many invoices to doctors and other health professionals unpaid. According to MHS, as at the end of July, around half of health professionals were submitting "non compliant" invoices.

Dr Hambleton said that MHS has made no effort to work with organisations like the AMA to communicate this issue to the medical profession.

"Many doctors have already been disenfranchised by the contracting arrangements put in place by MHS and it is our valued service personnel who suffer as a result."

AMA Careers Advisory Service – meeting the needs of the profession

Since the launch of the AMA Careers Advisory Service in September 2012 there has been a keen interest from and growth in engagement from members of the medical profession, and medical students, in seeking advice and assistance along their medical career journey.

General advice and assistance can be sourced via the Careers website and personal advice and assistance is available via individual consultations with the AMA Careers Consultant. These consultations are provided via phone, email and face-to-face meetings.

The website includes information on the developing medical career beginning with medical students through to doctors in training and on to GP/Specialists and even addressing the area of career change either within the profession or outside.

There is also a section relevant to International Medical Graduates (IMGs) to assist in accessing information on the processes surrounding obtaining Australian Medical Registration, Immigration assistance and Employment information all of which can be a little confusing and daunting when uprooting and moving to a new country especially with a family in tow.

Throughout the past year there has been a constant growth in engagement of the AMA Careers Advisory Service in both visitors to the website and those seeking individual consultations.

The most popular elements to date are related to the "application tools" for those applying for positions post-graduation. The Careers Consultant provides assistance with the important elements of every job application, resume, cover letter and then on to interview skills.

The Careers Service provides a resume review, cover letter review and interview skills assistance to both AMA members and also non-members. AMA members receive the benefit of a substantial discount on these services through their membership.

The application tools services have been particularly popular with those applying for Intern and Resident Medical Officer (RMO) positions; however, there has been a recent interest from doctors seeking a career change from clinical to non-clinical roles, full-time practice to part-time practice or a complete change in career and seeking advice on what opportunities are available dependent on their current skill set and experience.

New additions to the website in 2013 have included the Doctors in Training Profile page which is currently one of the most popular pages within the website. These profiles outline the journeys of several doctors through their medical career to date in a variety of settings including balancing work, life and family and all that comes with it, a medical career in the Australian Defence Force, the "theatre" life – from emergency to 'The Boy From Oz' and many more. It is thanks to the generous contribution of our local doctors that this page exists and it is with enthusiasm that we continue to seek further contributions to this section of the website in order to continue providing support, advice to our upcoming doctors and an overall good read for all those accessing the website. If you would your journey chronicled on the Careers website, please contact Kathryn Cassidy for further information.

Mentors for medical students and junior doctors are always needed and your support in assisting to nurture a junior colleague are always welcome and we encourage anyone interested in providing this support to newer colleagues to contact Kathryn Cassidy at the AMA Careers Advisory Service.

In order to access any of the services mentioned in this article or to read the Doctor in Training Profiles you can visit the website at http://careers.ama.com.au or contact the AMA Careers Consultant via the hotline 1300 884 196 or email careers@ama.com.au.

As this service is conveniently located in Canberra within the AMA ACT secretariat, Kathryn can be contacted on 6270 5410 during business hours.

Celebrating 30 years with the AMA

Past and present Members of the Board, colleagues, family and friends celebrated Christine Brill's 30 years with the AMA.

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