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Cannabis on prescription in the ACT?

Greens MLA and Speaker, Mr Shane Rattenbury has introduced a Bill to amend the ACT Drugs of Dependence Act to permit the use of medical cannabis.

The legislation, if enacted, would permit people suffering from chronic pain due to illness to legally use cannabis to self-medicate. It would also permit the person, or their nominated persons, to grow cannabis plants for that purpose. The legislation relates to botanical cannabis and does not include pharmaceutical or synthetic cannabinoids.

The Australian Medical Association, Cancer Council Australia are among others that support patients having access to cannabis in certain circumstances.

The discussion document states that eligibility to use cannabis for medical purposes would be strictly controlled. The intention is that cannabis possession and use be permitted only as treatment for people with genuine and serious illness.

As a "doctor", you will be required to declare that you agree that the illness and pain justifies the use of cannabis. The declaration will require you to include details such as: the applicant's medical condition; that you (the doctor) have discussed the likely risks and benefits of using cannabis; how the applicant would administer the cannabis and manage its use; and certification that the patient has tried or considered conventional treatments. The patient will then apply to the Chief Health Officer for a permit to possess and use cannabis.

Under the proposal there would be three categories of application for a permit to use cannabis:

Category 1 is for the mitigation of a symptom of a terminal illness or its treatment. The definition of "terminal illness" is a medical condition for which the prognosis is death within 1 year.

Category 2 is for the mitigation of symptoms of serious diseases or conditions. For example, the legislation lists diseases or conditions such as cancer, AIDS, HIV infection, spinal cord injury. The legislation allows for further diseases or conditions and symptoms to be prescribed in this category by regulation. The declaring "doctor" will need to be a specialist in the treatment of the patient's medical condition.

Category 3 is for the mitigation or other medical conditions or their treatment and include chronic and debilitating conditions. Two doctors will be required to complete the declaration and must be specialists in the area of medicine relevant to the treatment of the medical condition. Included in this category are, for example; glaucoma, Crohn's and Parkinson's diseases.

An application can also nominate a person who will help the person to administer the cannabis.

The Act permits a person to apply for a licence to cultivate cannabis which is renewable after one year. There are restrictions on who may apply for a licence, how much cannabis can be grown, both of which are intended to minimise potential abuse and misuse of the legislation.

The Netherlands, for example, highly regulate the cultivation and supply of cannabis for medical use to ensure pharmaceutical quality and accessibility to the treatment. States in the USA provide access to medical cannabis through shop-front dispensaries which sell the product.

The proposed ACT legislation does not provide for either of the above, but takes steps to allow people who are terminally ill and suffering to access cannabis as pain relief and treatment.

The Australian Medical Association's position statement acknowledges that cannabis has constituents that have potential therapeutic uses.

It acknowledges that there is a growing body of evidence that certain cannabinoids are effective in the treatment of chronic pain, particularly as an alternative or adjunct to the use of opiates, when the development of opiate tolerance and withdrawal can be avoided. Controlled trials have also shown positive effects of cannabis preparations on bladder dysfunction in multiple sclerosis, tics in Tourette syndrome, and involuntary movements associated with Parkinson's disease. Based on existing data, the adverse events associated with the short-term medicinal use of cannabis are minor. However, the risks Associated with long-term medicinal use are less well understood, particularly the risk of dependence, and any heightened risk of cardiovascular disease.

In short, the AMA believes that:

- Appropriate clinical trials of potentially therapeutic cannabinoid formulations should be conducted to determine their safety and efficacy compared to existing medicines, and whether their long-term use for medical purposes has adverse effects.
- Therapeutical cannabinoids that are deemed safe and effective should be made available to patients for whom existing medications are not as effective.
- Smoking or ingesting a crude plant is a risky way to deliver cannabinoids for medical purposes. Other appropriate ways of delivering cannabinoids for medical purposes should be developed; and
- Any promotion of the medical use of cannabinoids will require extensive education of the public and the profession on the risk of the non-medical use of cannabis.
- Prohibition of cannabis use with criminal penalties has the potential to produce harms and risks. The effectiveness of criminal prohibition of cannabis use in reducing the health-related harms associated with cannabis use is questionable.

Of necessity, the above report on the legislation is brief but full details on the legislation can be downloaded from the ACT Legislative Assembly website. It is noted too, that there is no definition of "doctor" within the draft Act although it is presumed the reference is to a qualified medical practitioner.

For the President's view on the legislation, see "Capital Conversations" on page 2 of this edition. This is a debate the profession should engage in prior to the legislation being debated in the Assembly.

Capital Conversations with President, Dr Elizabeth Gallagher

Prescribed cannabis

Over the past few weeks, local news (and my media requests) has been dominated by Shane Rattenbury's discussion paper and draft legislation on legalising marijuana for medical use in the ACT. We have included a good summary of the proposal in this addition of Canberra Doctor.

While I cannot deny there is mounting overseas evidence to support the use in certain medical conditions, my initial thoughts are that we cannot support this legislation in its current form. The first problem is that giving people permission to grow their own cannabis is a very crude way of delivering a product that is going to being used essentially as a prescription drug. There is no way to control dosage, or who gets access to it once the doors are closed. There is no way to monitor whether it is achieving its aim. Giving someone permission to grow and use an otherwise prohibited substance is also a big responsibility for us as doctors, and especially our Chief Medical Officer who is given final responsibility to "sign off".

There are still many unanswered questions about adverse effects of long term use. While this will not be an issue for those with a terminal condition – it could certainly be an issue for those with "chronic pain" and other non lethal conditions.

Certainly, if medical marijuana is to be made legal – it should be in the context of a trial, where the risks and benefits can be quantified, where the doses can be monitored, and the method of delivery can be directed, and administered in its safest form. Ideally, we would develop synthetic cannabinoids directed at the therapeutic benefits while bypassing the psychotropic and psychological effects.

The experience of "Medicinal Cannabis" overseas is quite variable. In some states of the USA touters stand outside the "Medicinal Marijuana Clinics" encouraging people in for their medical assessments. Heaven help us! In Canada on the other hand, Health Canada's cannabis is supplied by a company that specialises in growing, harvesting and processing plants for pharmaceuticals and research and produces a standardised, safe, homogenous supply of cannabis.

My general feeling is that this is an area that needs developing, but enacting the legislation in its current form goes against medical sense in terms of the motto "above all do no harm".

There have been a number of other local issues that have crossed my in-box and across the many meeting tables I have sat at over the past few weeks.

After hours general practice services

We have become aware that the National Home Doctor Service is opening a branch in Canberra in mid August. This is a private organisation that offers bulk-billed home visits and nursing home visits after hours from 6pm to 8 am Monday to Friday and weekends. As yet, we have had no contact with this organisation but the AMA is planning to join the Medicare Local to meet with them in the next week. The impact this will have on our local after-hours service CALMS is likely to be significant, and the impact on the GPADS will also need to be assessed. Watch this space!

Primary Health Networks

As most of you would be aware, the Federal Government announced a disbanding of the Medicare Locals from July 2015. Based on the recommendations of the Horvath Report, the Medicare Locals will be disbanded in favour of forming a smaller number of Primary Health Networks (PHN) to try and improve the service and efficiencies. They will not be a service provider. The details of what these organisations will look like, and what they are expected to do, is still not clear. Local organisations will be able to tender to provide the service, and the tender documents will be available later this year. Once released, we will have a better idea of what the government will expect from the PHN.

Currently, the AMA has attended a number of consultative and planning meetings, involving a wide range of primary health providers including allied health and hospital representatives, to try and gauge what interested parties would like to see make up our local PHN. While the current Medical Local is planning to submit a tender – it is not a given that they will be the only local organisation to do so. There is talk of private health insurers tendering as well. The AMA has concerns about the appropriateness of such an arrangement and the inherent conflicts of interest. The AMA ACT has made available and promoted its "blueprint" for the PHNs and it is hoped that these will provide a framework for both the PHNs and the GPs who are involved.

NSP at Alexander Maconachie Centre

We met with Shane Rattenbury in conjunction with representatives from Winnunnga Nimmityjah recently to try and keep the Needle Exchange Programe at the Alexander Maconachie Centre on the agenda. The Government, as well as the AMA are still committed to try and get this up and running, but trying to find common ground and support for a model that is acceptable to all parties in the space is still the biggest stumbling block. We need to try and prevent the transmission of Hep C within the jail, as it is not just an issue in jail – but these people will again become members of the community when they are released. This involves a duty of care to individual patients (whether they are incarcerated or not) as well as to Public Health in the wider community. Perhaps, in the future, the NSP will be as easily accepted as condom vending machines, which also created controversy (and are still banned in QLD) back in the day!

I wish you all the best and enjoy this edition of Canberra Doctor, till next month…

GP training under threat

In a recent letter to the General Practice Registrars Association (GPRA), AMA President, Dr Brian Owler and GPRA President, Dr David Chessor said:

"We are writing to inform you about changes to general practice training announced in the May Federal Budget, and discussions about these changes at a Forum convened by the AMA in Sydney on 18 July.

"Delegates to the Forum agreed that the AMA, GPRA and other stakeholder organisations should work together to ensure that GP registrars are not disadvantaged by the changes, and that the quality of general practice training is preserved.

"The sweeping changes announced in the May Federal Budget include:

- The abolition of General Practice Education and Training (GPET), with some of its functions being moved to the Commonwealth Department of Health.
- The abolition of Regional Training Providers, with their role being put out to a competitive tender process.
- The axing of the Prevocational GP Placements Program (PGPPP), which each year provides almost 1,000 junior doctors with valuable GP experience and services to communities, especially in rural areas.
- The creation of an additional 300 first-year GP training places from 2015 onwards.

"Registrars who attended the Forum welcomed the additional 300 training places but expressed grave concerns that the proposed changes take control and leadership of general practice training away from the profession. This risks fragmenting and reducing the quality of training in Australia, and has the potential to discourage junior doctors from choosing a career in general practice.

"Both the AMA and GPRA have already highlighted this risk in our discussions with the Government following the Budget.

"We have serious concerns that the Department of Health does not have the necessary experience or standing to run GP training programs. We fear the quality of training will be severely compromised.

"Clearly, the Government's changes will dismantle existing GP training infrastructure that has taken many years to put in place.

"The Government appears to be putting its faith in marketplace solutions.

"There are also very strong concerns that the Department of Health will not be able to implement these changes in the required timeframes.

"The messages that we took away from this Forum were clear:

- GP training must have strong professional oversight through the existing general practice colleges.
- The Colleges must have an expanded role in GP training to help fill the void that will be created by the loss of GPET.
- To ensure continuity and stability in GP training, the Government should defer the abolition of the Regional Training Providers while proper consultation takes place with the profession about the future structure and role of these organisations.
- Giving junior doctors the opportunity to undertake prevocational placements in general practice is highly beneficial. With the axing of the PGPPP, the profession must encourage the Government to consider alternative funding models to support this valuable experience.

"With much of the post-Budget focus being on the Government's co-payment plan, changes to GP training have clearly not received the public attention they deserve.

"We want to assure you that they are a priority for both our organisations and the future sustainability of a skilled general practice workforce for the nation.

"Without adequate, detailed consultation, the quality of GP training is clearly under threat and both GPRA and AMA are committed to working closely together to protect your interests, as well as the interests of junior doctors who will look to enter GP training in the future."

More support needed for teaching in general practice says AMA

AMA President, A/Prof Brian Owler, said recently that the future for family doctors living in and serving local communities in sufficient numbers depends very much on the capacity to attract medical students to pursue general practice, and be able to provide quality training experiences within general practice.

A/Prof Owler said that, despite a range of initiatives being in place to support GPs and practices to be involved in teaching and training, the number of practices teaching medical students, pre-vocational doctors, and GP registrars remains relatively low.

"Only 10 to 20 per cent of vocationally registered GPs are teaching or are being accredited to teach," A/Prof Owler said.

"The growing number of medical students and graduates is placing enormous pressure on existing teachers and practices to take on more students and trainees.

"The AMA has welcomed the May Budget decisions to provide $119 million to double the Practice Incentive Program Teaching Incentive for teaching medical students, and the $52.5 million in GP Infrastructure Grants, but this is not enough to build a long-term sustainable training program.

"A recent AMA survey shows that more needs to be done to address the barriers that discourage GPs and practices from being involved in teaching.

"Teaching students and GP registrars puts pressure on GPs to keep up with appointments, and this additional work goes largely unpaid and unrecognised."

A third of the AMA survey respondents highlighted the following impediments to providing GP teaching:

- lack of up-skilling opportunities;
- lack of administrative support to manage placements and funding arrangements;
- lack of non-financial recognition from training bodies;
- lack of space;
- teaching accreditation requirements;
- additional effort not recognised; and
- lack of time to up-skill.

"Despite the recognition of these barriers, the overall survey results suggest that GPs want to teach," A/Prof Owler said.

Radiation oncology critical for skin cancer treatment

The Royal Australian and New Zealand College of Radiologists (RANZCR) has recently highlighted the role of radiation therapy in the management and treatment of skin cancers.

Dean of the Faculty of Radiation Oncology, Dr Dion Forstner, gave evidence at the House of Representatives Standing Committee on Health, Inquiry into Skin Cancer in Australia.

Dr Forstner said, "Radiation therapy is a highly effective treatment for cancer, it is involved in around 40% of patients cured of their cancer including skin cancers.

"However, while almost half of all patients diagnosed with cancer in Australia could benefit from radiation therapy, only a third will actually access treatment.

"This under-utilisation has a number of contributing factors, but one of them is a lack of awareness of the treatment by patients and healthcare professionals.

"This is a tragedy – there is a highly advanced cancer treatment available for Australians, and thousands aren't being told about it.

"Because of this, the College is supporting the Radiation Oncology: Targeting Cancer campaign which aims to raise awareness of radiation therapy."

The Radiation Oncology: Targeting Cancer campaign aims to increase awareness among patients and healthcare professionals about the benefits of radiation therapy.

More information on the Radiation Oncology: Targeting Cancer campaign is available at www.targetingcancer.com.au

Former AMA president, Dr Mukesh Haikerwal to head AIHW

Eminent doctor and leader in the medical profession, Dr Mukesh Haikerwal, will be the new Chairperson of the Australian Institute of Health and Welfare (AIHW).

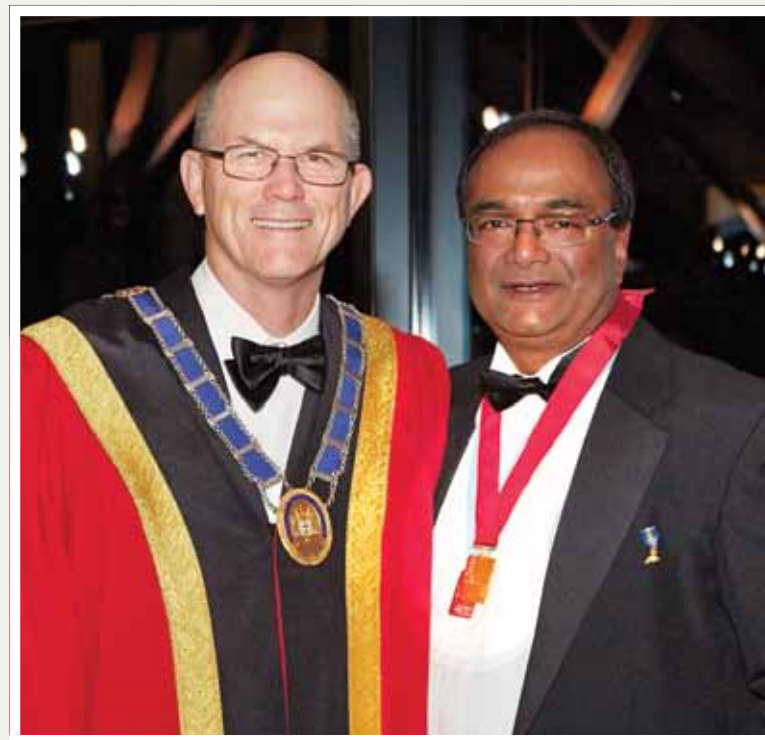
The Minister for Health, Peter Dutton, said the Governor-General, Sir Peter Cosgrove, had approved Dr Haikerwal's appointment for one year starting on 19 July 2014.

"Dr Haikerwal is highly respected in medical circles and is also an extremely experienced administrator," Mr Dutton said.

"He will be a great asset to the AIHW, Australia's premier source of data on health and welfare.

"He is a former national president of the AMA and current Chairperson of the World Medical Association Council.

"His interests in health are broad – he is also Chairperson of the Beyondblue National Doctors' Mental Health Programme and a member of the CSIRO Australian E-Health Research Committee."



Dr Mukesh Haikerwal and immediate past AMA president, Dr Steve Hambleton at AMA conference dinner in May

The AIHW is an independent statutory authority established in 1987, and accountable to the Australian Parliament through the health portfolio.

Its role is to provide the Australian Government and public with reliable, regular and relevant information and statistics on Australia's health and welfare.

Dr Haikerwal was awarded the Order of Australia in 2011 for distinguished service to medical administration, to the promotion of public health through leadership roles with professional organisations, to the reform of the Australian health system through the optimisation of information technology, and as a general practitioner.

New report shows cancer one of the leading causes of alcohol-related deaths

A new report showing that cancer was one of the leading causes of alcohol-related deaths in Australia should help raise public awareness of alcohol as a significant cancer risk factor, according to Cancer Council Australia.

CEO Professor Ian Olver said the new report, *Alcohol's burden of disease in Australia*, published by the Foundation for Alcohol Research and Education and VicHealth, added to the growing evidence base that showed alcohol consumption was one of the most preventable causes of cancer.

"We have long known that alcohol causes as many cancer deaths in Australia as melanoma, yet the level of public awareness is low," Professor Olver said. "Australians who choose to drink should try to stay within the National Health and Medical Research Council guidelines and have no more than two standard drinks a day.

"There are plenty of good reasons to moderate consumption – and preventing cancer is one of the most significant of them.

"Today's report adds a new and alarming perspective by calculating that cancer is the cause of 25% of all alcohol-related deaths in Australian men and 31% of alcohol-related deaths in Australian women – making cancer one of the leading causes of all alcohol-related deaths.

"The number of alcohol related cancer deaths is similar to the number of alcohol-related deaths attributed to injury. When people contemplate the risks they take when consuming alcohol, they need to think about cancer, as well as all the other potential causes of death that are attributable to alcohol consumption."

According to the World Cancer Research Fund, American Institute for Cancer Research *"Food, nutrition, physical activity, and the prevention of cancer: a global perspective"* there is convincing evidence that alcohol causes cancers of the breast, mouth, pharynx, larynx and oesophagus in men and women and bowel cancer in men. Alcohol is also a probable cause of bowel cancer in women and liver cancer in men and women.

(Note: WRCF classifies evidence at different levels, with the highest being 'convincing' and second being 'probable'. There is an overview of the different classifications at http://wiki.cancer.org.au/policy/WCRF_classifications)

Sexual health physicians support HIV home test kits

Sexual health physicians from The Royal Australasian College of Physicians (RACP) have welcomed the introduction of HIV home test kits in Australia, saying they are likely to increase testing rates and help reduce the spread of HIV.

Dr Lynne Wray, President of the RACP's Australasian Chapter of Sexual Health Medicine (AChSHM) said allowing the registration and sale of HIV home test kits via the Therapeutic Goods Association (TGA) will reduce the numbers of people purchasing non-regulated and unreliable kits via the internet.

The benefits of HIV home test kits outweigh the potential risks.

"If we are to reduce all new HIV transmissions in Australia by 50% by the end of 2015, we must remove every barrier to HIV testing for those Australians currently undiagnosed," Dr Wray said.

Individuals likely to access home testing may not identify with particular community groups where sexually transmitted infection (STI) health education efforts have typically been concentrated.

"So it's important that appropriate educational resources are developed to target 'hard to reach' populations such as young men that may not identify as gay, migrant groups and Indigenous people," Dr Wray said.

There is also a need to consider how the registration and sale of HIV home test kits will impact on the surveillance and monitoring of HIV testing and positivity rates.

The Department of Health and the TGA should therefore explore options for registering sales levels of HIV home-test kits in Australia, including their location of sale.

Dr Wray acknowledged the potential for invitro diagnostic devices (IVDs) to render higher false results, especially amongst low HIV-prevalence populations.

"These risks can be mitigated by ensuring home test kits have appropriate information about their limitations and highlight the importance of a follow-up test with a general practitioner (GP) or sexual health clinic," Dr Wray said.

The RACP welcomed the Federal Government's national strategy for increased testing and treatment for HIV and other STIs, but said more needs to be done. The RACP also recommends:

- Federal Government funding of rapid 30 minute HIV testing by a GP and at sexual health clinics through Medicare;
- Integrating sexual health into primary care services in rural and remote areas;
- Supporting an increase in the number of S100 drug prescribers in these areas; and
- Working with states and territories on legislative changes to allow patient-delivered partner therapy for the treatment of chlamydia and other STIs across Australia.

The Government's co-payment model – dialogue continues

Constructive discussions

A/Prof Brian Owler, said his meeting with Peter Dutton to discuss the AMA's alternative plan to address concerns with the Government's proposed co-payments for general practice, radiology, and pathology services had been constructive.

A/Prof Owler said the AMA had been a strong critic of the Government's co-payment plan since it was announced in the May Budget, and has explained its concerns face-to-face with the Prime Minister, the Health Minister, and the Treasurer in recent weeks.

"The AMA has highlighted the harmful impact of the Government's proposed co-payments on the elderly, the chronically ill, the poor, and Indigenous Australians," A/Prof Owler said.

"We have also highlighted how the proposals would disadvantage medical practices.

"The AMA has enjoyed positive dealings with the Prime Minister, the Treasurer, and the Health Minister over our concerns, and this spirit of cooperation was in evidence again last night in my talks with Mr Dutton.

"The Minister has agreed to have his office and his Department examine our alternative proposals.

"We have been quite open that our plan will not deliver the savings that the Government sought with its Budget proposals.

"Instead, we have offered the Government a fairer and more equitable plan. We have proposed a health policy, not an economic policy.

"The Minister said the Government will continue to engage the AMA over the way forward with its co-payment proposals.

"We will meet again soon, once the AMA alternative plan has been properly considered by the Minister and his Department," A/Prof Owler said.

General practice leaders welcome government negotiations on proposed co-payment model

General practice leaders have welcomed the Government's willingness to negotiate on the proposed $7 co-payment model for general practice services at a recent meeting of United General Practice Australia (UGPA) held in Canberra.

In May, UGPA publically called for an overhaul of the proposed co-payment model, concerned over the potential impacts on Australia's most vulnerable populations' access to healthcare and the divestment of general practice services.

The Australian Medical Association (AMA) has been requested by Prime Minister, The Hon. Tony Abbott MP, to propose an alternative co-payment model.

UGPA supports the AMA in leading negotiations with government on an alternate model on behalf of general practice with the AMA committed to working with UGPA as discussions progress.

The AMA indicated its negotiations with the government will be centred on the following principles:

- No cuts to Medicare Benefit Schedule (MBS) patient rebates for general practice, pathology and imaging services
- The need to protect vulnerable patients, including children to ensure timely and clinically appropriate access to general practice services at no detriment to the general practitioner
- Improving the value patients place on general practice services, recognising it is reasonable for those with appropriate means to share in the costs of accessing general practice care.

UGPA is committed to work alongside the AMA in finding a workable solution to the proposed co-payment model.

A/Prof Brian Owler, has referred to the highly-respected Byte from the Beach report from the University of Sydney as providing further evidence that the Government's proposed co-payment for GP, radiology, and pathology services, and increased co-payments for medicines, will hit vulnerable patients the hardest.

A/Prof Owler said the Byte from the BEACH report is the first to clearly quantify the likely impact of the Government's Budget measures for health.

"This is the sort of research that the Government should have conducted before the Budget," A/Prof Owler said.

"The report shows the cost impact for patients who have the types of conditions that must be properly managed in the community to avoid more costly hospital treatment," A/Prof Owler said.

"It highlights that older Australians, who generally need more medical care, will be hardest hit by the co-payments.

"The current proposal not only lacks protection for the vulnerable, such as the elderly and those with chronic disease, it actually affects them more than other people in the community.

"People will put off seeing their doctor and their conditions could worsen, placing greater pressure on already overstretched public hospitals."

A/Prof Owler said that the AMA is encouraged that the Government is showing signs of having another look at some aspects of the current co-payment model.

"The Prime Minister and the Health Minister have acknowledged that there may be issues for residents of aged care facilities," A/Prof Owler said.

"Following my recent meeting with the Prime Minister, the AMA is working on some alternatives that protect the most vulnerable.

"The AMA acknowledges that GP services are undervalued, and that a form of co-payment may be appropriate.

"We have accepted the Government's invitation to provide alternative models that promote health policies such as chronic disease management and preventive health care, and which value general practice, radiology, and pathology services.

"It is important that people, especially the most vulnerable in the community, are not discouraged from seeing their doctor.

"It is equally important that we avoid health policies that either directly or indirectly put pressure on the capacity of our public hospitals," A/Prof Owler said.

Australia has a high rate of hospital admissions compared to countries such as the United States, Canada, the United Kingdom, New Zealand and Japan.

A National Health Performance Authority report identified nine chronic conditions that were associated with avoidable hospitalisations in 2011-12 – including asthma, diabetes complications, lung disease, angina, and high blood pressure.

There were also avoidable hospitalisations associated with acute and vaccine-preventable conditions – dehydration; a perforated or bleeding ulcer; ear, nose and throat infections; dental conditions; and influenza and pneumonia.

It is no surprise that the NHPA found higher rates of avoidable hospitalisations in lower socio-economic communities.

There is plenty of evidence that co-payments affect patients' access to medical care, and medication adherence.

Following an increase in the PBS co-payment in January 2005, there was a significant decrease in dispensing volumes in 12 of 17 medicine categories – anti epileptics, anti-Parkinson's treatment, combination asthma medicines, eye drops, glaucoma treatment, osteoporosis treatment, proton-pump inhibitors and thyroxine.

All of these medications seek to maintain a patient's condition, improve function and the quality of life, prevent complications and reduce morbidity and mortality. The same study also found that social security beneficiaries were particularly affected by the increase in the co-payment.

There are clear relationships between cost sharing, adherence, and outcomes. Increases in a patient's share of medication costs was significantly associated with reduced adherence to treatments for diabetes, cardiovascular, mental health, and pulmonary conditions.

Increasing the level of patient cost sharing for medical care and prescription drugs to slow the rising cost of health care is short-sighted and counterproductive because increases in medical utilisation due to poorer outcomes may outweigh the savings.

Majority of Australians say 'no way' to $7 co-payment

An alarming number of Australians have confirmed they will avoid visiting their GP if the $7 co-payment is implemented, driving costs to more expensive areas of the healthcare system according to research commissioned by the Royal Australian College of General Practitioners (RACGP).

The independent survey of a broad cross section of the Australian general public was conducted to identify and determine public sentiment on healthcare issues resulting from the introduction of a co-payment model.

The research found 76% of respondents believe the introduction of the co-payment will result in visiting their GP less.

RACGP President, Dr Liz Marles said the results confirm the fear that if implemented, a co-payment model will leave Australia's most vulnerable populations behind in a healthcare system that forces patients and GPs to absorb the cost of primary healthcare delivery.

"All of the research findings support the mounting body of evidence that patients will choose to avoid or delay seeing their GP if the co-payment is implemented as a result of increased out-of-pocket costs.

"This has a profound flow on affect, with patients likely to heavily rely on more expensive hospital services after failing to seeking timely care at the primary healthcare level.

"Families, the elderly, those with a chronic disease and Australia's most vulnerable populations will be particularly hard hit, with the reality of the co-payment so much more than a nominal $7 payment here and there," said Dr Marles.

The research also found more than 56% of respondents said they oppose the general practice co-payment.

"The government has failed to deceive the public about the true economic impact of the co-payment, with the research findings affirming it is of genuine concern to the vast majority of Australians.

"The government has also neglected to adequately communicate to the public that by requesting for the co-payment to be waived, the GP directly absorbs this cost. Under this model, the delivery of healthcare will always be at the detriment of someone.

"Despite abundant evidence that a co-payment model is not a viable solution, the government continues to ignore expert and public opinion detailing the harmful implications a co-payment model will have on our communities," said Dr Marles.

The research results also revealed that 71% of the general public want the RACGP and GPs to publicly oppose the co-payment and lobby the Government to abandon the idea.

"Since it was first rumoured in December, the RACGP has been a vocal advocate against the introduction of a co-payment model and demanded the preservation of access to universal healthcare.

"The RACGP has been meeting regularly with government since the Federal Budget announcement, reaffirming its opposition to any model that is likely to exacerbate health inequalities or present an additional barrier to accessing clinically appropriate and timely healthcare services and seeks direct involvement in negotiations about any funding options that impact GPs and their patients.

"Support for the RACGP's social media awareness campaign #CoPayNoWay has been unprecedented with the medical community and patients alike taking to these platforms to express their concern," said Dr Marles.

This research, conducted by Sweeney Research, focused on consumers only and excluded anyone who worked in a medical practice as a doctor, nurse, receptionist, administrator or similar, or lived with someone in such an occupation or profession.

Key research findings:

- Three in four respondents (76%) believe the introduction of the proposed $7 co-payment will result in people visiting their GP less.
- More than a half of all respondents oppose the introduction of the co-payment, with those that visit their GP more than 7 times a year most likely to oppose the model.
- Six in ten (60%) of respondents would ask their GP to waive the co-payment, with those most likely to ask including those studying full time, unemployed and those earning less than $41K.

- 46% of the public believe the RACGP should publically oppose the co-payment, with 25% wanting the RACGP to lobby the government to abandon the idea.

Correction to media reports

It was recently reported that the Health Minister, Peter Dutton, said in a media doorstop:

"Before the election, I discussed with Dr Hambleton and the now President Professor Owler the Government's interest in a co-payment".

The AMA has confirmed there were no discussions of co-payments with then AMA President, Dr Steve Hambleton, or then AMA NSW President, A/Prof Brian Owler, prior to the 2013 Federal Election and the Minister has since corrected his earlier statement to reflect this.

The AMA has confirmed the Australian Centre for Health Research (ACHR) issued a paper early this year advocating a GP co-payment. The AMA was publicly critical of the ACHR model, and shared those criticisms in correspondence with the Minister.

The National Commission of Audit recommended a similar co-payment model shortly before the May Budget. The AMA was strongly critical of this proposal, too.

These seriously flawed co-payment proposals were raised in discussions and correspondence with the Minister.

Five days before the May Budget, the Minister flagged with A/Prof Owler that he would be introducing a co-payment but provided no details of the amount, who would be affected, or what services would be covered. A/Prof Owler was AMA NSW President and an Executive Councillor at that time.

The Government's current co-payments for general practice, radiology and pathology services – as proposed in the May Budget – were never discussed with the AMA prior to Budget day.

The AMA attacked the Government's co-payment proposals in its response to the Federal Budget, and has been consistent and forthright in its criticism of the proposals ever since.

Ebola watch

Australia has one of the best border protection systems in the world checking people who are unwell in flight and at the airport.

These systems have been rigorously tested with both the SARS outbreak and the more recent Swine Flu pandemic of 2009.

Since the ebola outbreak the Department of Health has been in contact with all Border Protection agencies to alert them to look out for the possibility of ebola when identifying a person landing in Australia who is unwell.

Advice on ebola virus disease for the public, GPs, clinicians, and laboratories have been posted on the Department's website and been widely disseminated to state and territory health authorities and medical colleges and associations (http://www.health.gov.au/internet/main/publishing.nsf/Content/ohp-ebola.htm)

A meeting has also been convened of the Communicable Diseases Network of Australia, consisting of the key infectious diseases doctors, with all state and territory health authorities represented to discuss the possibility of the disease coming to Australia and ways to respond.

The Australian Government Department of Health assesses the likelihood of ebola being imported to Australia as very low. To assist with ongoing analysis of that risk, Health is actively monitoring the epidemiology of the outbreak, with a particular focus on the potential spread of the disease.

If in fact there was a suspected case, Australia has sophisticated, high-end laboratory diagnostic capability at Physical Containment Level 4 (PC4 – the highest level), which provides laboratory space, testing facilities, diagnostic methods, and highly trained virology and medical science staff capable of handling ebola and other viruses that cause viral haemorrhagic fever.

While the possibility of ebola coming to Australia is very low, Australia's Chief Medical Officer, Professor Chris Baggoley and his team in the Office of Health Protection are closely monitoring the overseas outbreak and Australia's domestic response.

According to International SOS, The largest ever outbreak of ebola virus is currently underway in three countries in West Africa (Guinea, Liberia, and Sierra Leone). The disease is spreading person to person, causing significant international concern and disrupting both the health and economy of these countries as well as neighbouring nations. The capital cities of all three nations are affected and in late July, the World Health Organization declared the outbreak a Grade 3 emergency, its highest level of any emergency response.

This outbreak began in Guinea. The first case there occurred in December 2013, though it was not reported to the World Health Organization and identified as ebola until March 2014. This significant delay means that control measures were not enacted for months, allowing the virus to take hold in the community. Soon after the disease was brought to international attention, cases were also reported in neighboring Liberia. This progression was upsetting but not unpredictable: borders in the affected area are often porous, with people walking from one nation to another on a daily basis.

Control measures were enacted in both countries, and seemed effective. By the beginning of April, disease activity slowed. It looked like the outbreak was heading to its end.

However, unexpectedly, cases spiked again in late May. New areas were affected. ebola struck people in areas that had never had an ebola infection before. The disease also intensified in places where people had previously been infected.

The disease also began actively spreading for the first time in Sierra Leone in late May. New cases continue in all three affected countries and beyond: Nigeria reported the first imported case in late July, in a man who had flown internationally.

The World Health Organization states there is a high risk that the outbreak will spread to other countries that border Guinea, Liberia and Sierra Leone and a moderate risk that other countries in the West African subregion will be affected. Infrastructure limitations will contribute to international spread, as it is difficult to implement health measures at border points or to effectively trace and monitor contacts of ebola patients. People may travel from one area to another to seek healthcare, which is limited in some places.

This ebola outbreak is not under control, and resources and personnel are stretched in trying to handle the situation. Cultural concerns also play a role: some people in these countries do not believe ebola is an actual disease. Others are unethically selling a counterfeit "vaccine" to protect people (there is no vaccine for ebola). Conspiracy theories circulate. Misinformation and mistrust make it difficult to implement national and international health measures – which are critical to bringing the disease under control.

Travel Advice for Australians

- The Australian Government through Smartraveller (smartraveller.gov.au) advises all Australians to reconsider their need to travel to Liberia, Guinea, and Sierra Leone. This reflects the seriousness of the outbreak, the challenges in containing it, and the evolving travel restrictions.
- The Australian Government will have very limited capacity to provide consular assistance in these circumstances, and any medical evacuation would be very difficult to conduct.
- Travellers should be aware of the increasingly serious restrictions on travel:
- Some regional airlines in West Africa have curtailed services to limit the possible spread of the disease.
- Liberia has closed the majority of its borders in an effort to combat the spread of Ebola, and ordered non-essential civil servants to remain at home.
- Sierra Leone has imposed a 60 to 90 day state of emergency in affected-areas to combat the spread of disease. This will involve movement restrictions enforced by the military and police.
- Many countries in Africa and further afield have started to put in place heightened health scrutiny of passengers arriving from affected areas.
- The Department of Foreign Affairs and Trade, in consultation with the Department of Health, continues to issue regular updates on the Ebola outbreak, in addition to our country-based advisories. The last update was sent by email to subscribers and posted on social media on 31 July.
- Australians who choose to travel to Ebola-affected areas in West Africa should familiarise themselves with the travel advice at Smartraveller, register their details on this website before departing Australia and contact their insurance provider to check their details of coverage.
- Approximately 50 Australians have registered on the Smartraveller website for the three countries affected, with several hundred in neighbouring countries. We note that the actual number of Australians in these countries may be higher.

Areas of West Africa affected by Ebola as of 3 July 2014 – CDC.

International SOS

Australian Government
Department of Health

HealthPathways: whole of system working

In the May issue of Canberra Doctor, *HealthPathways* was introduced as a new ACT Medicare Local and ACT Health initiative 'enabling general practice and specialists to work together to manage patients'. *HealthPathways* has now expanded to incorporate Southern NSW with new partners Southern NSW Local Health District and Southern NSW Medicare Local coming on board.

HealthPathways has the potential to make fundamental improvements to health care in the ACT and Southern NSW region and it is important for GPs and specialists to be involved in getting the system working as a whole.

To provide you with an opportunity to gain firsthand information, a clinician-focussed ***HealthPathways* Familiarisation Event** will be held on **Tuesday 26 August 2014 (evening event)** at the **Canberra Business Event Centre, Regatta Point.** This will provide ACT and NSW GPs and specialists with information and case study exposure to the benefits of *HealthPathways*. It will also provide an opportunity to hear from local clinicians as well as from GPs from elsewhere in Australia and NZ who are utilising *Health Pathways*. There will also be two similar regional events held in Southern NSW on Wednesday 27 August and Thursday 28 August. General practices and a number of specialist disciplines (those likely to be associated with initial health pathway clinical topic development) have already received formal invitations.

ACT and NSW GPs and specialists are contributing their expertise to the development of health pathways, with work well underway for diabetes, breast cancer shared care, adult sexual assault, needlestick injury and HIV PEP. Health pathway development for heart failure, COPD, liver conditions and back pain is in the planning stage. A survey will be going out to GPs shortly that will seek views about which pathways should be considered as priorities for early development.

To express interest in any of the above activities and/or for further information including a Familiarisation Event Invitation and Program, please contact healthpathways@actml.com.au and a *HealthPathways* team member will be in touch.

HealthPathways will be launched on clinicians' desktops later this year.

medicare local ACT

Connecting health to meet local needs

Feedback invited on Cancer Services Plan

Act Health and Southern NSW Local Health District have released their Cancer Services Plan for consultation.

The draft plan is available on the ACT Health and Southern NSW LHD's website and consultation closes on 10 September.

It is known that cancer is already a leading cause of premature death. Despite advances in screening, treatment and in survival rates it has been estimated that cancer will continue to be a leading contributor to the burden of disease as the population ages.

ACT Health in collaboration with Southern NSW Local Health District (SNSW LHD) is developing a new strategic plan for the delivery of cancer related services to residents of the ACT and surrounding region of NSW.

The draft ACT and Southern NSW Local Health District Cancer Services Plan sets out a vision for providing integrated, high quality cancer care and support services to residents of the ACT and surrounding region of New South Wales over the next five years.

This consultation phase ensures that a broad range of stakeholders are targeted to provide input towards the strategic directions identified for cancer related services and consumers are able to participate more fully in decisions which affect the quality of health services that they or their family member receive through ACT Health and SNSW LHD.

Reviewing the Draft Plan and providing feedback enhances service providers and service planners' ability to understand the range of perspectives and expectations regarding the organisation and delivery of health care services.

Feedback is sought on the strategic directions and proposed high level actions identified to improve population health outcomes and systems and programmes.

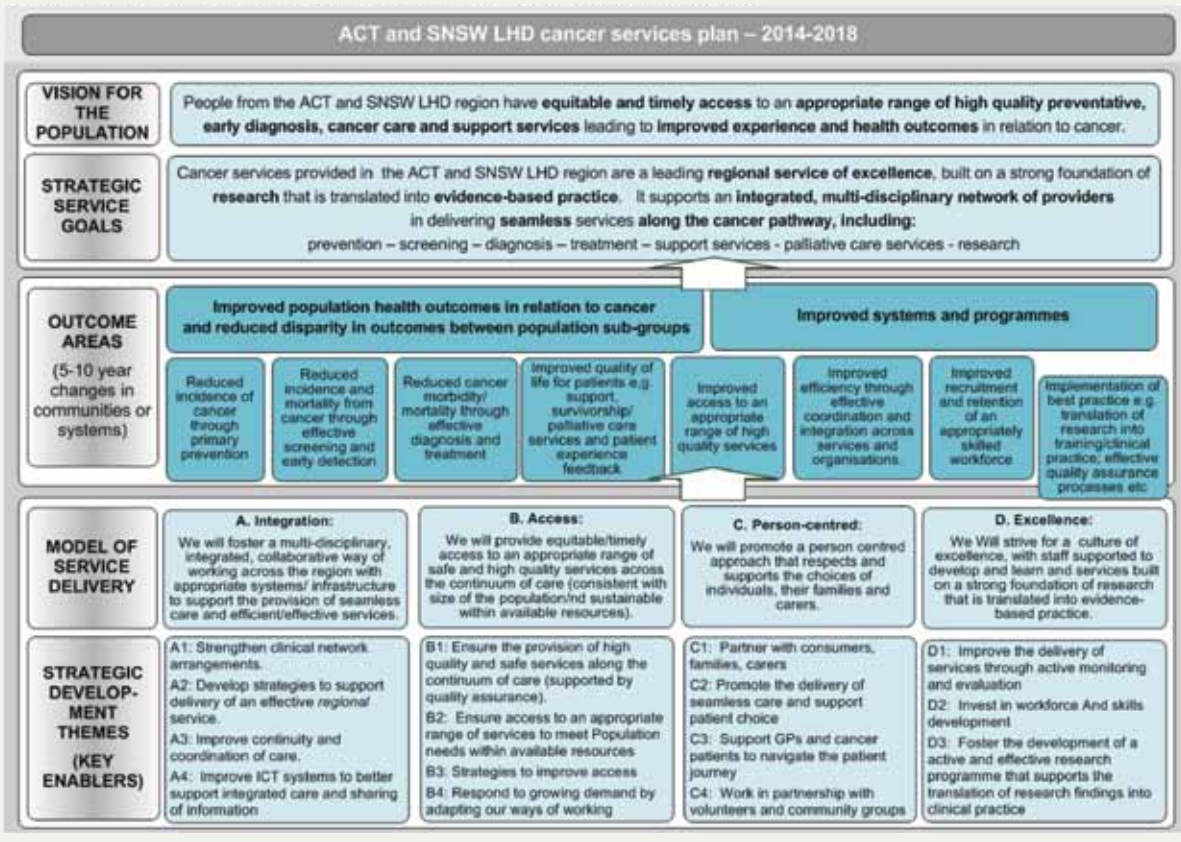
A summary of the plan is shown below as the "Outcomes Framework".

Feedback from the consultation process will be themed and considered by the Plan's Steering Committee. Consideration of feedback incorporated into the Final Plan will be documented.

For full details visit http://www.timetotalk.act.gov.au/ and responses can be emailed to HealthPlanning@act.gov.au or by mailing to GPO Box 825, Canberra ACT 2601. For further information contact Health Services Planning Unit on 02 6205 0863.

ACT Government Health

NSW GOVERNMENT Health Southern NSW Local Health District



Medical Colleges and AMA speak out on detention of asylum seekers

The AMA has joined RACP and RACGP in renewing calls for the establishment of an independent medical advisory body to monitor and oversee the treatment of asylum seekers in detention. This call follows shocking revelations at the national inquiry into immigration detention recently.

The AMA has consistently advocated for better medical treatment of asylum seekers, and have urged successive governments to improve transparency and accountability regarding the health of children and other asylum seekers in detention.

The AMA president, A/Prof Brian Owler, said the AMA was alarmed at the reports of serious and prolonged mental health issues affecting child asylum seekers in particular.

"The AMA has long called for openness and honesty about the state of physical and mental health of all asylum seekers in detention in Australian care," he said. "It is our duty to act compassionately and ethically to these vulnerable people, many of whom have fled conflict and danger."

He reiterated the association's previous calls for a highly qualified, independent panel of medical experts to regularly visit detention centres, assess the health services and the health status of detainees, and report back directly to the Parliament.

"Such a process would help the government fulfil its human rights obligations in regard to asylum seekers," A/Prof Owler said.

Call to government to be open and transparent

RACP President Professor Nicholas Talley said Dr Peter Young's evidence highlighting the significant mental health issues amongst children and young people in detention was deeply concerning.

"I am even more alarmed at the evidence from Dr Peter Young that the Federal Government requested figures showing the true extent of these mental health concerns be suppressed," Professor Talley said.

"We urge the Federal Government to be open and transparent regarding the health of children in detention."

The RACP says the decision by the Federal Government in December last year to disband its expert advisory body on the health of people seeking asylum was unjustified.

"Expert independent immigration health advice is needed now more than ever. The Government must start acting on the recommendations and advice of health experts to protect children in immigration detention."

RACP paediatrician, Associate Professor Karen Zwi, who visited Christmas Island and gave evidence to the AHRC inquiry in May, said the reports of delays in transferring people in detention from Christmas Island to receive appropriate medical care must be addressed immediately.

"It seems from today's evidence that the health of children has deteriorated even further since our last visit. We are also particularly concerned about the unaccompanied children, who have no family to protect them or advocate for them," Associate Professor Zwi said.

"Considering the Minister is their legal guardian, one must question whether he can be acting in their best interests in implementing the current policies.

"Today's evidence presented at the public must not be ignored and I urge the Minister to visit Christmas Island so he can see for himself the deteriorating health of children locked up in detention."

The RACP is calling on the Federal Government to remove every child from Australian immigration detention to protect their health.

RACGP says 'enough is enough'

The Royal Australian College of General Practitioners (RACGP) is also concerned by the prolonged detention of asylum seekers, maintaining the Government has failed to uphold its ethical obligations in accordance with international law and human rights standards.

The RACGP is strongly opposed to the policy of restrictive mandatory detention, in particular the detention of children, and calls on the Government to protect these vulnerable individuals and their families without delay.

RACGP President, Dr Liz Marles said a standard of living that supports health and wellbeing, including access to appropriate medical services, is a fundamental human right.

"The Australian Government must treat asylum seekers as a humanitarian rather than a political issue.

"The majority of those in detention have unique mental and physical healthcare needs as a consequence of the circumstances they have fled and these are further exacerbated by a prolonged period of uncertainty in detention.

"The primary care staff in these facilities, many of whom are GPs, are continuing to work in ethically challenging environments.

"As a consequence, GPs may not be able to uphold the appropriate clinical and ethical standards of quality patient care, because of the restrictions of these settings.

"There is a substantial body of evidence, which demonstrates that detention, particularly prolonged detention causes negative physical and mental health consequences for asylum seekers.

"We know there are more humane ways of processing those who arrive on our shores seeking asylum and it is our duty to ensure these people, particularly children, are treated ethically and with respect.

"The act of holding children in restrictive detention must cease as an urgent priority and the RACGP recommends the standard model of care be one of community residence where families are kept together and they have access to appropriate and priority medical services.

"The RACGP is urging the Government to action immediate policy reform and increase efforts to improve the speed and efficiency of refugee status assessment for all asylum seekers," said Dr Marles.

The RACGP calls for the establishment of an independent mechanism for the oversight and review of healthcare service provision in all detention facilities and processing centres and remains committed to ensuring the most vulnerable patients, regardless of their status or circumstances, are protected and treated equitably.

New national campaign targets doctors: Women Want to Know

Did you know that 97% of Australian women wanted to be asked about alcohol use in pregnancy?

Most women visit a health professional when they are pregnant for advice on a range of health and lifestyle topics, alcohol being one of them. These visits present the ideal opportunity to discuss alcohol consumption and reinforce that not drinking alcohol during pregnancy is the safest option.

However, some medical professionals are reluctant to discuss alcohol with women, because they are concerned that women may feel uncomfortable, or they are unsure of what advice to provide and where to refer women if necessary. A new national campaign known as Women Want to Know, aims to overcome these barriers by educating medical professionals about the effects of alcohol consumption during pregnancy to ensure that women are fully informed.

As part of the campaign a pre-intervention survey was undertaken with 100 General Practitioners (GPs) which found that:

- The majority (80%) of GPs believe that pregnant women cannot drink any alcohol without risk to fetus, 14% said that a pregnant woman could drink two to three standard drinks per day, 1% said a woman could drink three to four standard drinks a day and 5% said they didn't know.
- The vast majority (89%) of GPs said that they would discuss alcohol consumption with a woman who is pregnant for the first time, fewer (74%) said they would discuss alcohol with a woman in her second or subsequent pregnancy and less than half (43%) would discuss alcohol with a woman of childbearing age.
- Less than a third (31%) of GPs said they had never heard of the Australian Alcohol Guidelines and only 3% were very familiar with the content of the guidelines.

When asked about what advice they provide to women about alcohol consumption during pregnancy, 87% of GPs said that they advise abstinence, but other statements included:

- One standard drink a day as a maximum
- Abstain in the first trimester
- Avoid or limit to 1-2 standard drinks per week
- Max 1 standard drink twice per week

These results reveal that the majority of GPs do talk to women about alcohol and pregnancy, but that few GPs are familiar with the Australian Alcohol Guidelines. As a consequence women are receiving a range of messages about alcohol consumption during pregnancy and this highlights the need to provide clear and consistent advice to women. Conversations about alcohol with women who are pregnant or planning pregnancy are important as these can assist women to stop or reduce their alcohol use and prevent adverse consequences from occurring.

Alcohol is linked to several adverse effects in pregnancy including miscarriage, premature birth, low birth weight and Fetal Alcohol Spectrum Disorders (FASD). FASD has severe lifelong consequences for the child including physical and behavioural deficits. For these reasons the National Health and Medical Research Council's Australian Guidelines to Reduce Health Risks from Drinking Alcohol (Alcohol Guidelines) recommend that for women who are pregnant or planning pregnancy, not drinking is the safest option.

The Alcohol Guidelines are supported by evidence from systematic reviews and prospective cohort studies which have not been able to ascertain a safe level of alcohol consumption and no known level of alcohol consumption has been found where damage to the fetus will not occur.

More information about Women Want to Know and the resources that have been developed is available at www.alcohol.gov.au. Women Want to Know has been developed by the Foundation for Alcohol Research and Education (FARE) in collaboration with leading health professional bodies including the AMA and the Royal Australian College of General Practitioners (RACGP).

FREE print materials and online training for medical professionals is also available through www.alcohol.gov.au

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